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

Thu 24 June 2021, 09:30 - 12:30

The Lombard Room, Hotel du Vin, Crescent Rd, Royal Tunbridge Wells, Kent TN1 2LY

NHS
Maidstone and Tunbridge Wells
NHS Trust

Agenda

06-1
To receive apologies for absence

David Highton

06-2
To declare interests relevant to agenda items

David Highton

06-3
To approve the minutes of the 'Part 1' Trust Board meeting of 27th May 2021

David Highton

Board minutes, 27.05.21 (Part 1).pdf (9 pages)

06-4
To note progress with previous actions

David Highton

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

06-5
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

06-6
Report from the Chief Executive

Miles Scott

Chief Executive's report - June 2021.pdf (2 pages)

Integrated Performance Report

06-7
The Integrated Performance Report (IPR) for May 2021

Miles Scott and colleagues

IPR for May 2021 (incl. planned and actual ward staffing).pdf (32 pages)

Planning and strategy

06-8
To approve the capital plan for 2021/22

Steve Orpin

To approve the Capital Plan for 2021-22.pdf (10 pages)

06-9
Approval of the Full Business Case (FBC) for the Laboratory Information Management System (LIMS)

Miles Scott

Approval of the FBC for the LIMS.pdf (136 pages)

Quality items

06-10
To approve the Trust's Quality Accounts, 2020/21

Claire O'Brien

To approve the Trust’s Quality Accounts, 2020-21.pdf (119 pages)

06-11
Quarterly mortality data

Peter Maskell

Quarterly mortality report - June 2021.pdf (23 pages)

Assurance and policy

06-12
Infection prevention and control board assurance framework

Sara Mumford

IPC Board Assurance Framework - June 2021.pdf (45 pages)

06-13
Update from the Senior Information Risk Owner (SIRO) (incl. approval of the Data Security and Protection Toolkit submission for 2020/21, and Trust Board annual refresher training on Information Governance)

Claire O'Brien

Siro Report to Board - June 2021.pdf (9 pages)

Reports from Trust Board sub-committees

06-14
Quality Committee, 09/06/21

Sarah Dunnett

Summary of Quality C'ttee, 09.06.21.pdf (1 pages)

06-15
Patient Experience Committee, 10/06/21 (incl. an update on End of Life Care)

Maureen Choong

Summary of Patient Experience Committee, 10.06.21 (incl. update on End of Life Care).pdf (24 pages)

06-16
People and Organisational Development Committee, 18/06/21

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 18.06.21.pdf (2 pages)

06-17
Finance and Performance Committee, 22/06/21

Neil Griffiths

N.B. The report will be issued after the meeting on 22/06/21.

06-18
Audit and Governance Committee, 23/06/21

David Morgan

N.B. The report will be issued after the meeting on 23/06/21.

06-19
Audit and Governance Committee Annual Report 2020/21

David Morgan

Audit Committee Annual Report 2020-21.pdf (8 pages)

Annual Report and Accounts

06-20
To approve the Annual Report, 2020/21 (incl. the Annual Governance Statement)

David Morgan

Annual Report 2020-21 (incl. Gov. Statement).pdf (88 pages)

06-21
To approve the Annual Accounts 2020/21

David Morgan

Annual Accounts 2020-21.pdf (50 pages)

06-22
To approve the Management. Representation Letter, 2020/21

David Morgan

Management Representation Letter 2020-21.pdf (4 pages)

06-23
To consider any other business

David Highton

06-24
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 27TH MAY 2021, 9:45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	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 (N.B. Joined during item 05-8 – refer to the specific minute for details)	(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)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Isabel Gilbert	Assistant General Manager - Cancer Performance (for item 05-12)	(IG)
	Katie Goodwin	Divisional Director of Operations, Cancer Services (for item 05-12)	(KG)
	Doug Ward	Director of Estates and Facilities (for item 05-11)	(DW)
	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]

05-1 To receive apologies for absence

Apologies were received from Sean Briggs (SB), Chief Operating Officer; and Sarah Dunnett (SDu), Non-Executive Director.

05-2 To declare interests relevant to agenda items

KC declared that she was the Vice Chancellor of the University of Kent, which had relevance to item 05-10.

05-3 To approve the minutes of the 'Part 1' Trust Board meeting of 29th April 2021

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

05-4 To note progress with previous actions

The content of the submitted attachment was noted and the following actions were discussed in detail:

- **04-7 ("Provide Trust Board members with details of the support available to staff members affected by long COVID").** SS reported that there were three clinical definitions and all staff with a positive COVID-19 test result were contacted by the Occupational Health team, while those suffering from long-term issues were offered support. SS also reported the number of staff that had taken up the offer. It was therefore confirmed the action could be closed.
- **04-9 ("Arrange for the Trust Board to receive a considered response to the challenge posed at the Trust Board meeting on 29/04/21 as to where environmental impact should feature within the Trust's future objectives").** MS reported that the Trust's Green Plan would be discussed under item 05-11, so proposed that the objectives within that Plan be discussed at

that point, as these objectives would be part of the Trust's 'business as usual' objectives. DH therefore confirmed that the action could be closed.

- **04-10 ("Arrange for the recommendations in the "Nursing & Midwifery staffing review" that was discussed at the Trust Board meeting on 29/04/21 to be considered by the Executive Team, and notify the Trust Board of the response/outcome").** COB stated that the report and recommendations would be reviewed within the senior nursing team and it was intended to develop a programme of work to address each recommendation. COB continued that some of the recommendations would be included as part of the mid-year staffing review, which would be submitted to a future Trust Board meeting. COB added that she intended to submit some recommendations to be considered by the Executive Team Meeting (ETM) by the end of June 2021, and sooner if that was possible. It was therefore confirmed the action should remain open.

05-5 Report from the Chair of the Trust Board

DH referred to the 'go live' for the Electronic Patient Record (EPR), which was scheduled for 16/06/21, and stated that the EPR Programme Board and Finance and Performance Committee had received positive assurance regarding the implementation, and he looked forward to the Trust Board receiving a positive report on progress at its next meeting.

DH also commended staff for enabling the Trust to return to its pre-COVID-19 activity levels, which was a great achievement.

DH then referred to the submitted report and highlighted the appointment of three new consultants, in Obstetrics & Gynaecology and Oncology. DH also noted that future interviews had been scheduled, which reflected the Trust's continuing ability to attract high-quality consultants.

05-6 Report from the Chief Executive

MS referred to the submitted report and highlighted the key points therein, which echoed DH's' sentiments regarding the EPR, noting that PM was the Senior Responsible Officer (SRO). MS also reported that the "MTW story", which set out the key organisational priorities for the next 12 months and beyond, had been launched, and the launch had been attended by over 200 members of staff. MS continued that the next step in the process was called "catchball". EPM asked MS for further details of the "catchball" process and MS provided the requested explanation. DH pointed out that the process had been delayed because of the COVID-19 pandemic, so by the time the process was completed, there would only be circa six months left in 2020/21. AJ acknowledged the point and confirmed that the objectives that would be set would last until the end of 2021/22, and discussions had commenced regarding the objectives beyond that period.

Integrated Performance Report

05-7 Integrated Performance Report (IPR) for April 2021

MS introduced the report and invited colleagues to report on each domain. COB then referred to the "Safe" domain and reported the following points:

- It was intended to apply the Statistical Process Control (SPC) method to the safe staffing data, and work was taking place with the Business Intelligence team regarding that.
- Falls remained an area of concern, and the Lead Nurse for Falls Prevention was undertaking proactive work with relevant clinical teams following the higher number of patient falls that had been experienced on certain wards.

PM added further details of falls and confirmed that falls would feature as a breakthrough objective with the quality "true north", and the aforementioned "catchball" process would finalise the details, although he expected falls to feature as a priority for the Medicine & Emergency Care and Surgery Divisions. PM continued that he had tasked the clinical lead for falls to provide details of what lessons could be learned from other Trusts, and the National Audit of Inpatient Falls, and consider further action that could be taken.

COB then continued and highlighted the latest position regarding pressure ulcers.

PM then referred to “Effective” domain and reported the following points:

- The ‘Getting It Right First Time’ (GIRFT) process had been reinstated following the COVID-19 pandemic, and it would focus on High Volume, Low Complexity (HVLC) procedures. The Trust would therefore focus on such aspects.
- The 12-month rolling Hospital Standardised Mortality Ratio (HSMR) had increased, and the Chief of Service for Medicine & Emergency Care had informed the last Quality Committee meeting that he believed the cause of the issue was more to clinical coding issues.

PM noted that he had stated at the last Trust Board meeting that a mortality report would be submitted to the Trust Board meeting in May 2021, but KR had pointed out that the report was not scheduled for consideration until the Trust Board meeting in June 2021, so further details of the situation would be provided at the that point.

PM then reported the latest position regarding stroke, and noted that although he had previously reported that the Trust remained within its stroke bed base, he had discovered, through his on-call duties, that there were increasing pressures on that bed base. PM did however note that the mechanical thrombectomy service was progressing very well.

DH asked whether the pressure on community beds had made it more difficult to discharge stroke patients when they reached their rehabilitation phase. PM confirmed that no such concerns had been escalated to him as Medical Director.

MS then noted that he would ask SM to report the infection control issues aspects of the “Safe” domain under item 05-14.

COB then referred to “Caring” domain and reported the following points:

- Complaints response performance had been challenging recently, and the number of complaints had increased, as had been expected following the COVID-19 period.
- The Friends and Family Test (FFT) response rates were not as wanted, but work would take place to increase the focus over the coming weeks.

MS then referred to “Responsive” domain and reported the following points:

- In terms of emergency access and performance, April had been an excellent month, despite emergency activity returning to pre-COVID-19 levels. There had however been pressure in May, and emergency demand was now significantly greater than before the pandemic. Despite that, the Emergency Department (ED) 4-hour waiting time target performance was still over 90% each day. The reported pressures on General Practice were very real, and MS understood that some practices had seen 20% more activity than they would have expected in March. Discussions would therefore continue with the Integrated Care Partnership (ICP).
- Cancer access target performance had also been strong, but the increase in cancer referrals had continued.
- For elective activity, the key issue to note was the reduction in patients waiting longer than 52 weeks for their treatment. However, the aforementioned rise in referrals meant that more and more patients were moving into each of the waiting list categories.
- In summary, activity and capacity levels were back to pre-COVID-19 pandemic levels, but demand was increasing, so the Trust needed to consider this in the context of any potential third wave of COVID-19 cases.

MS then also reported the Children’s Services directorate had seen an increase in patients who required mental health support and transfer to a dedicated mental health facility, but there was a shortage of such facilities. MS continued that the team had been able to manage, but if the assumptions regarding the expected more ‘normal’ next winter proved to be accurate, the service would be very extremely challenged by such activity, so Trust Board members needed to be aware of such challenges.

EPM then referred to MS’ comments regarding GP activity and the impact on the ED, and the comment in the IPR that “…where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs” and asked if that was having an impact on patients’ behaviour towards primary care and ED. MS replied that one of the key

questions for the use of virtual appointments was whether the Trust was just managing the current situation or progressing patients' treatment. MS continued that clinicians had stated that some appointments would be more effective if they could be held face-to-face, particularly where a physical examination was required; while certain specialties, such as cancer, had found there to be overall benefits from the use of virtual appointments. PM gave his further perspective and noted that face-to-face appointments were often considered to be required if bad news needed to be given. PM also noted that demand for primary care service had definitely increased and there was some evidence that demand for ED had been adversely affected by patients not being able to see their GP face-to-face, which was a different situation from outpatient follow-up appointments. PM stated that he would meet with the Local Medical Committee (LMC) in the near future to discuss primary care demand.

JW then referred to the tier 4 Child and Adolescent Mental Health Services (CAMHS) and noted that the situation described by MS was an Integrated Care System (ICS) issue, which had been a problem for several years, so asked whether it was a priority for the ICS. MS explained the context, and the shortage of specialist staff, and noted that discussions were being held on alternative solutions to providing beds, which included provided additional support within patients' homes. JW asked whether CAHMS was one of the nationally commissioned services that would be transferred to ICSs. MS agreed to check and confirm.

Action: Check and confirm whether Child and Adolescent Mental Health Services (CAMHS) was one of the nationally-commissioned services that would be transferred to Integrated Care Systems (ICSs) to commission (Chief Executive, May 2021 onwards)

MS then referred to the financial aspects of the "Well-led" domain & reported the following points:

- SO had worked hard to ensure that the Trust had submitted a balanced financial plan.
- The Trust intended to get ahead of the national productivity agenda and develop its Cost Improvement Programme (CIP), so discussions were being held with all budget holders.

SS then referred to the workforce aspects of the "Well-led" domain & reported the following points:

- There had been a marked increase in the use of agency staffing across the Trust, but that trend had started to reduce, although the position would continue to be monitored.
- The nurse and Clinical Support Worker (CSW) recruitment plans had been developed further, which included the pipeline for international recruitment.
- The People and Organisational Development Committee had undertaken a 'deep dive' review regarding staff retention, which was a priority for the Kent and Medway ICS, and a range of collaborative work was being considered.

EPM asked whether the patient falls data had been triangulated with safe staffing data, to identify whether there was a link. COB confirmed that was part of the safe staffing data with the IPR, and elaborated that although staffing had returned to 'normal' levels, the number of falls had still increased. COB also gave further details of certain actions, such as "bay watch", where a member of staff stayed within a bay at all times, to monitor the patients within that bay.

Planning and strategy

05-8 <u>Update on 2021/22 planning</u>

AJ referred to the submitted report and highlighted the following points:

- The Trust was engaged with the truncated planning round for the first six months of 2021/22, and the report reflected the intended final planning position as of 20/05/21, but there were still some aspects that were not yet resolved.
- The plans were intended to be submitted to the Clinical Commissioning Group (CCG) on 01/06/21, and they would be submitted upwards on 03/06/21.
- The Trust had been reassured by its modelling for elective activity, so it was proposed that the planning submission be based on such modelling, rather than on conservative estimates against the targets set by NHS England/Improvement (NHSE/I).
- One of the final elements to resolve was the deployment of the EPR, the effect of which had been modelled and in total these changes were only expected to cause a 0.88% variance to

total activity in June 2021. The operational teams had however been challenged to ensure that the modelling was as accurate as possible.
- Another element to be finalised was that an element of oncology activity that had not been fully recognised in the first draft plan. That was being investigated but it was expected that the outpatient trajectory would decrease slightly, but the Trust would still meet the NHSE/I target.
- Further elements not yet finalised were the Independent Sector Provider (ISP) activity; and the impact of the ophthalmology service that used to be provided at Dartford and Gravesham NHS Trust by Moorfields Eye Hospital NHS Foundation Trust.

DH noted that the actual data for April 2021 showed that the Trust was delivering 99% of inpatient elective activity, and 88% of day case activity, so asked whether the differences meant that clinical prioritisation and longer waiting times meant that there were more inpatients among those waiting a long time for treatment. AJ stated that the data for day cases in April 2021 would have been closer to 92%, if the position on endoscopies had been taken into account in the Trust's baseline. DH acknowledged the point but observed that there would be a higher preponderance of inpatients among those waiting over 52 weeks for their treatment.

[N.B. SO joined the meeting at this point]

AJ then continued and highlighted the following points:
- For the 52-week wait position there would be a negative effect of patients currently waiting in the over 18- and 26-week categories becoming 52-week breaches.
- The colonoscopy plan had deteriorated as the Trust was not providing the bowel scope service that had been active in 2019/20. The Trust had requested that such activity was removed from the Trust's baseline, and if that request was granted, that would have a significant positive effective on the plan.

DH acknowledged the difficulty of the planning process but commended the work involved by AJ and his team.

SO then referred to the submitted plan and highlighted the following points:
- The Trust had submitted a balanced plan, which had to address the £13m difference between the original demand that had been made of the Trust, to make a £5m surplus, and the Trust's original forecast outturn of an £8m deficit.
- The ICS had now removed the requirement for the Trust to have a surplus of £5.1m and some additional actions had been taken to remove some risks from the delivery of the financial plan.
- However some risks still remained, one of which was that the plan assumed additional income from Kent and Medway CCG for stroke (£1.4m) and Prime Provider (£5.4m) which had not yet been confirmed

RF referred to the statement in the report that "Kent and Medway CCG has confirmed funding to MTW which was £6.1m lower than previously expected" and asked for further details. SO explained the intricacies of the process and noted that many of the discussions regarding the assumptions that the Trust had made would, ordinarily, be discussed 'behind the scenes', but the tight timescales by which the plan needed to be developed had meant that some of the differences between the Trust's assumptions, and the CCG's assumptions, had been reflected more formally in the planning submissions. DH pointed out that the ICS was in a transition period in relation to its commissioning and system management roles, and that would inevitably have an impact on the planning process. SO confirmed that was correct but noted that the Trust was a part of, and had a voice in, that system. SO also reported that there was an intention to return to pre-COVID-19 funding levels, and that would lead to challenges across the ICS.

JW referred to the Elective Recovery Fund (ERF) and asked whether SO was confident that the assumed income of £2.2m would be received. SO explained that the ERF framework was set nationally, but the ICS had confirmed that it would underwrite such funding, so SO had assessed that aspect as a "Low" risk. SO also highlighted that the ERF was a non-recurrent source of funding so it had no impact on the Trust's underlying funding. MS however stated that he chaired the elective activity workstream for the ICS and all provider Trusts had confirmed they expected to deliver their ERF targets, so he did not expect ERF funding to be a pressure for the ICS.

05-9 The 'go live' for the Sunrise Electronic Patient Record (EPR)

PM referred to the submitted report and highlighted the following points:

- The report had already been considered by the Finance and Performance Committee and the ETM, and the latter continued to be closely involved in the EPR implementation, via weekly reports. PM also met twice per week with the Programme Director for EPR (Sunrise) and Digital Transformation and the Director of IT to address any problems as they arose.
- The Trust Board meeting was the last before the scheduled 'go live' and PM wanted to acknowledge the considerable work that had been undertaken by all staff across the Trust.
- Some of the numbers within the report were understandably now out of date, as the position was fast moving.
- Staff training was a risk, and the target suggested by Allscripts was 80% of staff trained. If those already booked in were included, the Trust's rate would be over 50%, and with the intended training levels, there was some confidence that the 80% would be achieved. The rate in ED was at 71%, which would go live first.
- The fifth round of User Acceptance Testing (UAT) had identified some issues, but these were being worked through & PM was confident that these would be addressed ahead of the 'go live'
- Order Comms was an area where some unpredicted problems had arisen.
- The other red-rated area was the Windows 10 rollout, and the IT team had worked tirelessly to ensure the equipment was in place before the go live. PM was again therefore confident that the issues that had emerged would be addressed.
- There was much activity in relation to communications and further details were contained within the submitted report.
- Work was taking place with Directorates, in response to a request made at the ETM for a 'star chamber', to ensure the operational risks that may occur have been considered and that appropriate mitigating actions were in place.
- 420 Change Ambassadors / One Team Runners had been engaged to support the implementation.

DH welcomed the engagement of the Change Ambassadors, as that would be a great help.

NG confirmed that the implementation had been considered in detail by the Finance and Performance Committee on 25/05/21, and assurance had been given. NG however referred to training and asked why the target had not been achieved. PM stated that he believed part of the reason was the approach to not 'strongarm' staff to undertake the training, but there was an increasing realisation of the need to take a stronger stance.

NG also asked how the benefits realisation would be captured and PM explained the approach.

RF emphasised that there would definitely be a reduction in performance because of the change in practice that the EPR would entail. RF also commented that beyond training, he had not seen much reference to educational support that would be provided. PM stated that he hoped the Change Ambassadors would provide such support.

RF also asked what support would be provided when problems occurred, as they inevitably would. PM elaborated on the approach that would be taken and COB added further details. RF welcomed the assurance, but stated that it needed to be acknowledged that these were, according to the report, the highest risks, so focus needed to be applied. DH agreed and noted that he understood the process would provide an early warning of any problems, should, for example, certain areas be submitting paper-based forms.

05-10 Strategy Deployment – corporate objectives for 2021/22

AJ referred to the submitted report and highlighted the key points therein, which included the latest position with the targets and KPIs in the "Breakthrough Objectives", and the relationship with the aforementioned "catchball" process with the Directorates. AJ illustrated his point by elaborating on the "Quality" True North, for which PM was the lead. AJ clarified that it was not yet therefore possible to provide the Trust Board with full details of the final KPIs.

AJ then elaborated on the development of the KPIs within the “Corporate Projects”, and stated that the process was expected to be completed when the “catchball” process was completed, on 28/06/21.

MS pointed out that page 3 of 12 contained an old label for the “Breakthrough Objectives” as “Quality” would not be used. The point was acknowledged.

EPM asked where the “Breakthrough objectives” and “Strategic Initiatives” would be monitored and AJ explained the approach. EPM also asked when the Trust Board would see the final version. AJ confirmed that the earliest time would be the Trust Board meeting in July 2021. DH however pointed out that there was a Trust Board ‘Away Day’ in July 2021, so it should be possible to devote some time at that Trust Board ‘Away Day’ to the issue.

Action: Ensure that a discussion of the Strategy Deployment/corporate objectives for 2021/22 was scheduled at the Trust Board ‘Away Day’ on 12/07/21 (Trust Secretary, May 2021 onwards)

MC observed that the sustainability objective on page 3 of 12 read like the Trust wanted to increase temporary staffing. SO confirmed that objective had since been amended. MC also noted that the same page contained acronyms of “AEC” and “NEL”. AJ confirmed that any acronyms would be spelled out in the final version.

DM asked whether the KPIs would be subject to SPC. AJ confirmed that would be the case, and SPC formed a key part of the associated training. DH added that he assumed the reporting against the strategic deployment would be important, so the grouping of the SPC charts and indicators would be expected to change to match the Strategy Deployment work rather than the Care Quality Commission (CQC) domains. MS confirmed that would be the case, but the Trust Board would primary see reporting that focused on the six strategic themes.

05-11 <u>Annual approval of the Trust’s Green Plan</u>

DW referred to the submitted report and highlighted the key points therein, which included the sustainability vision, and the drivers for change. DW then reported that the Trust had, in 2016, set a target of a 28% reduction in scope 1 and 2 carbon emissions by 2020/2021 against a 2013/14 baseline, and the Trust had exceeded that target a year early, in March 2020. DW added that he intended to submit the Trust’s work for a Health Service Journal sustainability award.

DM commented that he often saw a disconnect between organisations signing up to long-term targets, such as being net zero by 2050, so asked how far the Trust could go with current knowledge. DW stated that he believed the key aspects for the future was not the current form of electrification, which he believed would be relatively short-lived, but the use of hydrogen fuel cells, which released energy without emissions. DH suggested that the Green Plan include more forward-looking aspects when it was next considered. However, MS instead proposed that he liaise with DW to ensure that a specific response was provided to DM’s queries. This was agreed. DM clarified that he was interested in what actions the Trust was able to do, and what actions others needed to do.

Action: Liaise with the Director of Estates and Facilities to ensure that a specific response was provided to the queries posed about the Trust’s Green Plan at the Trust Board meeting on 27/05/21 (Chief Executive, May 2021 onwards)

RF asked how the Green Plan linked with the Exceptional People Outstanding Care work. MS stated that the objectives in the plan resided within the ‘business as usual’ objectives, which meant that they did not require improvement resources but would still be subject to monitoring and appropriate escalation. RF asked whether that meant there would be something on the Green Plan within the IPR. MS explained the approach. RF stated that he was content with the exception reporting approach, provided that appropriate escalation was in place for the KPIs i.e. that the relevant issue would be escalated to the relevant sub-committee or Trust Board. DH noted that not everything could be a priority.

The Trust’s Green Plan was approved as submitted.

05-12 To approve the proposal for a Maggie's Centre to be built at Maidstone Hospital

KG referred to the submitted report, highlighted the key points therein, and confirmed that the Trust Board was asked to approve the next steps to proceed, which included the identification of a location at Maidstone Hospital (MH).

DH asked DM whether he had anything further to report, given the Charitable Funds Committee's recommendation to the Trust Board that the project be approved. DM stated that the key issue was the need to align the proposed location for the Centre with the Site Development Plan, to ensure the selected location was 'future-proofed'. AJ highlighted that DW had drafted a Development Control Plan, as part of the Trust's draft Estates Strategy, and had committed to providing an updated version in the near future, so AJ gave assurance that chosen location would be 'future-proofed'. DH added that he had been on site and DW had introduced him to the new person that had been appointed to focus on project governance and Development Control Plans, so additional resource had been allocated.

RF emphasised that the demand on the Trust's Cancer Services was linked to the continuing care required by cancer patients, so the proposed Centre would help the Trust at a low cost. The point was acknowledged.

The proposals were approved as submitted.

Quality items

05-13 Quarterly update on progress with the Perinatal Mortality Review Tool (PMRT)

COB referred to the submitted report and highlighted the following points

- All perinatal deaths were reported to the "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) programme.
- The work was linked to the work the Women's, Children and Sexual Health Division had undertaken in response to the Ockenden report of the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust.
- The Trust was working with the Local Maternity System (LMS) with regards to strengthening external assessment of the perinatal mortality reviews.

KC asked for further details on the issues relating to access to senior medical expertise, and also asked whether there were any trends of concern. COB confirmed there were no trends of concern, but noted that the Division had a comprehensive risk management process, and there were always lessons to be learned.

Assurance and policy

05-14 Infection prevention and control board assurance framework

SM referred to the submitted report and highlighted the following points:

- The volume of new infection guidance that had been issued had reduced.
- The restrictions that had been in place for those visiting hospital inpatients had been released.
- It was hoped that new guidance would be issued regarding expected behaviour in hospitals, particularly given the anticipated move to the next step in the government's COVID-19 response roadmap on 21/06/21, as some challenges had been seen with regards to patients wearing face masks within the hospitals.

05-15 NHS provider licence: Self-certification for 2020/21

KR referred to the submitted report and highlighted the following points:

- NHS Trusts were required to self-certify against the licence for providers of NHS services at that time each year, and the timescales had not been affected by the COVID-19 period.
- The evidence to support compliance against the licence conditions would usually be included in the Trust's Annual Report, and in particular the Annual Governance Statement, rather than in a separate report to the Trust Board. However, because the timetable for the Annual Accounts for 2020/21 had been deferred, the Annual Report for 2020/21 had not been submitted to that

month's Trust Board meeting, as would usually be the case. The draft Annual Report and Annual Governance Statement had however been reviewed by the Audit and Governance Committee on 13/05/21. The draft Annual Governance Statement for 2020/21 had therefore been submitted to support the proposed self-certification, and supplement the various other sources of evidence that had been received by the Trust Board and its sub-committees throughout the year.
- The self-certification did not need to be submitted to NHSE/I but was required to be posted on the Trust's website.
- NHSE/I may select a small number of NHS Trusts for a follow-up review of the evidence used to support their self-certification.

Questions were invited. None were received. The Trust Board then approved the proposed self-certification for 2020/21 as submitted.

Reports from Trust Board sub-committees

05-16 Extraordinary Charitable Funds Committee, 07/05/21

DM referred to the submitted report and highlighted that the key points had been covered under item 05-12, as the proposal for a Maggie's Centre to be built at MH that was the only issue that had been considered. Questions were invited. None were received.

05-17 Quality Committee, 12/05/21 (incl. approval of revised Terms of Reference (annual review))

MC referred to the submitted report and highlighted that the revised Terms of Reference had been submitted for approval. Questions were invited. None were received.

The revised Terms of Reference were approved as submitted.

05-18 Audit and Governance Committee, 13/05/21 (incl. approval of revised Terms of Reference)

DM referred to the submitted report and highlighted that the revised Terms of Reference had been submitted for approval. Questions were invited. None were received.

The revised Terms of Reference were approved as submitted.

05-19 People and Organisational Development Committee, 21/05/21

RF referred to the submitted report and highlighted the key points therein, which noted that it had been the first meeting under the Committee's new 'deep dive' format. Questions were invited. None were received.

05-20 Finance and Performance Committee, 25/05/21

NG referred to the submitted report and noted that many of the issues discussed at the meeting had already been covered during the Trust Board meeting. Questions were invited. None were received.

05-21 To consider any other business

There was no other business.

05-22 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]
04-10	Arrange for the recommendations in the "Nursing & Midwifery staffing review" that was discussed at the Trust Board meeting on 29/04/21 to be considered by the Executive Team, and notify the Trust Board of the response/outcome.	Chief Nurse	April 2021 onwards	The recommendations from this work have been discussed at the Corporate Nursing senior team meeting and it has been agreed that the Deputy Chief Nurse will develop a plan that sets out the key actions that are being taken forward. This will be submitted to the Executive Team Meeting (ETM) before 25/07/21.
05-11	Liaise with the Director of Estates and Facilities to ensure that a specific response was provided to the queries posed about the Trust's Green Plan at the Trust Board meeting on 27/05/21.	Chief Executive	May 2021 onwards	A written update will be submitted to the Trust Board meeting in July 2021. In addition, Key Performance Indicators (KPIs) on implementing the Green Plan will be included among the 'watch metrics' feeding into the Strategy Deployment Review (SDR) process.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-7	Check and confirm whether Child and Adolescent Mental Health Services (CAMHS) was one of the nationally-commissioned services that would be transferred to Integrated Care Systems (ICSs) to commission.	Chief Executive	June 2021	There are no proposals or discussions for CAMHS commissioning to be devolved to any ICS at present, as the commissioning has only just been devolved to Provider Collaboratives. Sussex Partnership NHS Foundation Trust is the Lead Provider for collaborative contracts for the Trust's geographical area.
05-10	Ensure that a discussion of the Strategy Deployment/corporate objectives for 2021/22 was scheduled at the Trust Board 'Away Day' on 12/07/21.	Trust Secretary	June 2021	A "Walkthrough of the various components of the Exceptional People Outstanding Care programme" item was already scheduled for the Trust Board 'Away Day' on 12/07/21. That item was therefore extended to

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				include a discussion of the Strategy Deployment/corporate objectives for 2021/22.

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 scheduled 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
02/06/2021	Consultant Paediatric Ophthalmologist	Christos	Moraitis	Ophthalmology	To be confirmed
09/06/2021	Consultant Paediatric Neonatologist	Adina	Olariu	Paediatrics	To be confirmed
14/06/2021	Consultant Intensivist	Andrew Robert	Bailey	Anaesthetics	To be confirmed
16/06/2021	Consultant Physician - 7-day service	Andrew Callum	Ross-Parker	Medicine	To be confirmed
16/06/2021	Consultant Physician - 7-day service	Kumudhini	Giridharan	Medicine	To be confirmed
16/06/2021	Consultant Physician - 7-day service	Justin Alexander	Fegredo	Medicine	To be confirmed
16/06/2021	Consultant Physician - 7-day service	Andrew Kimba	Coutinho	Medicine	To be confirmed
16/06/2021	Consultant Physician - 7-day service	Babiker Elnur	Babiker	Medicine	To be confirmed

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. Our recovery programme is continuing to progress well and we have now treated over three quarters of the number of long waiting patients in the last few months. We have seen emergency activity recover to pre-Covid numbers with our Emergency Departments still placing within the top ten nationally. Our Emergency Departments across both sites continue to be very busy with average weekly attendances of 4,371 patients – we experienced the busiest ever week for attendances in the week ending 13 June. The teams saw 303 patients within the 24 hour period at each site on consecutive days. An enormous thank you goes out to all colleagues across the Trust for their tireless efforts in our recovery work and continuing to provide outstanding care.

2. Our new Electronic Patient Record system launched on 16 June across our clinical areas, with extensive communication and support in place for staff as they move over to the new way of working. This new system will bring change to the way we work across the whole Trust and key benefits will include saving time and improving the uniformity of notes. Thank you to all colleagues who have been involved in this work it is a fantastic achievement.

3. Our consultant recruitment position is now at its best for several years - this is a reflection of our improvement journey and our attractiveness as an employer. This month we have also launched a Theatre staff recruitment drive – you can watch the video here. I wish to thank our team in Recruitment and colleagues across the Trust for progressing these areas of work.

4. We continue to invest in the training and development of our staff. Just recently we have upskilled 13 colleagues at the Trust to become Systemic Anti-Cancer Therapy (SACT) trained staff nurses enabling them to deliver chemotherapy for patients, with all types of cancer. The qualification also certifies the nurses to deliver consultations to patients prior to, and between cycles of chemotherapy, enabling doctors to focus on other areas of care, with the newly trained SACT nurses working across both sites. This is an extremely specialised area in treatment as it requires such an intense course of extra learning, so to be able to welcome on-board such a large group of expertly trained staff is fantastic news for the Trust and our patients. Our dementia champions across the Trust have this month undertaken dementia simulation training, providing them with experience of what living with dementia might be like, and helping them understand how simple changes to our clinical practice and the hospital environment can improve the hospital experience for those living with dementia.

5. Congratulations to Maria Haynes (GI Consultant Biomedical Scientist) who has been approved by the Kent and Sussex Deanery to become a clinical supervisor, subject to completion of training. She is the first Biomedical Scientist in the country to be approved for this role and will see Maria formally train Speciality Registrars (StRs) in the dissection of specimens across the major specialities such as gastro-intestinal, skin, gynaecology, urology and head and neck. Another example of how the Trust is leading the way in the development of Advanced Practitioner roles.

6. Our Radiology team at Tunbridge Wells Hospital are to be congratulated as they have improved further on their target of delivering urgent CT scans for patients with head injuries within 60 minutes of arrival in our Emergency Department. The current compliance (with NICE Head Injury Guidelines) is 88% compared with a national average of 49% - fantastic work by all involved.

7. On 25 June we will be opening our upgraded Aseptic Unit based at Tunbridge Wells Hospital - this provides a sterile controlled environment for preparation of specific injectable medicines including chemotherapy and non-chemotherapy products such as monoclonal antibodies. The modern facilities will provide increased capacity, to enable us to meet the growing demands for injectable chemotherapy products, expand the compounding of monoclonal antibodies and introduce the compounding of other non-chemotherapy products such as Central Intravenous Additives (CIVAS). Tom Tugendhat, local MP for Tonbridge and Malling, will join us to officially open the unit on 25 June.

8. The Trust is celebrating Pride this month, with flags flying at both sites to show support for our LGBT+ community and a range of events are in place for colleagues here at MTW organised by our LGBT+ Network.

9. Our Cultural and Ethnic Minorities Network (CEMN) has been very busy this month hosting events for all MTW colleagues to join, including a conversation with David Sellu, Hon. Consultant, St. Mark's Hospital London, on "Regulation & The Law in Medicine and the disproportionate impact on BAME Colleagues". The next meeting is planned for 24 June where the guest will be Steve Orpin, our Deputy Chief Executive/Chief Finance Officer. We are now halfway through the Reverse Mentoring programme in which we have BAME staff members from across MTW mentoring our Executive Board, including myself. We have received very positive feedback to date from all involved and the programme is encouraging some very honest and open conversations.

10. I wish to say a huge thank you on behalf of the Trust to our Chief Nurse Claire O'Brien, who is retiring this month. Claire has worked in the NHS for 41 years, joining MTW in 2016. She has been an exceptional member of the Trust Executive team and will be greatly missed by all of us here at MTW. On behalf of everyone at the Trust I would like to wish Claire a very happy retirement.

11. Congratulations to the winner of the Trust's Employee of the Month scheme for May – Olufunsho (Tutu) Otenaike. On behalf of the Trust Board I would like to say thank you to Olufunsho for her fantastic work to help support our colleagues and patients.

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

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for May 2021	Chief Executive / Members of the Executive Team

The IPR for month 2, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 22/06/21 (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

May 2021

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.

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

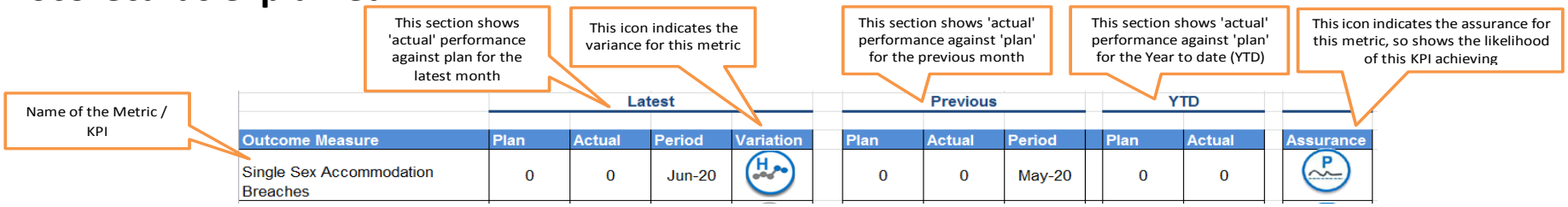
Maidstone and Tunbridge Wells NHS Trust

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



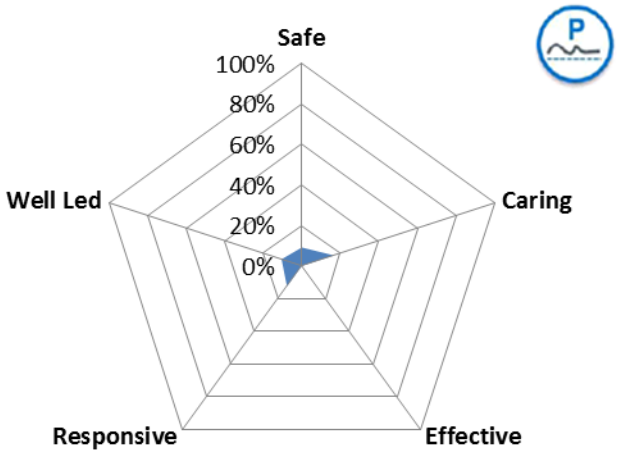
Further Reading / other resources

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:

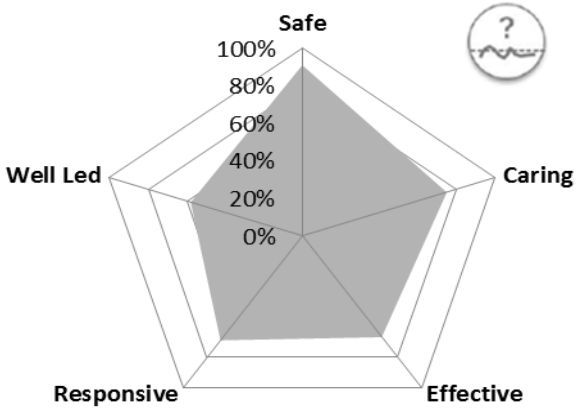
Safe:
- Trust Mortality (HMSR)

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 Advanced Practitioners

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

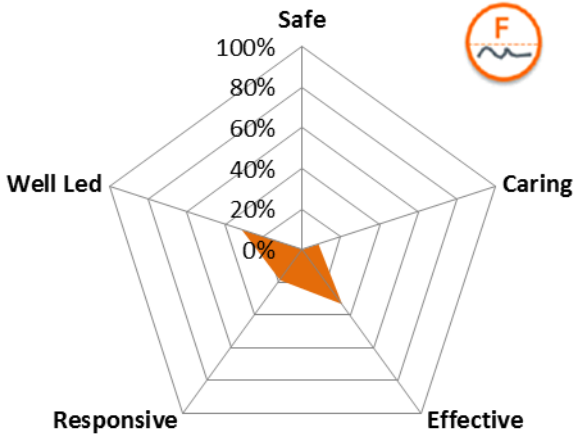
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions & Stroke Indicators

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

Responsive:
- Theatre Utilisation, Diagnostics Waiting Times, Cancer 31 Day Standard, A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NE LOS, Cancer PTL – size of Backlog

Well-Led:
- Capital Expenditure, Sickness Rates, Vacancy Rates, Appraisals, Staff FFT Recommended to work, Staff FFT Recommended Care and Health and Well-Being

Consistently Failing



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

Caring:
- OP Friends & Family Response Rate

Effective:
- Percentage of Virtual OP Appointments
- Outpatient Utilisation
- Outpatient –Calls answered within 1 min
- Outpatient – Calls Abandoned

Responsive:
- RTT performance
- RTT Number of >40 week Waiters
- RTT Number of >52 week Waiters

Well-Led:
- Agency Staff used
- Agency Spend
- Turnover Rate
- Clinical Strategy Indicators
- Percentage of Trust policies within review date

Matrix Summary

May 2021

Variance	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause - Improvement	Stat and Mandatory Training (W)	Infection Control - Number of Hospital acquired MRSA (S), A&E Friends & Family (FFT) % Positive (C), Staff Friends and Family % recommended work (W), Staff Friends and Family % recommended care (W), Appraisal Completeness (W)	Percentage of Trust policies within review date (W),
Common Cause	Standardised Mortality HSMR (S), Single Sex Accommodation Breaches (C), % VTE Risk Assessment (estimate) (C), Cancer - 2 Week Wait (R), Cancer - 62 Day (R), Number of advanced practitioners (W)	**See box (right)**	Calls Answereed in under 1 min (E), Percentage of Calls abandoned (E), RTT (Incomplete) performance against trajectory (R), Number of patients waiting over 40 weeks (R), Agency Spend (W), Number of specialist services (W), Elective Spells in London Trusts from West Kent (W), Turnover (W)
Special Cause - Concern	0	Size of backlog (R), Health and Wellbeing: How many calls received (W), Vacancy Rates (W)	Percentage of Virtual OP Appointments (E), Percentage OP Clinics Utilised (slots) (E), OP Resp Rate Recmd to Friends & Family (C), 52 week breaches (including those reported last month) (R), Use of Agency (W)

Hit & Miss /

Safe Staffing Levels (S),
Sickness Rate - Covid (S)
Infection Control - Hospital Acquired Covid (S),
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays (S),
Infection Control - Rate of Hospital E. Coli Bacteraemia (S),
Number of New SIs in month (S),
Rate of Total Patient Falls per 100,000 occupied beddays (S),
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions (S),
Never Events (S),
OP New DNAs (E)
OP Follow Up DNAs (E)
Outpatient Hospital Cancellation (E),
Outpatient Cancellations < 6 weeks (E),
Total Readmissions <30 days (E),
Non-Elective Readmissions <30 days (E),
Elective Readmissions < 30 Days (E),
Stroke Best Practice Tariff (E),
Rate of New Complaints (C),
% complaints responded to within target (C),
IP Resp Rate Recmd to Friends & Family (C),
IP Friends & Family (FFT) % Positive (C),
A&E Resp Rate Recmd to Friends & Family (C),
Mat Resp Rate Recmd to Friends & Family (C),
Maternity Combined FFT % Positive (C),
OP Friends & Family (FFT) % Positive (C),
Access to Diagnostics (<6w eeks standard) (R),
Average for new appointment (R),
Theatre Utilisation (R),
A&E 4 hr Performance (R),
Super Stranded Patients (R),
Ambulance Handover Delays Rate > 30mins (R),
Bed Occupancy (R),
NEL OS (R),
Cancer - 31 Day (R),
28 day Target (R),
Health and Wellbeing: What percentage of Calls related to Mental Health Issues (W),
Nursing vacancies (W),
Covid Positive - number of patients (W),
Capital Expenditure (£k) (W),
Research grants (£) (W)
Sickness (W)

Items for escalation based on those indicators that are Failing the target or are unstable ('Hit & Miss') and showing Special Cause for Concern by CQC Domain are as follows:

Safe: None
Caring: OP Response Rate Recommended to Friends and Family
Effective: % of Virtual OP Appointments, OP Utilisation
Responsive: RTT > 52 weeks, Size of 62 day Cancer backlog
Well-Led: Use of Agency, Health and Well Being: Number of Calls Received, Vacancy Rates

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains									No SPC	
CQC Domain Safe										
Infection Control	3			1				4		4
Harm Free Care	2							2		2
Incident Reporting	2							2		2
Safe Staffing	2							2		2
Mortality	1					1				1
Safe Total	***10***	***0***	***0***	***1***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	6	2					4	4		8
Quality & CQC	4							4		4
Strategy - Estates									5	5
Effective Total	***10***	***2***	***0***	***0***	***0***	***0***	***4***	***8***	***5***	***17***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	4					2		2		4
ED Care	1				1			2		2
Maternity Care	2							2		2
Outpatient Care	1	1					1	1		2
Caring Total	***10***	***1***	***0***	***0***	***1***	***2***	***1***	***9***	***0***	***12***
CQC Domain Responsive										
Elective Access	4		1				3	2		5
Acute and Urgent Access	4							4	1	5
Cancer Access	4		1			2		3		5
Diagnostics Access	1							1		1
Bed Management	1							1		1
Responsive Total	***14***	***0***	***2***	***0***	***0***	***2***	***3***	***11***	***1***	***17***
CQC Domain Well-Led										
Staff Welfare	1		1					2	4	6
Finance and Contracts	2						1	1	4	6
Leadership					2			2	1	3
Strategy - Clinical and ICC	6				1	1	3	3	1	8
Workforce	2		2		2	1	2	3		6
Well-Led Total	***11***	***0***	***3***	***0***	***5***	***2***	***6***	***11***	***10***	***29***
Trust Total	***55***	***3***	***5***	***1***	***6***	***7***	***14***	***49***	***16***	***86***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	3		
S6	Rate of Total Patient Falls	6.00	7.34		
S7	Number of Never Events	0	1		
S8	Number of New SIs in month	11	8		
S10	Overall Safe staffing fill rate	93.5%	92.9%		

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	95.0%	91.9%		
R4	RTT Incomplete Pathway	86.7%	68.1%		F
R6	% Diagnostics Tests WTimes <6wks	99.0%	87.1%		
R7	Cancer two week wait	93.0%	93.4%		P
R10	Cancer 62 day wait - First Definitive	85.0%	85.7%		P

Effective

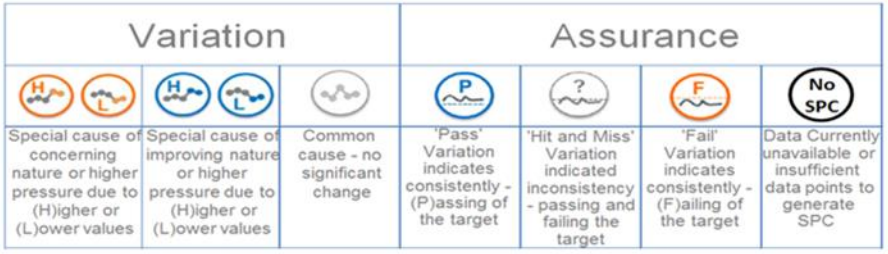
ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	95.1		P
E3	% Total Readmissions	14.6%	16.1%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	66.7%		
R11	Average LOS Non-Elective	6.50	5.94		
R12	Theatre Utilisation	90.0%	88.2%		

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	-0	0	No SPC	No SPC
W2	CIP Savings (£k)	434	85	No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	13.9%	H	
W8	Total Agency Spend (£k)	37	1,625		F
W10	Sickness Absence	3.3%	3.5%		

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%	67.6%		
C5	IP Friends & Family (FFT) % Positive	95.0%	97.4%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	97.1%	H	
C10	OP Friends & Family (FFT) % Positive	84.0%	83.8%		



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.

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

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%	92.9%	May-21		93.5%	89.8%	Apr-21	93.5%	91.3%	
Sickness Rate - Covid	0.0%	0.2%	Apr-21		0.0%	0.3%	Mar-21	0.0%	0.2%	
Infection Control - Hospital Acquired Covid	0	0	May-21		0	0	Apr-21	0	0	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	16.8	May-21		22.7	18.0	Apr-21	22.7	17.4	
Infection Control - Number of Hospital acquired MRSA	0	0	May-21	L	0	0	Apr-21	0	0	
Infection Control - Rate of Hospital E. Coli Bacteraemia	19.0	16.8	May-21		19.0	12.0	Apr-21	19.0	14.5	
Number of New SIs in month	11.0	8	May-21		11	6	Apr-21	22	14	
Rate of Total Patient Falls per 1,000 occupied beddays	6.0	7.3	May-21		6.0	6.5	Apr-21	6.0	7.2	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	1.8	May-21		2.3	1.9	Apr-21	2.3	1.8	
Standardised Mortality HSMR	100.0	95.1	Feb-21		100.0	94.2	Jan-21	100.0	95.1	P
Never Events	0	1	May-21		0	0	Apr-21	0	1	

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 Virtual OP Appointments	60.0%	33.1%	May-21		60.0%	35.0%	Apr-21	60.0%	34.0%	
Percentage OP Clinics Utilised (slots)	85.0%	53.2%	May-21		85.0%	54.2%	Apr-21	85.0%	53.7%	
OP New DNAs	5.0%	7.0%	May-21		5.0%	7.0%	Apr-21	5.0%	7.0%	
OP Follow UP DNAs	5.0%	6.9%	May-21		5.0%	7.0%	Apr-21	5.0%	7.0%	
Outpatient Hospital Cancellation	20.0%	16.9%	May-21		20.0%	17.7%	Apr-21	20.0%	16.4%	
Outpatient Cancellations < 6 weeks	10.0%	13.4%	May-21		10.0%	13.1%	May-21	10.0%	13.4%	
Calls Answereed in under 1 min	95.0%	52.9%	May-21		95.0%	44.2%	May-21	95.0%	44.2%	
Percentage of Calls abandoned	0.0%	8.8%	May-21		0.0%	10.0%	May-21	0.0%	10.0%	

Organisational Objectives: Quality and CQC

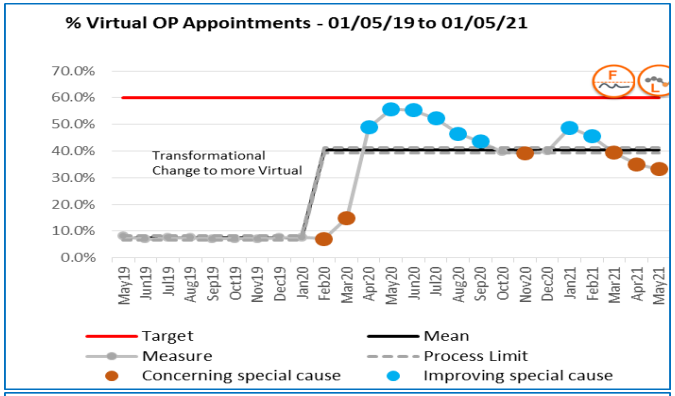
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	16.1%	Apr-21		14.6%	16.7%	Mar-21	14.6%	16.1%	
Non-Elective Readmissions <30 days	15.2%	16.4%	Apr-21		15.2%	16.8%	Mar-21	15.2%	16.4%	
Elective Readmissions < 30 Days	7.8%	9.7%	Apr-21		7.8%	14.7%	Mar-21	7.8%	9.7%	
Stroke Best Practice Tariff	50.0%	66.7%	May-21		50.0%	65.6%	Apr-21	50.0%	60.1%	

Effective - CQC Domain Scorecard

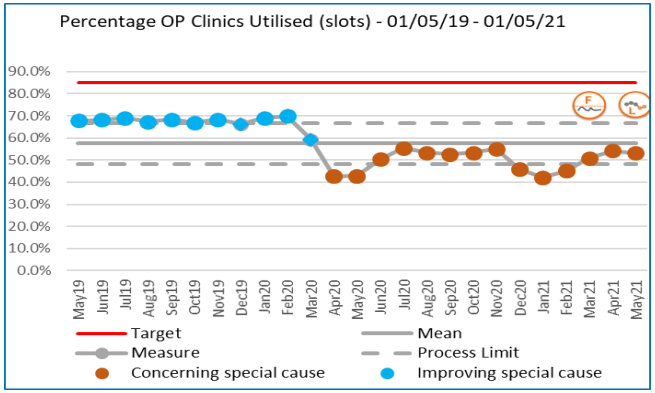
Organisational Objectives: Strategy - Estates

	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	May-21	No SPC	Under review	100:0	Apr-21	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	May-21	No SPC	Under review	4.4:1	Apr-21	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	May-21	No SPC	Under review	0	Apr-21	Under review	5808	No SPC
Staff occupancy per m2	Under review	21.5	May-21	No SPC	Under review	22.6	Apr-21	Under review	22.0	No SPC
Energy cost per staff	Under review	£ 796.16	May-21	No SPC	Under review	£ 979.43	Apr-21	Under review	£1,775.6	No SPC

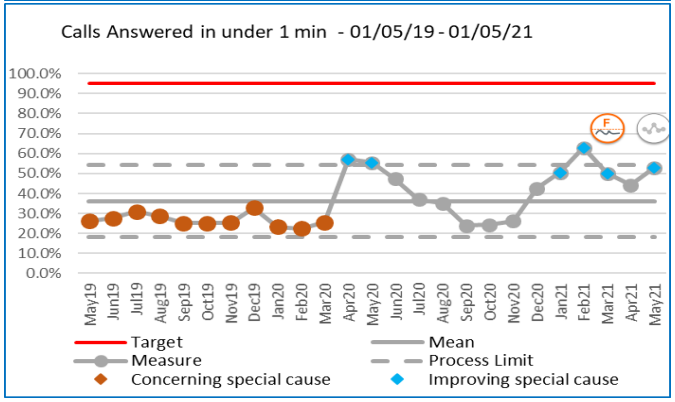
EFFECTIVE- Reset and Recovery Programme: Outpatients



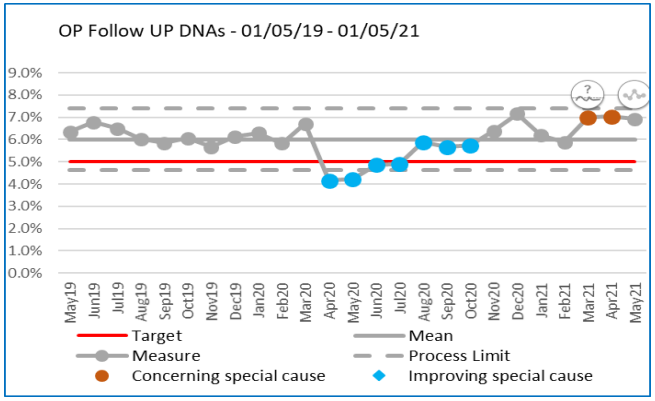
May-21
33.1%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
60%
Target Achievement
Metric is consistently failing the target



May-21
53.1%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target



May-21
44.2%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
95%
Target Achievement
Metric is consistently failing the target



May-21
6.9%
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:

% Virtual OP Appointments: As we begin to recover activity the volume of face to face and virtual are fluctuating due to services understanding their new baseline activity.

Calls Answered: The number of calls answered in less than 3 minutes and less than 1 minute are both experiencing common cause variation but are consistently failing the 100% target.

Outpatient Utilisation: As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels – continuing out of wave 2

DNA Rates: DNA rates for both New and Follow-up are now experiencing common cause variation and variable achievement of the target.

Actions:

% Virtual OP Appointments: Due to the lack of space and social distancing we are restricted on the number of clinics allowed in the department and volume of F2F patients.

Outpatient Utilisation: The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients. This includes viewing the clinic templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection.

Assurance:

Outpatient restart and recovery plan is being considered with the different speciality teams and will be implemented with support from the Transformation Team.

The demand and capacity remodelling has been completed and shared with the divisions. This is being reviewed to ensure we are aiming to achieve reset and recovery targets and that activity where clinically appropriate remains virtual.

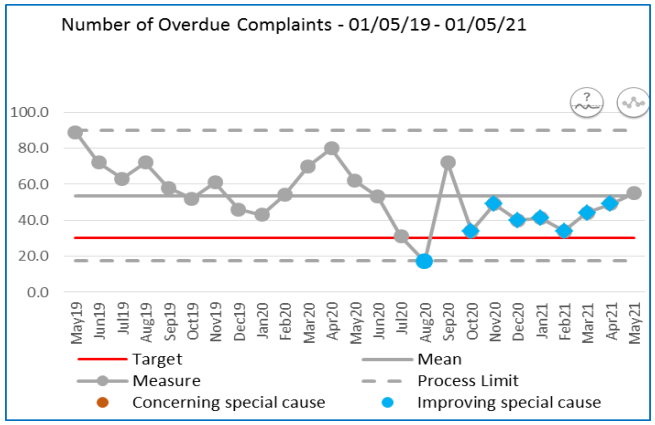
Weekly meeting with specialties regarding clinics restarting is being undertaken to ensure we operate safety and the most efficient possible.

Caring - CQC Domain Scorecard

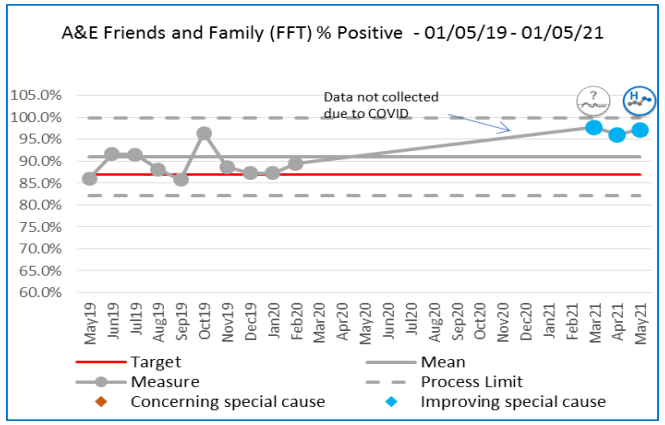
Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	May-21		0	0	Apr-21	0	0	P
Rate of New Complaints	3.9	3.5	May-21		3.9	2.7	Apr-21	3.9	1.8	?
% complaints responded to within target	75.0%	67.6%	May-21		75.0%	73.3%	Apr-21	75.0%	67.6%	?
IP Resp Rate Recmd to Friends & Family	25.0%	20.2%	May-21		25.0%	9.2%	Apr-21	25.0%	14.8%	?
IP Friends & Family (FFT) % Positive	95.0%	97.4%	May-21		95.0%	98.5%	Apr-21	95.0%	97.8%	?
A&E Resp Rate Recmd to Friends & Family	15.0%	8.0%	May-21		15.0%	2.4%	Apr-21	15.0%	5.3%	?
A&E Friends & Family (FFT) % Positive	87.0%	97.1%	May-21	H	87.0%	96.0%	Apr-21	87.0%	96.9%	?
Mat Resp Rate Recmd to Friends & Family	25.0%	10.9%	May-21		25.0%	15.3%	Apr-21	25.0%	13.1%	?
Maternity Combined FFT % Positive	95.0%	100.0%	May-21		95.0%	100.0%	Apr-21	95.0%	100.0%	?
OP Friends & Family (FFT) % Positive	84.0%	83.8%	May-21		84.0%	83.5%	Apr-21	84.0%	83.6%	?
OP Resp Rate Recmd to Friends & Family	68.0%	16.9%	May-21	L	68.0%	16.9%	Apr-21	68.0%	16.9%	F
% VTE Risk Assessment (estimate)	95.0%	96.0%	May-21		95.0%	96.1%	Apr-21	95.0%	95.0%	P

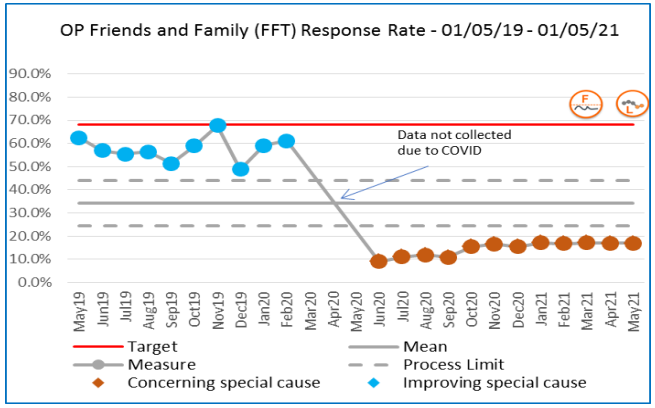
CARING- Organisational Objective: Quality and CQC



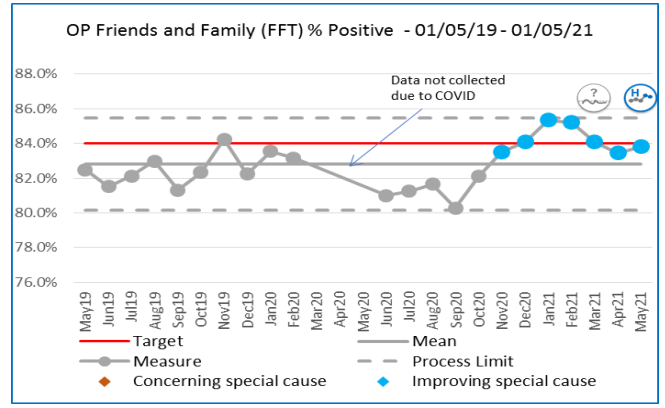
May-21
55
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
60
Target Achievement
Metric is experiencing variable achievement



May-21
97.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
87%
Target Achievement
Metric is experiencing variable achievement



May-21
16.9%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
68%
Target Achievement
Metric is consistently failing the target



May-21
83.8%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (National)
84%
Target Achievement
Metric is consistently achieving the target

Summary:

Complaints: The number and rate of new complaints received continues to remain consistent experiencing common cause variation. An increase of overdue complaints in May returns it to common cause variation

Outpatient Friends and Family Response Rate continues to experience special cause variation of a concerning nature, however of those that have responded the percentage of responses that are positive is showing special cause variation of an improving nature.

A&E Friends and Family % Positive: Of the responses received those that are positive is increasing and is showing special cause variation of an improving nature, however the level of those responding has increased in May but remains lower than expected levels.

Actions:

Complaints: Regular meetings with key divisional staff continue to monitor progress on open complaints. New format weekly reports issued with particular emphasis on overdue cases.
Realignment of complaints leads' portfolios to address fluctuations in activity between divisions.

OP FFT: OP leads have purchased IPADS and stands to enable ease of access for feedback and support timely submission during face-face appointments.

FFT: Currently working with NetCall liberty to implement SMS text messaging in high flow areas to increase submission rates on IQVIA. An addition of 4 new areas have now been set up to be included in the FFT submission.

Assurance:

Complaints: Continued regular monitoring of all open complaints with reports to CN. Learning and key messages published in the Governance Gazette. Daily complaint huddles continue to ensure work is prioritised and redistributed as required.

OP FFT: increases in activity is supporting an increase in seeking live feedback opportunities

FFT: FFT and PPEE meetings are ongoing providing an opportunity for feedback updates from each division / department. These meetings enable collaborative working and sharing of best practice. Commencing the 'Always events' work in relation to the strategy and live feedback.

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	YTD Plan	YTD Actual	Assurance
RTT (Incomplete) performance against trajectory	86.7%	68.9%	May-21		86.7%	63.4%	Apr-21	86.7%	68.9%	F
Number of patients waiting over 40 weeks	222	821	May-21		222	893	Apr-21	222	821	F
52 week breaches (including those reported last month)	0	215	May-21	H	0	423	Apr-21	0	215	F
Access to Diagnostics (<6weeks standard)	99.0%	87.1%	May-21		99.0%	87.6%	Apr-21	99.0%	87.1%	?
Average for new appointment	10.0	9.3	May-21		10.0	10.1	Apr-21	10.0	9.3	?
Theatre Utilisation	90.0%	88.2%	May-21		90.0%	82.0%	Apr-21	90.0%	88.2%	?

Reset and Recovery Programme – Acute & Urgent Care

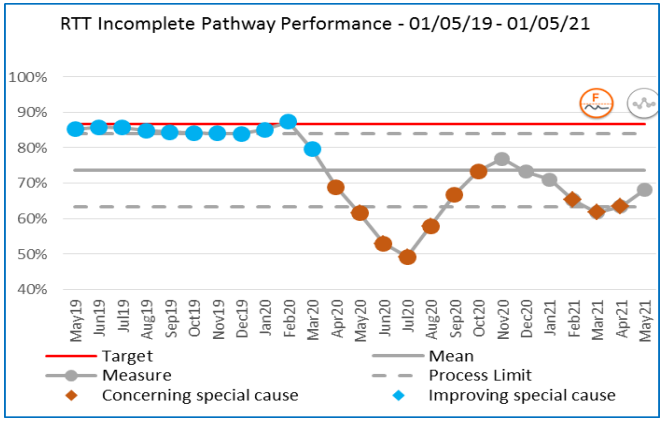
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	YTD Plan	YTD Actual	Assurance
Referrals to ED from NHS 111	Coming June 21		May-21	No SPC	Coming June 21		Apr-21	Coming June 21		No SPC
A&E 4 hr Performance	95.0%	91.9%	May-21		95.0%	94.5%	Apr-21	95.0%	93.1%	?
Super Stranded Patients	80	60	May-21		80	72	Apr-21	80	66	?
Ambulance Handover Delays Rate > 30mins	7.0%	6.0%	May-21		7.0%	4.2%	Apr-21	7.0%	4.6%	?
Bed Occupancy	90.0%	87.3%	May-21		90.0%	85.4%	Apr-21	90.0%	86.4%	?
NE LOS	6.5	5.9	May-21		6.5	6.2	Apr-21	6.5	5.9	?

Responsive - CQC Domain Scorecard

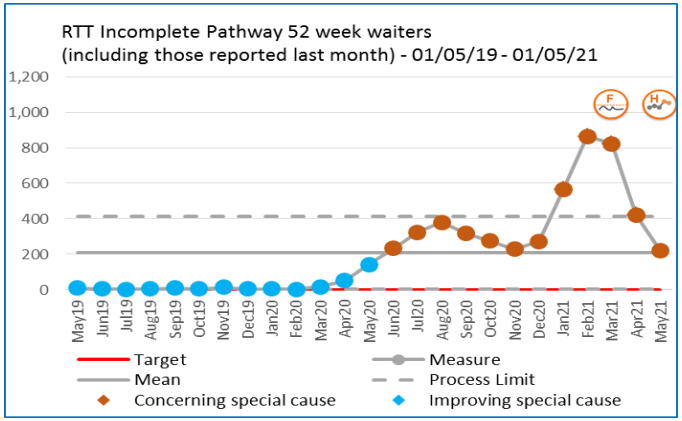
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	93.4%	Apr-21		93.0%	95.8%	Mar-21	93.0%	93.4%	
Cancer - 31 Day	96.0%	97.8%	Apr-21		96.0%	95.0%	Mar-21	96.0%	97.8%	
Cancer - 62 Day	85.0%	85.7%	Apr-21		85.0%	85.4%	Mar-21	85.0%	85.7%	
Size of backlog	30	102	May-21		30	83	Apr-21	30	102	
28 day Target	75.0%	81.9%	Apr-21		75.0%	79.6%	Mar-21	75.0%	81.9%	

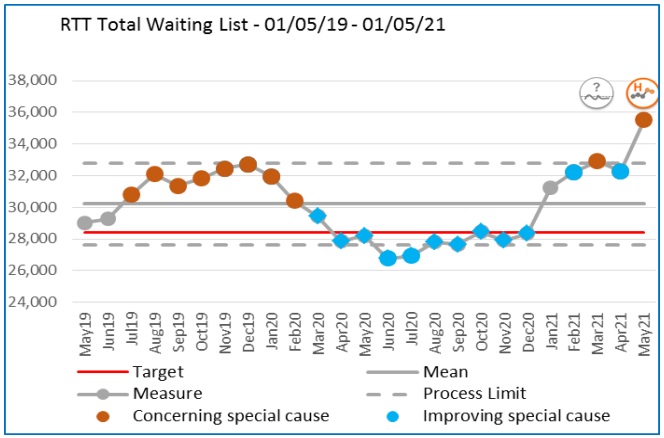
RESPONSIVE- Reset and Recovery Programme: Elective



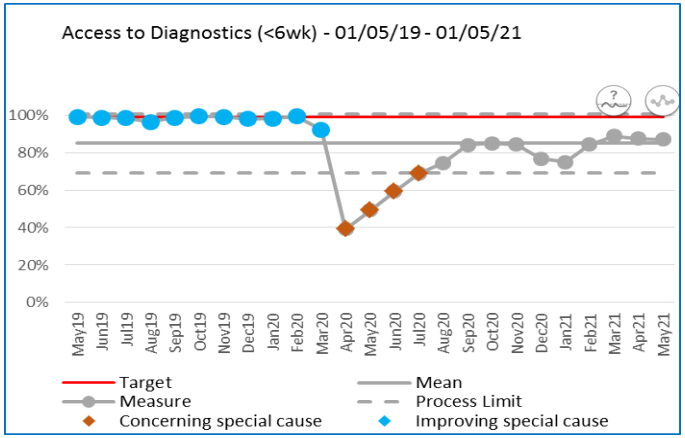
May-21
68.87%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



May-21
215
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
0
Target Achievement
Metric is experiencing variable achievement



May-21
35,526
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



May-21
87.1%
Variance Type
Metric is currently experiencing common cause variation
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

RTT: Performance has started to improve with May's provisional performance sitting at 68.1% The May performance was a 4.7% improvement on April.

RTT 52 wk waiters: There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 643 waiters over the last 3 months.

Elective Activity: With the reopening of theatres, 91% of 2019/20 elective activity levels were achieved and the Trust is on track to achieve the desired levels in June. Outpatients are back to 1920 levels overall (96% for first outpatients). The actuals achieved and percentages stated do not currently include any activity done in the Independent Sector so this will improve further once this data is available.

Diagnostic Activity: CT Scans in May were at 125% of 2019/20 Activity levels, MRI has a performance of 97% of 2019/20 Activity levels and NOUS is running below the national target at 90%.

Actions:

RTT: Continued focus on long waiting patients, pre operative assessment performance, patient cancellations, scheduling and utilisation.

Efficiency: Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity.

Diagnostics: To increase capacity & improve the waiting times for MRI and NOUS

Assurance:

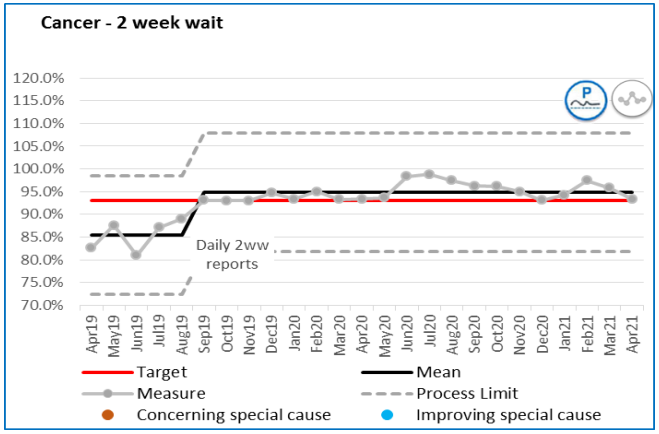
RTT and Elective Activity: Weekly performance meeting in progress, 6-4-2 and scheduling meetings, cancellations RCA's completed to identify trends. TUB re-instated on the 17th May.

RTT Long Waiters: Clinical Prioritisation of waiting lists continues in line with national recommendations. Long waiting patients are in the process of being treated or are being scheduled for treatment.

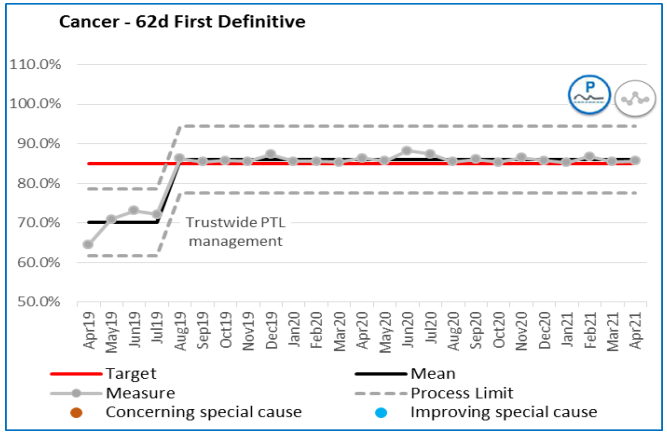
Diagnostics: Work is ongoing on the managed MRI project and is on track to deliver.

Elective Activity: We continue to work closely with ISP partners. Work continues to streamline process and link with ISP where appropriate

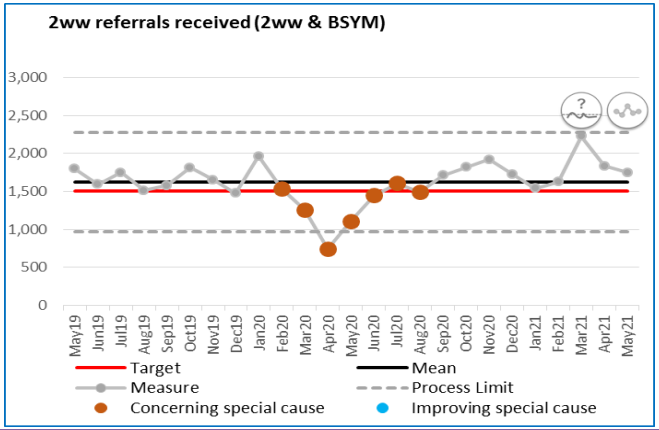
RESPONSIVE- Reset and Recovery Programme: Cancer



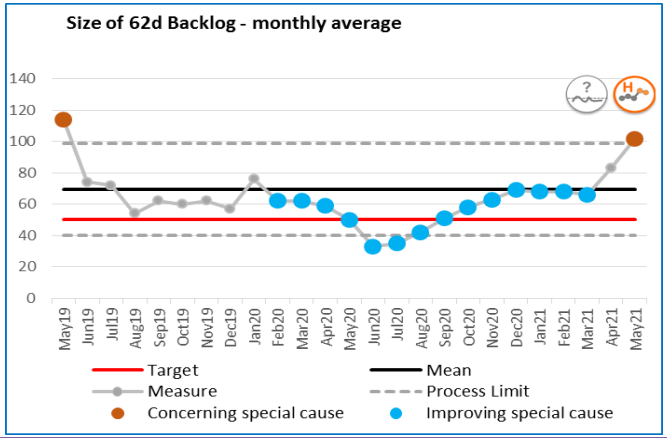
Apr-21
93.4%
Variance Type
Process change Sept 2019 now showing common cause variation
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Apr-21
85.7%
Variance Type
Process change Aug 2019 now showing common cause variation
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



May-21
1751
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target
1500
Target Achievement
Metric is experiencing variable achievement of locally set target



May-21
102
Variance Type
Common Cause variation with last point at the upper process limit
Max Target (Internal)
50
Target Achievement
Metric is experiencing variable achievement of locally set target

Summary:

2ww: The 2ww standard continues to achieve the 93% target, and the process remains within expected levels of variation.

Referrals: The 2ww referral numbers remain within expected variation, with 1751 referrals in May 2021.

62 day: The Trust has continued achievement of the 62 day standard and is reporting 85.7% for April 2021.

62 day PTL: As the numbers on the 62d PTL continue to grow, the backlog has seen an increase in the past 2 months. Overall the process is showing common cause variation, with May sitting at the upper process limit due to unprecedented 2ww referral numbers. Improved in June, likely to remain at common cause variation.

Actions:

Cancer Performance and PTL: The ongoing daily huddles with each tumour site team are in place and monitoring the growth in the PTL as referral numbers fluctuate. Increased focus and in depth review of high 'backlog' areas has been ensured to support backlog drive between process limits.

Referrals: Services are reviewing baseline 2ww provision in line with trajectory of demand and implementing various models to support. The CCG and cancer alliance have supported in prioritising patient referrals and ensuring we are appropriately appointing those at highest risk of cancer within the national guidelines.

Additional resource has helped to support pathway implementation e.g. STT nurses and pathway navigators.

Assurance:

Cancer Performance and PTL: 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.

28 Day FDS Standard: 28 day FDS meetings have been implemented to manage data completeness and ensure we are submitted a representative view of our performance.

Weekly triumvirate meetings help to support key areas of concern and give clinical guidance across services.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	YTD Plan	YTD Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	909	Jan-21	No SPC	Improving Quarterly	688	Sep-20	Improving Quarterly	688	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		69.0%	Jan-21	No SPC		67.0%	Sep-20		67.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jan-21	No SPC		68.0%	Sep-20		68.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Jan-21	No SPC		69.0%	Sep-20		69.0%	No SPC
Health and Wellbeing: How many calls received	40	78	May-21	H	40	38	Apr-21	480	78	?
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	35%	May-21		44%	45%	Apr-21	44%	49%	?

Organisational Objectives: Workforce

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	YTD Plan	YTD Actual	Assurance
Sickness	3.3%	3.5%	Apr-21		3.3%	3.2%	Mar-21	3.3%	0.0%	?
Turnover	10.0%	11.6%	May-21		10.0%	11.4%	Apr-21	10.0%	11.6%	F
Vacancy Rates	9.0%	13.9%	May-21	H	9.0%	13.9%	Apr-21	9.0%	13.9%	?
Use of Agency (WTE)	2	234	May-21	H	2	234	Apr-21	2	234	F
Appraisal Completeness	95.0%	82.7%	May-21	H	95.0%	91.0%	Apr-21	95.0%	82.7%	?
Stat and Mandatory Training	85.0%	89.9%	May-21	H	85.0%	90.1%	Apr-21	85.0%	89.9%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty (£k)	0	0	May-21	No SPC	-	0	Apr-21	0	0	No SPC
CIP Savings (£k)	434	85	May-21	No SPC	434	85	Apr-21	434	85	No SPC
Cash Balance (£k)	43,542	38,943	May-21	No SPC	40,828	40,828	Apr-21	43,542	43,542	No SPC
Capital Expenditure (£k)	341	147	May-21		161	119	Apr-21	341	147	?
Agency Spend (£k)	37	1,625	May-21		25	1,574	Apr-21	37	1,625	F
Use of Financial Resources	No data		May-21	No SPC	No data		Apr-21	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%	15.6%	May-21		13.5%	20.1%	Apr-21	13.5%	15.6%	?
Covid Positive - number of patients	0	1	May-21		0	9	Apr-21	0	11	?

Well Led - CQC Domain Scorecard

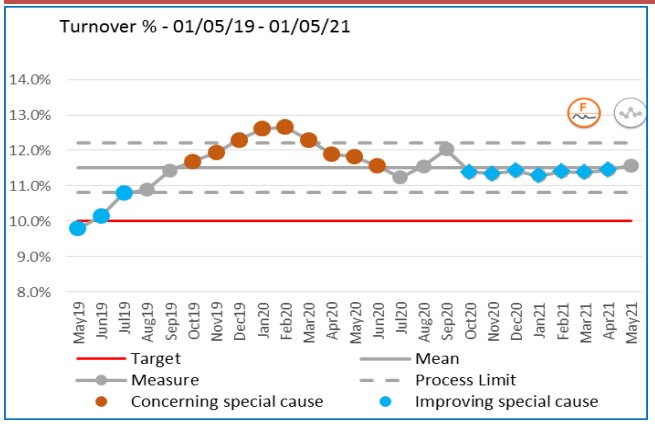
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	May-21		35	30	Apr-21	35	360	F
Elective Spells in London Trusts from West Kent	329	200	May-21		329	300	Apr-21	329	3,532	F
Service contribution by division	Coming June 21		May-21	No SPC	Coming June 21		Apr-21	Coming June 21		No SPC
Research grants (£)	114	90	May-21		114	149	Apr-21	114	90	?
Number of advanced practitioners	25	31	May-21		25	31	Apr-21	25	31	P
Percentage of Trust policies within review date	90.0%	75.1%	May-21	H	90.0%	76.2%	Apr-21	90.0%	75.1%	F

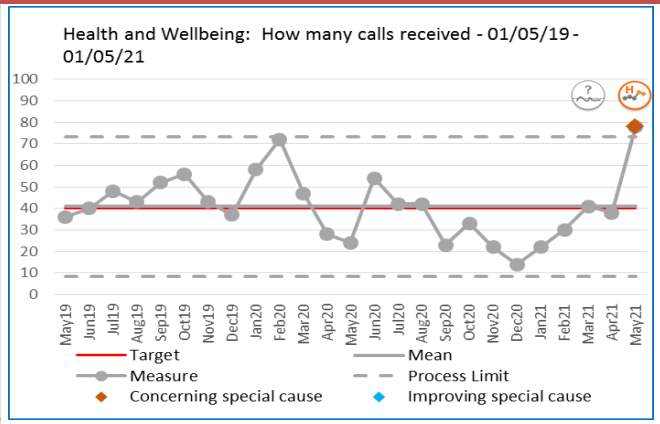
Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	70.0%	71.3%	May-21	H	70.0%	71.3%	Apr-21	70.0%	71.3%	?
Staff Friends and Family % recommended care	80.0%	81.4%	May-21	H	80.0%	81.4%	Apr-21	80.0%	80.0%	?
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming June 21		May-21	No SPC	Coming June 21		Apr-21	Coming June 21		No SPC

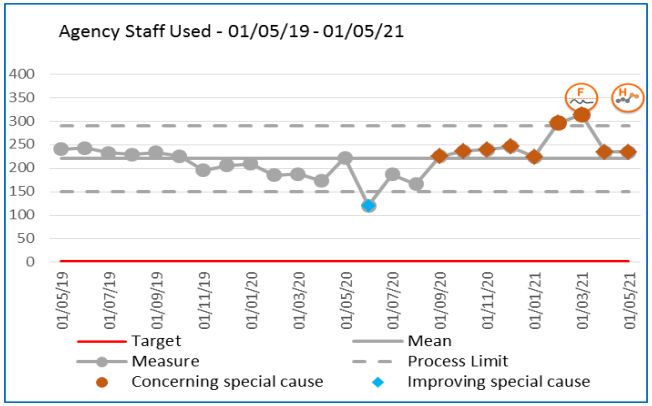
WELL LED- Operational Objective: Workforce



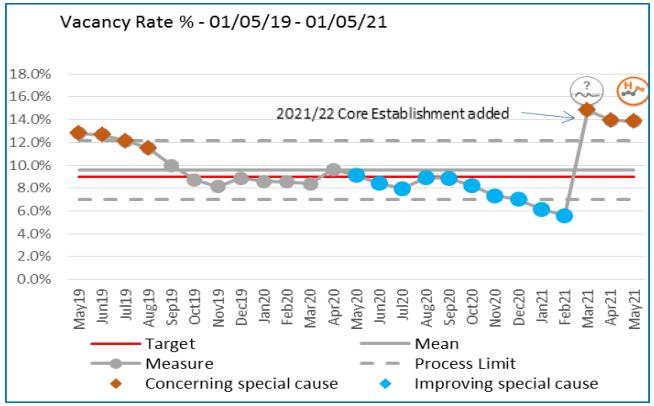
May-21
11.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
10%
Target Achievement
Metric is consistently failing the target



May-21
78
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Target (Internal)
40
Target Achievement
Metric is experiencing variable achievement



May-21
234
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Target (Internal)
2
Target Achievement
Metric is consistently failing the target



May-21
13.9%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
9.0%
Target Achievement
Metric is experiencing variable achievement

Summary:

Turnover: The Turnover rate continues to be within common cause variation but is consistently failing the target.

Health and Wellbeing: The volume of health & wellbeing calls received in May increased significantly putting this KPI into Special Cause Variation of a concerning nature

Agency Staff Used: The level of Agency staff used has continued to increase in May in line with a slight increase in demand for temporary Staffing.

Vacancy Rate : This continues to experience special cause variation of a concerning nature.

Actions:

Turnover : There has been a marginal movement bring the KPI closer to the mean average this month. This will continue to be monitored.

Health & Wellbeing: How many calls received: This KPI reflects the number of calls received by our EAP provider, Health Assured. The trend has been for an increasing number of calls but in May this significantly increased (from 38 to 78). Other EAP metrics also indicate more staff reaching out for support, making this a special cause variation of a concerning nature. We are triangulating this data with the MTW Climate Survey that has just closed and the MTW Psychological Wellbeing Service and looking to see what additional, targeted actions can be taken quickly to respond.

Agency / Vacancy Rate: In May we saw a slight increase in demand of c.3% for Temporary Staffing. Nursing saw an increase of almost 7% compared to the previous month due to an increase in the need for RMN's, the demand level remains considerably higher than the same period last year (similarly the same for CSW's). Medical demand increased by c.2.5% but is comparable to the same period last year. Agency usage, although higher than plan has continued to reduce year on year, but we are beginning to see an upturn in usage, albeit still lower than pre-covid usage. A further update will be provided in the next IPR.

Assurance:

Delivery of 2020/21 Workforce plans are supported by the HRBP and workforce information teams. Divisions are reviewing existing workforce and recruitment plans and 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.

The Nursing workforce plans have been finalised which confirms a need for 193.83WTE Band 5 Staff Nurses this financial year, plans have been put in place to achieve this target which has been shared with the relevant departments.

There are 45WTE international nurses in the pipeline., We are still unable to arrange start dates for any international nurses from India due to the guidance by NHSI. This has meant that we have 6 nurses on hold, if this continues then there will be a delay in the volume of OSCE ready nurses commencing this year.

The Recruitment Team are working with Critical Care, Medicine, ED and Blood sciences for Recruitment and retention campaigns. We are attending the Nursing Times event on the 19th June and we are currently organising our yearly events internal and externally. We are also holding a Step into Health engagement event on Wednesday 23rd June on both sites.

The Trust continues to scope out plans for a Staffing Hub to provide a centralised view of staffing across the Trust, to help improve care by providing the resource required and access to real time data. The bank team continues to work closely with the site team and matrons on finding solutions to reduce agency spend including paying enhanced rates for Bank staff working within Rapid Response Pool ward to mitigate staff shortages, with a review of future incentives taking place. Various options are currently being explored to provide support with the additional requirement for RMN's.

Appendices

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 85.7% and 93.4% respectively. A&E 4hr performance continues to experience common cause variation at 91.9% in May. RTT performance increased in May as elective activity recovers following the re-opening of Theatres. The national target for May to get back to 70% of 2019/20 elective activity levels were exceeded for inpatients at 91% and total outpatients are now back to 2019/20 levels (96% for First Appointments). The Trust is on track to achieve the desired levels in June. Demand and capacity analysis has been undertaken for all specialities in order to reset the recovery plan for elective care. Patient safety and quality indicators continue showing signs of improvement as bed occupancy and staffing issues continue to stabilise.

Key Performance Items:

- **Infection Control:** Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The Trust admitted 1 patient with Covid-19 infection during May, however there were no cases of probable or definite hospital acquired infection. Assurance of compliance continues through the IPC BAF. Focus on reminding staff to continue with lateral flow testing and appropriate registering of results .
- **Falls:** The overall rate of falls continues to experience common cause variation and variable achievement of the target. Three SIs relating to Falls was reported. Falls rate continue to be monitored monthly across the trust and on individual wards. Themes and trends for falls identified and shared at the Falls Group meeting. Monthly LSBP audit undertaken . Yearly Falls prevention compliance audit to commence in June for all inpatient areas.
- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers continues to decrease and remains in common cause variation. The higher level of Deep Tissue Injuries (DTIs), particularly in the Medical and Care of the Elderly specialties has returned to previous levels. Total pressure ulcers (including inherited) has also reduced enough to return to common cause variation. The Pressure Ulcer group have discussed learnings from recent incidents to ensure that they are shared across Directorates. Pressure Ulcer information has been provided to the Governance gazette for the next newsletter, to enable learnings to be shared with all Professional groups.
- **Incidents and SIs:** The level of SIs reported increased to 8. Of these, 1 related to a leak of confidential information, 1 was a never event, 3 related to Falls, 2 related to a treatment delay and 1 related to an obstetrics incident. The level of incidents reported and the rate of incidents that are severely harmful remains below the maximum limit of 1.23. Senior members of the Patient Safety Team continue to carry their own caseload of SIs to ensure that investigations are completed thoroughly and in a timely manner to support our staff, patients and their families. The team is working with the divisions to allocate investigators to these SIs.
- **Stroke:** The overall Best Practice Indicator continues to experience common cause variation and variable achievement of the target. All four indicators have achieved the internal targets so far this year.
- **A&E 4 hour Standard and Flow:** Overall Ed Performance continues to be within common cause variation (91.9% in May). The Trust continues to implement the ED improvement action plan to support flow throughout the Trust with Flow Coordinators appointed across both sites. Development of 111/Urgent Treatment Centre (UTC) is in progress to extend the service. A&E Attendances have reached predicted levels modelled prior to Covid, with record breaking volumes seen in May. Emergency admissions continue to be at the increased levels driven by SDEC attenders. Total Bed Occupancy continues to experience common cause variation, raising slightly above the mean in May. Both Medical Outliers and Super-Stranded Patients are also starting to recover.
- **Ambulance Handover Delays**: Ambulance delays increased in May, but continues to experience common cause variation (6% in May)

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** RTT performance increased to 68.87% (+5.5%) as elective activity has started to recover. With the reopening of theatres, 93% of 2019/20 elective activity levels were achieved in May 21 and the Trust is on track to achieve the desired levels in June. First Outpatient Appointments achieved 98% of 2019/20 activity levels in May. A further recovery plan is being devised which includes increased use of the Independent Sector. There has been huge efforts made to reduce the number of 52 week waiters. Diagnostics waiting <6 weeks is starting to recover and is back to common cause variation (87.1% for May).

- **Cancer 62 Day:** From August 2019, when the Trust implemented robust PTL management with service managers across the Trust, the 62 day standard has shown an improved performance and has consistently achieved the 85% standard (reporting 85.7% for April 2021). A process step change has been applied to reflect this and this shows a significant improvement, where the calculated mean up to August 2019 was 66.7% and is now 86.0%, consistently above the target of 85%. The updated chart now reports common cause variation as confirmation of a currently stable process. The 62d Backlog remains at 5% of the total PTL. Numbers on the 62d PTL continue to grow, the backlog has seen an increase in the past 2 months.
- **Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, with a consistent achievement of the target (reporting 93.4% for April 2021). The recent 6 months of improved performance is likely due to the lower than expected number of 2ww referrals and the Trust continuing to appoint suspected cancer patients as a priority – utilizing the virtual clinics where possible. A process step change has been applied to this metric, which shows the improved performance increasing from a calculated mean of 86.7% up to September 2019 to 94.9% currently, consistently above the target of 93%.
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April 2020 due to COVID-19, incoming referral numbers have increased through the remainder of 2020, with some months reporting in excess of 114% over the same period in 2019. Overall the numbers of referrals being processed through the 2ww office has returned to expected numbers and is reporting common cause variation.

- **Finance:** The Trust is on plan generating a breakeven position. The Trusts key favourable variances to plan are:, Pay underspends (£1.2m), underspend in Drugs and clinical supplies due to lower activity than funded levels (£0.9m). The Trusts key adverse variances to plan are: Increase in doubtful debt (£0.7m), CIP slippage (£0.7m), bowel scope income underperformance (£0.3m - service has ceased), other income slippage (£0.3m - Private Patients (£0.1m), Car Parking (£0.1m) and RTA (£0.1m) and increase in contingency reserves (£0.2m).

- **Workforce**: The Safe Staffing Nursing Fill Rate reported continues to return to usual levels and remains in common cause variation, which has impacted on the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue to review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust. Increased multi professions representation are on the wards to help support the nursing staff. The level of Agency staff used had shown a considerable increase but continues to reduce. It continues to experience special cause variation of a concerning nature, however. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. The Turnover rate remains similar and is consistently failing the target. The Trust is working to improve the Appraisal Process and is implementing an Exceptional Leaders Programme. Climate survey and the "Moving On" survey data is being used to drive local interventions to aid retention. Following the high sickness levels reported in January as expected this has started to reduce with April at 3.5%, achieving the Trust target and experiencing common cause variation. Of the 3.5% reported 0.2% was COVID related sickness. The non-Covid related sickness remains at expected levels for this time of year. The level of Stress/Anxiety and Depression related sickness saw an increasing trend at the height of the Covid Waves but has now reduced. The Trust Daily Staff Hub / Cell continue to review and respond to any Covid pressures but this is now easing as the number of Covid patients within the Trust remains low.

Implementing a Revised Perinatal Tool

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA (?)

	2021											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Findings of review of all perinatal deaths using the real time data monitoring tool	2 cases Themes: - Extreme prematurity x 1 - HSIB case x 1	1 case Themes: - HSIB case x 1	3 cases Themes: - HSIB case x 2 - MTOP - fetal anomaly x 1	5 cases Themes: - MTOP fetal abnormality x 2 - Unexplained death x 2 - fetal cardiac anomaly x 1	1 case Themes: - MTOP fetal anomaly x 1							
Findings of review of all cases eligible for referral to HSIB	2 cases Themes: Case 1 - Escalation during neonatal resuscitation Case 2 - No safety concerns	1 case Themes: Patient information - fetal movements in labour Guideline for risk assessment in Triage	2 cases Investigations in progress	0 cases	1 case Investigation in progress							
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	4 moderate incident 1 serious incident Learning shared: - MDT Communication - Guidelines updated	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - situational awareness	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - obstetric cover for Triage - review of guideline for care in latent phase of labour	0 moderate incident 1 serious incident Learning shared: - reminder to staff to follow fetal growth assessment programme	5 moderate incident 2 serious incident Learning shared: - reminder to follow ED pathway for unwell maternity patients - review of process for follow up of investigation results - review of pathway for booking caesarean section - 1:1 feedback							
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	66%	73%	82%	91%	98%							
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	50%	56%	53%	53%	69%							
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	179	74	282	254	243							
Service User Voice Feedback - % positive responses	98%	99%	96%	99%	97%							
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	HSIB quarterly engagement meeting	CQC engagement meeting	Letter from HSIB requesting additional support for staff involved in investigations							
Coroner Reg 28 made directly to Trust	No	No	No	No	No							
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%

Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%

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 May financial plan by delivering a breakeven financial position.
- In line with NHSE/I guidance additional income (£1.1m) has been included in the month 2 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.
- The position assumes ERF is achieved in line with plan, early indications from April activity are that ERF value may be higher than plan but until the total system position is understood a prudent position has been reported.
- The key year to date variances are as follows:
  - **Favourable Variances**
    - Pay underspends (£1.2m). Underspends within Scientific and Technical staff (£0.9m), Nursing (£0.7m), support to clinical staff (£0.7m) and Admin and clerical are partly offset by overspend within Medical staffing (£1m) and support staff (£0.2m)
    - Drugs and Clinical supplies underspends (£0.9m) mainly due to activity being lower than funded levels
  - **Adverse Variances**
    - Increase in doubtful debt from Trade organisations (£0.7m)
    - CIP slippage (£0.7m)
    - Cease of bowel scope activity (£0.3m loss of income)
    - Reduction in other operating income (£0.3m) mainly within Private Patients (£0.1m), Car Parking (£0.1m) and RTA (£0.1m)
    - Increase in contingency (£0.2m)
- The key current month variances are as follows:
  - Income under performed by £0.7m in May, the underperformance is mainly due to £0.3m reduction in prime provider income (offset by reduction in expenditure), reduction in swabbing income (£0.3m - offset by expenditure reduction), low private patient and RTA activity (£0.1m) and £0.1m bowel scope income underperformance (service has ceased).
  - Expenditure budgets underspent by £0.7m. Underspends within pay budgets (£0.8m) and non pay (£0.4m) were partly offset by unidentified CIP slippage £0.4m and increase in reserves (£0.1m).

- The cash balance at the end of May is £38.9m compared to the closing balance of April of £40.8m. The first 6 months (H1) of SLA block payments are based on 2020/21 quarter 3 position extended for a 6 months period, which covers the initial base position; discussions are continuing to finalise the various adjustments based on this assessment and to incorporate any new items for 2021/22 H1 as well as the repayment of the £8.6m 2020/21 adjustment included within the carried forward cash balance of £26.2m. The cashflow is currently forecasting this repayment in March 2022. The remaining 6 months of the cashflow is based on similar values to the first 6 months with some minor adjustments. This will be updated alongside H2 Income & Expenditure planning. At present the closing cash balance is assumed at a level of £5m but this will need to be updated to reflect H2 assumptions. Part of the carried forward balance of £26.2m also relates to c£6m capital creditors where invoices were not received in March. These are expected to be paid within the first quarter of 2021/22 with £4.7m being paid in the first two months. The Trust is continuing to work with NHS colleagues to ensure both debtors and creditor balances remain low

- The Trust's capital plan agreed with the ICS/STP for 2021/22 is £10.57m comprising of net internal funding £8.9m, PFI lifecycle per Project model of £1.2m and donated assets of £0.4m.
- The Plan includes;
  - **Estates:** The Backlog schemes include contractual commitments from 20/21 relating to enabling works for CT Simulator, Pharmacy Robot, MRI, Interventional Radiology and Mammography equipment. General Backlog Maintenance works relating to statutory requirements and condition survey, to be prioritised. Development schemes include ICC modular build and KMMS enabling work.
  - **ICT:** The EPR costs relate to contractual commitments. Other ICT schemes include wireless controllers replacement, over-age laptops/PCs, switches, hubs and servers.

- **Equipment:** The Linac machine was delivered to the Canterbury site at the end of March, this year's costs include ancillary equipment and commissioning. Trustwide equipment will be prioritised.

- The year to date capital spend is £267k compared to the Plan of £502k. The majority of the spend relates to the EPR project but there were also elements of carry forward spend from projects commenced in 2020/21.

Plan update

- The Trust is resubmitting the financial plan for H1 (April to September) on the 15th June at a system level and 22nd June at a provider level.
- The Trusts plan is to deliver a breakeven position but will be updated to reflect the following key changes:
  - Increase of Elective Recovery Funding (ERF) income to reflect latest activity projections (£10.5m, £8.3m increase above current plan)
  - Increase in spend associated with ERF delivery (£6,2m)
  - Remove income expectation associated with bowel scope activity which has ceased (£0.9m)
  - Increase in spend associated with EPR implementation (£0.5m)

Maidstone and Tunbridge Wells NHS Trust

1. Dashboard

May 2021/22

	Current Month				Year to Date				Annual Forecast / Plan (Month 1-6)			
	Actual £m	*Plan* £m	*Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*	*Forecast* £m	*Plan* £m	*Variance* £m	*RAG*
Income	47.8	48.5	(0.7)		95.7	97.0	(1.3)		298.5	291.0	7.5	
Expenditure	(45.2)	(45.9)	0.7		(90.4)	(91.7)	1.3		(282.3)	(274.9)	(7.4)	
EBITDA (Income less Expenditure)	2.6	2.6	(0.0)		5.3	5.3	0.0		16.2	16.1	0.1	
Financing Costs	(2.7)	(2.7)	(0.0)		(5.4)	(5.4)	(0.0)		(16.5)	(16.4)	(0.1)	
Technical Adjustments	0.1	0.0	0.0		0.1	0.1	0.0		0.3	0.3	0.0	
Net Surplus / Deficit (Incl Top Up funding support)	**0.0**	**(0.0)**	**0.0**		**0.0**	**(0.0)**	**0.0**		**(0.0)**	**(0.0)**	**(0.0)**	
Cash Balance	38.9	43.5	(4.6)		38.9	43.5	(4.6)		36.4	36.4	0.0	
Capital Expenditure (Incl Donated Assets)	0.1	0.3	0.2		0.3	0.5	0.2		1.7	1.7	0.0	

Summary Current Month:

- The Trust was on plan generating a breakeven position.
- Income under performed by £0.7m in May, the under performance is mainly due to £0.3m reduction in prime provider income (offs et by reduction in expenditure), reduction in swabbing income (£0.3m - offset by expenditure reduction), low private patient and RTA activity (£0.1m) and £0.1m bowel scope income underperformance (service has ceased).
- Expenditure budgets underspent by £0.7m. Underspends within pay budgets (£0.8m) and nonpay (£0.4m) were partly offset by unid entified CIP slippage £0.4m and increase in reserves (£0.1m).
- In line with NHSE/I guidance additional income (£0.4m) has been included in the month 2 position to offset additional costs f or PCR swabbing, Rapid testing and vaccination centre.

Year to date overview:

- The Trust is on plan generating a breakeven position.
- The Trusts key variances to the plan are:

Favourable Variances:

- Pay underspends (£1.2m), underspend in Drugs and clinical supplies due to lower activity than funded levels (£0.9m)

Adverse Variances:

- Increase in doubtful debt (£0.7m - Trade debt over 60 days provided in full), CIP slippage (£0.7m), bowel scope income underperformance (£0.3m - service has ceased), other income slippage (£0.3m - Private Patients (£0.1m), Car Parking (£0.1m) and RTA (£0.1m) and increase in contingency reserves (£0.2m).
- In line with NHSE/I guidance additional income (£1.1m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

Risks within reported financial position:

- The Trust has the following key income assumptions included within the position which are pending confirmation from Kent and Medway CCG
    - Prime Provider (Patient Choice activity) income of £1.5m has been incorporated to offset the costs reported in the month.
    - Stroke development (£0.4m)

Opportunities not reflected within the reported financial position

- The position assumes ERF is achieved in line with plan, early indications from April activity are that ERF value may be higher than plan but until the total system position is understood a prudent position is reported. Any benefit relating to ERF will be non recurrent with the scheme ending in September 2021.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Expedniture

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	0
Sick pay at full pay (all staff types)	16
COVID-19 virus testing (NHS laboratories)	0
Remote management of patients	0
Support for stay at home models	14
Direct Provision of Isolation Pod	0
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0
Segregation of patient pathways	1,158
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	113
Decontamination	0
Backfill for higher sickness absence	1
NHS 111 additional capacity	0
Remote working for non patient activites	0
National procurement areas	8
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	92
PPE - locally procured	1
Other	280
COVID-19 virus testing- rt-PCR virus testing	985
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	3
COVID-19 virus testing - Rapid / point of care testing	63
Total Expenditure (£000s):	**2,734**

Income

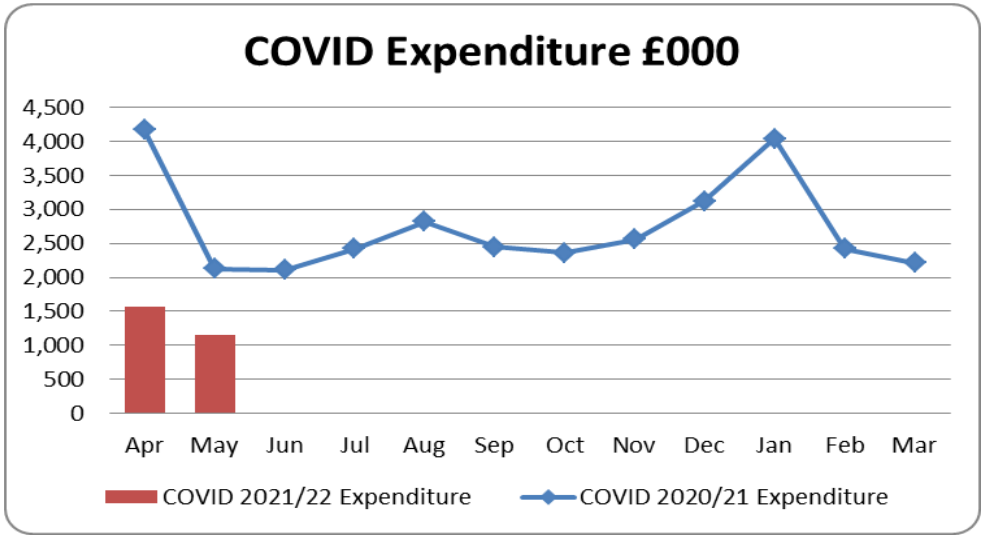
Breakdown by income type	£000s
Free staff car parking	95
Catering - Income loss	23
Total Income (£000s):	**118**

Grand Total (£000s):	**2,852**

Commentary:
The Trust has identified the year to date financial impact relating to COVID to be £2.9m.

The main cost includes costs associated with virus testing , staff welfare such as providing meals, additional shifts required in ED to support patient flow and escalation of Edith Cavell and Peale Wards.

The Trust has included £1.1m income in the position to offset the costs of COVID swabbing , rapid testing and vaccination programme. This will be validated by NHSE/I over the next few months before funding is confirmed.



May-21		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	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	75.2%	143.1%	-	100.0%	90.3%	109.7%	-	-	24.8%	46.9%	298	19.28	70	8.7	0.0%	84.8%	12	3	271,510	273,254	(1,744)
MAIDSTONE	Culpepper Ward (M) - NS551	98.7%	98.4%	-	-	100.0%	102.5%	-	-	24.0%	20.7%	33	2.28	0	5.2	34.3%	91.7%	6	0	108,091	99,489	8,602
MAIDSTONE	John Day Respiratory Ward (M) - NT151	100.3%	96.2%	-	-	102.6%	119.3%	-	-	37.8%	29.2%	112	7.89	17	6.7	80.5%	97.0%	2	0	141,330	151,676	(10,346)
MAIDSTONE	Intensive Care (M) - NA251	89.8%	140.2%	-	-	84.6%	97.6%	-	-	11.6%	15.8%	134	8.50	51	46.2	0.0%	100.0%	0	0	245,486	209,594	35,892
MAIDSTONE	Pye Oliver (Medical) - NK259	100.9%	121.0%	-	-	111.8%	111.8%	-	-	40.6%	40.7%	165	10.41	51	6.9	49.3%	100.0%	3	0	119,709	136,077	(16,368)
MAIDSTONE	Whatman Ward - NK959	85.9%	98.1%	-	100.0%	101.1%	141.9%	-	-	28.5%	26.3%	82	5.85	8	8.2	11.8%	100.0%	2	0	89,023	108,673	(19,650)
MAIDSTONE	Lord North Ward (M) - NF651	92.8%	106.1%	-	100.0%	84.7%	96.8%	-	-	5.8%	16.3%	10	0.67	2	8.4	120.0%	97.2%	0	0	106,494	92,364	14,131
MAIDSTONE	Mercer Ward (M) - NJ251	93.3%	87.8%	-	-	99.3%	96.8%	-	-	12.7%	5.6%	27	1.80	6	5.6	6.7%	100.0%	4	2	106,617	107,043	(426)
MAIDSTONE	Edith Cavell - NS459	110.7%	102.8%	-	100.0%	119.2%	336.6%	-	-	56.1%	33.3%	115	7.96	13	7.1	50.7%	92.1%	1	0	114,962	103,285	11,677
MAIDSTONE	Acute Medical Unit (M) - NG551	107.9%	99.8%	-	-	138.0%	233.0%	-	-	42.6%	24.0%	129	8.92	34	14.3	0.0%	75.0%	4	0	136,864	143,052	(6,188)
TWH	Ward 22 (TW) - NG332	102.3%	115.6%	-	No Hours	120.4%	112.1%	-	-	34.7%	45.5%	149	10.75	49	6.5	0.0%	0.0%	20	1	126,783	153,403	(26,620)
TWH	Coronary Care Unit (TW) - NP301	90.6%	93.7%	-	-	95.0%	-	-	-	23.3%	23.7%	68	4.01	19	11.9	76.9%	100.0%	1	0	67,534	71,806	(4,272)
TWH	Ward 33 (Gynae) (TW) - ND302	99.1%	87.1%	-	-	98.4%	100.0%	-	-	30.3%	3.5%	43	2.67	3	7.1	26.1%	100.0%	0	0	127,454	102,126	25,328
TWH	Intensive Care (TW) - NA201	139.5%	111.9%	-	-	130.1%	90.3%	-	-	10.0%	0.0%	74	4.57	4	38.0	0.0%	0.0%	1	0	376,174	291,140	85,034
TWH	Acute Medical Unit (TW) - NA901	92.8%	107.2%	-	100.0%	102.0%	98.8%	-	-	16.9%	39.8%	162	11.16	64	11.0	1.7%	100.0%	5	0	206,716	218,282	(11,566)
TWH	Surgical Assessment Unit (TW) - NE701	96.1%	101.6%	-	-	40.5%	52.8%	-	-	7.8%	5.6%	16	0.85	2	91.9	0.0%	0.0%	1	0	69,264	53,020	16,244
TWH	Ward 32 (TW) - NG130	75.3%	93.8%	-	100.0%	79.8%	71.0%	-	No Hours	15.6%	15.5%	80	5.39	22	7.5	0.0%	0.0%	2	1	139,999	114,089	25,910
TWH	Ward 10 (TW) - NG131	108.2%	94.2%	-	100.0%	101.6%	114.5%	-	-	34.8%	24.7%	128	8.30	21	6.5	0.0%	0.0%	8	0	130,327	144,963	(14,636)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	11.8%	4.5%	-	-	40.9%	16.1%	-	-	16.4%	53.8%	92	6.38	35	7.8	0.0%	0.0%	0	0	0	18,274	(18,274)
TWH	Ward 12 (TW) - NG132	92.9%	108.8%	-	100.0%	104.3%	97.6%	-	-	28.4%	28.6%	124	7.77	49	6.0	3.2%	100.0%	12	0	135,385	141,765	(6,380)
TWH	Ward 20 (TW) - NG230	103.3%	117.4%	-	No Hours	97.8%	100.0%	-	-	27.9%	21.9%	100	7.03	34	5.6	11.8%	100.0%	4	0	158,596	137,673	20,923
TWH	Ward 21 (TW) - NG231	96.9%	126.8%	-	100.0%	95.5%	104.8%	-	-	28.1%	45.2%	140	9.25	31	6.8	11.4%	90.0%	6	0	142,779	156,349	(13,570)
TWH	Ward 2 (TW) - NG442	107.6%	110.7%	-	100.0%	117.7%	135.5%	-	No Hours	25.1%	17.4%	105	6.87	56	9.1	27.3%	71.4%	16	0	136,753	160,269	(23,516)
TWH	Ward 30 (TW) - NG330	106.8%	97.8%	-	100.0%	103.3%	126.9%	-	-	28.3%	8.7%	93	5.43	27	8.0	8.5%	90.0%	7	1	125,658	141,278	(15,620)
TWH	Ward 31 (TW) - NG331	84.7%	118.6%	-	100.0%	100.4%	133.3%	-	-	34.1%	29.8%	177	10.55	61	7.4	42.3%	90.9%	5	4	134,914	155,416	(20,502)
Crowborough	Crowborough Birth Centre (CBC) - NP775	34.3%	96.6%	-	-	0.0%	33.2%	-	-	2.5%	0.0%	13	0.66	1	-	52.4%	97.3%		0	69,201	66,916	2,285
TWH	Midwifery (multiple rosters)	79.3%	53.4%	-	-	93.9%	94.4%	-	-	13.6%	9.6%	710	40.58	202	10.4			1	0	683,537	719,553	(36,016)
TWH	Hedgehog Ward (TW) - ND702	142.6%	109.0%	-	-	140.1%	-	-	-	51.4%	64.1%	248	17.07	40	13.5	3.6%	100.0%	0	0	135,425	186,317	(50,892)
MAIDSTONE	Maidstone Birth Centre - NP751	115.5%	96.2%	-	-	96.8%	97.1%	-	-	17.3%	0.0%	34	2.02	0	49.8	96.7%	100.0%	0	0	70,015	78,117	(8,102)
TWH	SCBU (TW) - NA102	71.1%	847.3%	-	100.0%	94.0%	-	-	-	16.6%	0.0%	116	6.35	8	17.6	16.7%	50.0%		0	172,746	183,481	(10,735)
TWH	Short Stay Surgical Unit (TW) - NE901	56.7%	83.8%	-	-	77.4%	100.0%	-	-	22.4%	25.3%	52	3.61	8	10.9	6.7%	100.0%	0	0	73,587	63,658	9,929
MAIDSTONE	Accident & Emergency (M) - NA351	93.4%	75.3%	-	-	87.0%	60.4%	-	-	38.9%	33.8%	520	34.81	130		7.5%	95.7%	1	0	274,825	338,505	(63,680)
TWH	Accident & Emergency (TW) - NA301	86.2%	62.1%	-	100.0%	93.9%	77.7%	-	-	36.8%	45.7%	520	35.61	116		8.5%	98.3%	5	0	377,965	425,783	(47,818)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	91.2%	80.0%	-	100.0%	91.5%	-	-	-	4.1%	12.2%	6	0.33	0	12.80	87.3%	100.0%	1	0	65,523	46,912	18,611
MAIDSTONE	Peale Ward COVID - ND451	105.3%	128.1%	-	100.0%	113.8%	138.7%	-	-	28.4%	27.7%	81	5.66	31	13.20	20.5%	100.0%	2	0	107,230	100,954	6,276
MAIDSTONE	Foster Clark - NS251	100.3%	73.7%	-	100.0%	99.2%	80.6%	-	-	13.2%	1.4%	9	0.58	0	10.10	0.0%	0.0%	3	0	115,187	146,652	(31,465)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	54.8%	42.2%	-	No Hours	29.9%	0.0%	-	-	4.6%	5.4%	28	1.69	6	20.60	84.8%	99.3%	0	0	51,447	46,080	5,367
																Total Established Wards				5,715,110	5,887,285	(172,175)
																Additional Capacity beds		Cath Labs		54,431	41,763	12,668
																		Chaucer		0	425	(425)
																		Foster Clarke Winter Escalation 2(		0	150	(150)
																Other associated nursing costs				4,562,167	3,944,009	618,158
																				10,331,708	9,873,632	458,076

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

To approve the capital plan for 2021/22 **Deputy Chief Executive / Chief Finance Officer**

Please find enclosed the capital plan for 2021/22, for the Trust Board's approval. The Finance and Performance Committee considered the enclosed document and recommended that the Trust Board approve the capital plan for 2021/22 at its meeting on 25/05/21.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 25/05/21
- Finance and Performance Committee, 25/05/21

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

1. STP/ICS CAPITAL ALLOCATIONS 2021/22

Background
In March 2021 NHSEI set out the arrangements for capital allocations and planning for 2021/22, and issued a system allocation to each STP/ICS with a requirement for each system to prepare and submit a capital expenditure plan consistent with the published allocation. The plan is as usual a five year forward plan but with the primary emphasis on 2021/21 as no system level allocations are indicated for the years beyond next year.

For 2021/22, the NHS capital allocation has been split into three categories:

1. A system-level allocation (£3.9bn) – to cover day-to-day operational investments (which have typically been self-financed by organisations in ICS/STP or financed by the DHSC through emergency loans or PDC). This allocation includes funding for Critical Infrastructure (CIR), high and severe risk RAAC hospitals, diagnostic equipment and COVID-19 responses.

2. Nationally allocated funds (£1.2bn) – to cover nationally strategic projects already announced and in development and/or construction such as hospital upgrades (STP capital funded schemes) and new hospitals.

3. Other national capital investment (£1.1bn) – including national programmes such as Diagnostic Hubs, national technology funding and the continuation of the Mental Health Dormitory Replacement Programme started in 2020/21.

Whilst nationally the amount of capital has increased over 2020/21 levels (£6.2bn from £5.8bn in 2020/21), the amount for Kent & Medway is substantially reduced from the 2020/21 level – the principal reason for which has been the removal of exceptional items for interim capital that was agreed for Foundation Trusts in 2020/21. The system allocation has reduced by £17m from £94m to £77m. Further capital resource sums are likely to emerge during the year with respect to national programmes (see 2 and 3 above).

Each provider had already made early draft submissions of likely capital requirements for 2021/22 to assist in planning but the implication of the confirmed allocation is to substantially constrain the range of capital investments that had been indicated as required and desirable in 2021/22. To address this challenge a set of financial principles were agreed in principle by the STP CFO group, including:

- Each organisation, where possible, should be able to retain as a minimum their own internally generated capital resource through depreciation or other sources (e.g. asset sales or surplus cash). Where this is not possible this will not be to the detriment to the longer term capital plan requirement of an organisation. It should be noted that the centre has derived internally funded limits which in some cases are lower than the level of depreciation calculated by Trusts. The plan needs to be based on the limits provided in the system financial envelope.

- All members of the system will honour previous, and explicit, commitments toward schemes that had been deferred from earlier years

- All organisations will work together and jointly agree system priorities, and commit towards identifying sufficient resource to support these. This may require organisational priorities to be secondary to system wide priorities, in terms of allocation of system capital resources

- All organisations recognise the constrained nature of capital resources and agree to work together to make collective decisions for the benefit of the Kent & Medway population

The following was agreed as the proposed approach to distribution of the K&M capital envelope consistent with these principles. The steps involved were:

1. Employ the methodology utilised by NHSEI to assess the amount of internally generated capital resource through depreciation, and where applicable, a sum based on accumulated surplus (£59.660m);

2. Honour the commitment to replenish capital resource available to KMPT that was deferred from 2020/21 as a first call on 2021/22 capital resources (£4.000m). This enables KMPT to progress the PICU scheme delayed in 2020/21

3. The system supported a capital scheme at DGT for a Modular ward in 2020/21, for which there is a residual capital investment to be made in 2021/22 (£3.300m)

4. Support strategic priorities for:
   - Stroke reconfiguration (£7.376m). For 2021/22 the system agreed to finance early phase stroke costs as indicated by the Providers subject to OBC approval from DHSC.
   - Kent & Medway Care Record (£2.841m).

5. The sum of £1.022m made available by NHSEI will be held by the system, subject to an application process through NHSEI, to support the replacement of aged diagnostic equipment near the end of its economic life. The current STP proposals are to finance a number of smaller bids from the Trusts which includes MTW potentially receiving c. £0.43m.

Outcome of approach for 2021/22

The outcome of the STP approach to balancing to the given control total, using the NHSEI methodology plus the in-system adjustments identified above, is set out in Table 1.

Table 1: STP capital allocations by Provider 2021/22

Provider	Net Depreciation (less PFI/loan repayments)	self financed	surplus distribution	Sub total	FT loan	allocation to system	carry forward commitments	Stroke	STP reserve	TOTAL PROVIDER CAPITAL ALLOCATION
DGT	6,092	324	0	6,416			3,300	376	394	10,486
MFT	10,719	1,741	0	12,460	310				-	12,770
EKHUFT	17,061	2,145	0	19,206				1,178	-	20,384
MTW	7,511	1,157	0	8,668				280	-	8,948
KMPT	5,981	847	0	6,828			4,000			10,828
KCHFT	3,806	167	2,110	6,083		(1,150)	2,841		4,924	12,698
TOTAL TRUST RETURNS	**51,170**	**6,381**	**2,110**	**59,661**	**310**	**(1,150)**	**10,141**	**1,834**	**5,318**	**76,114**
System										1,022
										77,136

Overall MTW has therefore included a spend plan of £8,948k for 2021/22 in its submission to NHSEI in line with the system approach and control total. This includes £8,668k of internally financed resource, and £280k of system emergency PDC for the stroke design work. The stroke £280k PDC will need to be applied for through NHSEI by the end of November 2021 but is also subject to the Stroke OBC being signed off by DHSC.

The MTW latest forecast net depreciation for 2021/22 is £7.879m which is higher than the NHSEI formula but lower than the control total figure of £8,668k including “self-financing”. The difference of £706k is financed from existing cash reserves in the plan.

The STP unallocated system reserve is held by KCHFT (£4.9m) and DGT (£0.4m) – this funding will be recycled across the system (as emergency PDC) as the specific use of the overall £5.3m is agreed. In addition the STP has £1m of diagnostic fund capital available to it. Given all PDC applications need to be made by the end of November, this prioritisation process will need to be undertaken in the next few months.

No assumptions of further national capital allocations have been made by the System provider at this stage in the plan submission, with the exception of confirmed allocations or technical adjustments e.g. for MTW the PFI Lifecycle CRL adjustment.

2. MTW 2021/22 Plan

2.1 Resources

The table below sets out the forecast STP system resource position for 2021/22 of £8,948k. Additionally the Trust will have the PFI company Lifecycle capital of £1,224k for 2021/22, so the total resource position in the plan, excluding donated assets, is £10,172k.

The NHSEI Plan is a five year plan, so the future periods 2022/23 to 2025/26 include assumptions of additional STP emergency PDC and national allocations that have not been agreed, but serve to identify major capital investment requirements in the planning timescale. The spend section has the details of the assumed schemes.

The Plan did not at this stage ask for any estimates of the impact of the transition of leases onto balance sheet due from April 2022 when IFRS 16 is implemented and capitalises existing and future leases. The transitioned leases will act to reduce future internal capital resource in the same way that the capital loans/PFI do now. Any new leases after the transition date will be charges to capital, as if they were purchased capital.

Table 2: MTW Capital Sources

Capital Sources - all figures £000	2021/22	2022/23	2023/24	2024/25	2025/26
	£'000	£'000	£'000	£'000	£'000
Depreciation - Purchased	12,205	12,608	13,675	15,001	15,487
Depreciation - Donated	585	603	614	610	579
Depreciation - non-PFI	**12,789**	**13,211**	**14,289**	**15,610**	**16,066**
Depreciation - PFI/IFRIC 12	3,133	3,133	3,133	3,133	3,133
Total Depreciation	**15,922**	**16,344**	**17,422**	**18,744**	**19,199**
Less:					
Capital Investment Loan repayments - existing	-974	-974	-974	-974	-240
Salix Loan repayment	-443	-478	-376	-107	-35
PFI Finance Lease repayment	-5,402	-5,688	-5,992	-6,312	-6,237
PFI Lifecycle repayment	-1,224	-1,255	-1,286	-1,319	-1,966
Total Repayment deductions	**-8,043**	**-8,395**	**-8,628**	**-8,712**	**-8,478**
Plus: Other internal cash (surpluses/asset sales)					
Cash surplus (balancing to STP internal resource)	706				
Resource C/F	**706**	**0**	**0**	**0**	**0**
Total Internal Resources	**8,585**	**7,949**	**8,794**	**10,031**	**10,721**
Plus: Potential share of System Emergency PDC	280	51,630	7,300	25,300	5,300
Total STP system emergency PDC	**280**	**51,630**	**7,300**	**25,300**	**5,300**
Plus: Salix loan	83				
Total Loans within control total	**83**	**0**	**0**	**0**	**0**
Total STP system control total	**8,948**	**59,579**	**16,094**	**35,331**	**16,021**
Plus: National Funding & Technical sources					
PFI Lifecycle CRL	1,224	1,255	1,286	1,319	1,966
National PDC	0	42,628	0	0	0
Total External National Resources	**1,224**	**43,883**	**1,286**	**1,319**	**1,966**
Total CRL including PFI Lifecycle	**10,172**	**103,462**	**17,380**	**36,650**	**17,987**

2.2 Expenditure Plans 2021/22

The expenditure plans for 2021/22 are set out in Table 3 below. The first call on the £8.6m internal resource are the commitments carried forward from 2020/21 for projects partly completed at the end of March 2021. These include:

Estates
Enabling and installation works for major equipment items: CT Simulator (Oncology); MRI at Maidstone; Interventional Radiology room at Maidstone; Pharmacy robot replacement at Maidstone; Mammography enabling – estimates of £832k but not all yet confirmed. Any additional resource required to complete the projects will need to be found from the existing Estates/Equipment allocations.

ICC office development at Maidstone – within the £832k allocation.

ICT
EPR - £504k relating to the completion of the current modules including EPMA, assuming planned timescales

Equipment
£185k relating to the completion of the replacement Linear Accelerator (LA3C) at Canterbury

Table 3: MTW draft Capital expenditure plans

Capital Spend Plan - all figures £000	2021/22	2022/23	2023/24	2024/25	2025/26
Estates					
Estates Projects - b/f commitments	832				
Backlog maintenance	1,600	2,014	3,015	3,014	3,022
Estates developments	1,516				
Salix energy scheme - b/f commitment	83				
Subtotal - internally generated funds	**4,031**	**2,014**	**3,015**	**3,014**	**3,022**
ICT					
ICT - Backlog Wireless renewal	400				
ICT - Backlog essential Devices	400	500	1,000	1,000	1,199
ICT - Clinical Applications	153	1,300	779	1,500	1,500
ICT - Videoconferencing: TWH Education Centre/MDT	350				
ICT- network infrastructure		1,000	1,000	1,000	1,000
ICT - EPR: contractually committed	504			500	500
ICT - EPR additional	545	635			
Subtotal - internally generated funds	**2,352**	**3,435**	**2,779**	**4,000**	**4,199**
Equipment					
Equipment projects b/f part year impacts	185				
Backlog equipment replacement	2,100	2,500	3,000	3,017	3,500
Subtotal - internally generated funds	**2,285**	**2,500**	**3,000**	**3,017**	**3,500**
Subtotal - internally generated funds	**8,668**	**7,949**	**8,794**	**10,031**	**10,721**
System Emergency PDC funded projects					
Kent Medical School Accommodation		22,680			
Linear Accelerator replacement programme		3,000	3,000	3,000	3,000
Critical Medical Imaging replacement		2,300	2,300	2,300	2,300
IT Telephony replacement		750			
Centralised Cardiology Suite		18,940			
Maidstone Theatres - PDC				20,000	
HASU stroke	280	3,960	2,000		
Subtotal - Emergency PDC funded	**280**	**51,630**	**7,300**	**25,300**	**5,300**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	1,224	1,255	1,286	1,319	1,966
Oncology Site replacement - East Kent - PDC		42,628			
Subtotal - external national and technical financed	**1,224**	**43,883**	**1,286**	**1,319**	**1,966**
Total Capital Spend Plans	**10,172**	**103,462**	**17,380**	**36,650**	**17,987**

Beyond the contractual commitments there are varying degrees of priority that have been applied so far to the main capital budget headings, with finalisation of the resource needing to be aligned with business planning and confirmed through specific business case proposals. Given the tight settlement on capital, there will need to be clear contingency planning, and agreed timing of projects to ensure that the capital allocation is not overspent.

Estates

The Estates Development draft allocation of £1.5m for developments is intended to cover two particular projects:

- The resiting of the Clinical Coding department at Maidstone, following the decision to develop the ICC office in their current location
- A raft of enabling works at TWH to faciliate the Kent Medical School residences' development, itself currently being pursued through a revenue operating lease model. The enabling works relate to roads and paths to extend to the planned site of the new development.

The Salix project of £83k is the second phase of the flue economiser project from 2020/21.

The STP final plan agreed stroke allocations for 2021/22 to the three relevant providers from system PDC, and committed in principle to financing the future year HASU costs from system funding given that the availability of national or other system funding has become highly unlikely. The providers are still confirming the future costs, and post the plan submission MTW is now considering whether it can complete all the works in 2022/23, if the STP were able to finance that approach.

This leaves currently a draft allocation of £1.6m for backlog or other estates works. A provisional list from Estates had a figure of c. £3m but with varying levels of priority and need. There will need to be further work undertaken to prioritise the key schemes, and their timings, and ensuring that there is a contingency maintained until the uncertainties of the carried over commitments and the developments are crystallised with greater certainty.

ICT

The ICT capital budgets benefitted in 2020/21 from the additional STP emergency PDC and CRL funding that became available in the second half of the financial year. Therefore considerable progress was made in renewing the devices fleet prior to the Windows 10 transition (through the IVE programme) and in updating the access layer switches. For 2021/22 the main ICT capital allocation totals £1.3m with the EPR allocation set at £0.5m for the contractually committed element, but reserving a further £0.5m for potential additional modules for ITU and Surgery.

NHS Digital releases additional national allocations of capital for specific projects (e.g. Care records) so both the STP corporately and the Trust will need to seek to position itself to make use of any national funds that become available to bid against during the year.

Equipment

The 2020/21 programme benefitted from significant additional equipment funding from both STP and national sources that enabled the replacement of some large diganostic and treatment equipment. The Trust's draft capital allocation for 2021/22 for general equipment replacement is £2.1m. Some element of this budget will need to be held in reserve against emergency replacements, and further work will need to be undertaken by the equipment leads to prioritise need from this budget, taking into account alternative financing options including potential managed services/operating leases in 2021/22 (before IFRS 16 impacts on capitalising leases) and making maximum use of existing Charitable Funds.

Exclusions from the Plan

System wide

The STP also requested that no Provider include an assumption of national funding for a Community Diagnostic Hub at the plan submission stage, as it was understood that only one CDH would be funded in 2021/22 but the process of determining where that would be in the patch was not yet known. Subsequently NHSEI have issued guidance and initiated the process of selecting/prioritising the first CDH development for 2021/22.

Trust specific

Within the constrained capital envelope the Trust was not able to explicitly include the following schemes but these have been flagged with the STP as part of the consideration against the £5.3m unallocated pot, the £1.0m Diagnostic fund, and any future funding becoming available. The STP also wanted to identify the

specific risks regarding the lack of capital financing across the system. The finalised total of unfunded schemes across the system is £62m, with MTW having the largest organisation total at £16.5m.

The list has been compiled from current Divisional equipment lists taking into account materiality and age, and given the Trust has a £2.1m internal equipment allocation to utilise (plus charitable funds). It also considers schemes more likely to be seen to be wider system focussed e.g. Kent Cancer Centre/Diagnostics. The list has been reviewed and agreed at the Executive Team Meeting and reported to the Finance and Performance Committee. See Appendix 1.

3. CAPITAL MANAGEMENT ARRANGEMENTS

Overview

The capital plan is approved by the Trust Board each year, following recommendation from the Finance and Performance Committee as part of the Business Planning arrangements. Individual schemes require business cases which are in turn reviewed by the Business Case Review Panel, and approved at Executive Team meetings or at Finance and Performance Committee/Trust Board depending on the size of the value.

Actual sign off of Purchase Order requisitions follows the Scheme of Delegation with a restricted number of authorised officers at escalating levels of value (Deputy Director of Finance; Chief Finance Officer; Chief Executive Officer). There is an exceptional process to cover emergency replacement purchases.

From a budgetary perspective there are three main operational budget holders, managing each year's programme budgets:

- Estates Director – for estates schemes, or schemes with estates component
- ICT Director – for IT and Clinical systems
- Deputy COO – for Divisional and Trust-wide medical equipment

The medical equipment component includes the prioritisation of Divisional proposals within the existing resource and was established as the representative of the Medical Director, the Chief Nurse and the Chief Operating Officer.

Overall management and accountability for delivering the capital programme within the capital resource limit lies with the Chief Finance Officer and is supported by Deputy Director of Finance (Governance) and the Financial Accountant who provides programme management support.

For 2021/22, given the current constraints upon the available capital, and the development of the STP/ICS role in managing capital as a system, including access to resourcing, the Trust has re-established a Capital Steering group to review both the prioritisation of schemes, risks on the programme and the progress on projects on a monthly basis. This group is chaired by the Chief Finance Officer/Deputy CEO and include the main capital budget holders and other relevant officers that they may propose to support the monthly reviews. The first meeting took place on the 9th June.

4. RECOMMENDATION

The Trust Board is asked to review the five year capital plan submission, and approve the overall capital plan for 2021/22.

Appendix 1 - MTW Capital Risks and Priorities 2021/22

Capital schemes	2021/22 £m	Scheme Type	Priority Reason	Risk & Impact	Status
Interventional Radiology room – enabling works	0.18	Enabling build works to install replacement equipment bought in 20/21	Committed enabling works: need for additional ventilation plant replacement identified by contractor beyond original contract value	Potential delay in commissioning equipment; impact on other planned schemes	The impact will fall in 21/22 as the schemes will need to be progressed per the agreed contractual arrangements.
HIGH RISK - COMMITTED	**0.18**				
TWH Diagnostics: Replacement of Adora X ray room equipment	0.27	Major diagnostic Clinical Equipment replacement	Over-age equipment key to service continuity & patient care	Current equipment is 13 years old and unreliable; impact on patient access and outcome. Highest priority and risk register categories from Diagnostics	Fully deliverable within 21/22: business case and procurement would not be complex
Maidstone Diagnostics: X ray/Fluoroscopy room 4 equipment replacement	0.35	Major diagnostic Clinical Equipment replacement	Over-age equipment key to service continuity & patient care	Existing equipment is > 10 years old and at end of life; impact on patient access and outcome. Highest priority and risk register categories from Diagnostics	Fully deliverable within 21/22: business case and procurement would not be complex
Maidstone Diagnostics: 2 x breast screening ultrasound machines	0.17	Major diagnostic Clinical Equipment replacement	Over-age equipment key to service continuity & patient care	Existing machines 8 years old (5 year recommended life); impact on patient access and outcome. Highest priority and risk register categories from Diagnostics	Fully deliverable within 21/22: business case and procurement would not be complex
Maidstone Diagnostics: 3 x ultrasound machines	0.26	Major diagnostic Clinical Equipment replacement	Over-age equipment key to service continuity & patient care	Over-age equipment in excess of 5 years requiring replacement. Impact on patient access and outcome.	Fully deliverable within 21/22: business case and procurement would not be complex
Maidstone Obstetric ultrasound scanner	0.10	Clinical Equipment replacement (operational)	Over-age equipment key to service continuity & patient care	Maidstone scanner too old for imaging; causes delays in flow as radiographers have to repeat images. Maternity services are under close scrutiny due to the Ockenden report, it's essential that we are able to identify women and their babies who require early specialist involvement.	Fully deliverable within 21/22: business case and procurement would not be complex

Critical Care/Theatres (both sites)	0.15	Replacement of Gynae Camera Stacks	Over-age equipment key to service continuity & patient care	This will replace the existing outdated monitors and cameras/processing units/light sources which are over 10 years old with new HD ones.	Fully deliverable within 21/22: business case and procurement would not be complex
Kent Cancer Centre – rolling replacement of linear accelerators: LA3M Maidstone	1.90 1.01	Replacement of LA3M machine with Halcyon/Truebeam Enabling build and ancillary equipment	Over-age equipment key to service continuity & patient care	LA3M is 13 years old against recommended 10 year life. Continuity of cancer services/Reduced capability to new machines/impact on service access & patient outcomes	National funding may emerge to finance the LinAcc machine but it does not cover enabling and the necessary ancillary equipment
EEMU Unit consultant equipment	0.22	ENT microscope and middle ear kits	Reset and Recovery: elective activity	The Trust has a dedicated Ear Eye and Mouth unit and currently employs 4 ENT consultants. To respond to increasing elective and head and neck cancer referrals and backlog reset and recovery the Trust has committed to increase the Consultant workforce by 50%. This is essential equipment for service delivery.	Fully deliverable within 21/22 - business case would not be complex
Cancer Clinical Equipment	0.15	Replacement Dosimetry 2D Array x2	Over-age equipment key to service continuity & patient care	End of life - one matrix likely requiring repair, high use, high demand, high priority for linac and patient QA, little or no backup, 10+ years, no contract.	Fully deliverable within 21/22 - business case would not be complex
Kent cancer centre systems	0.20	ICT Kent & Canterbury network; Aria e-chemo upgrade	Service continuity, network issues persist at K&C cancer unit	Operational issues with K&C systems affecting delivery of patient care	Fully deliverable within 21/22 - business case would not be complex
Kent cancer centre systems	0.15	KOMS ICT server (including interface and Dicom requirements)	Service continuity and cyber risk	Infrastructure outdated and subject to failure – cyber security and service risk across the Cancer Division and Kent.	Fully deliverable within 21/22 - business case would not be complex
Unified Cisco System (UCS) replacement	0.40	ICT architecture servers with networking and storage access	Service continuity and cyber risk	Operational performance for clinical and non-clinical systems, and cyber resilience risks	Fully deliverable within 21/22 - business case would not be complex

ICT Storage	0.40	ICT Storage	Service continuity and cyber risk	Operational performance and cyber resilience risks	Fully deliverable within 21/22 - business case would not be complex
Maidstone Estates Backlog	1.00	Critical Backlog on Maidstone hospital site	Service continuity, Compliance issues	Risks to Operational performance and compliance with statutory requirements	Fully deliverable within 21/22 - business case would not be complex
PRIORITIES REMOVED	**6.73**				
Kent Medical School Accommodation	7.56m (full value c. £22m)	Development of Medical student accommodation and lecture room at TWH	Response to external body	Inability/severe restriction on housing medical student intake from Sept 2022 (c. 40 students per year rising to 120) – local rented market unlikely to provide sufficient capacity, alternatives require significant inter-site travel	MTW seeking to manage via an in year operating lease in 21/22 but this is high risk for delivery in terms of build programme timeline, contractual and lease assessment issues. If it is not accepted by auditors as an operating lease, or falls into 22/23 for completion, it will become a capitalisable IFRS16 lease.
TWH Diagnostics – MRI replacement	2.00	Replacement of MRI at TWH	Over-age equipment key to service continuity & patient care	Impact of equipment failure would be on patient access, delaying diagnosis and treatment. TWH MRI is over 10 years old.	Trust exploring an outsourced alternative and there may be national funding that might address
EMERGENT & POTENTIAL 21/22 ISSUES	**9.56**				
TOTAL RISK & PRIORITIES NOT IN PLAN	**16.47**				

NHS Maidstone and Tunbridge Wells NHS Trust

Approval of the Full Business Case (FBC) for the Laboratory Information Management System (LIMS) — **Chief Executive**

Please find enclosed the Full Business Case (FBC) for the Kent and Medway Laboratory Information Management System (LIMS) replacement. The Trust Board is required to approve the FBC, so the Finance and Performance Committee will therefore be asked, at its meeting on 22/06/21, to consider the FBC and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

The Business Case is for a LIMS replacement. There are currently three separate LIMS in Kent and Medway and this solution is for one LIMS across Kent and Medway. This is part of the wider Kent and Medway Integrated Care System (ICS) Pathology Programme.

The LIMS FBC succeeds the LIMS Outline Business Case (OBC) that was approved by the Programme Board in December 2019 and by Trust Boards in 2020. The FBC details the process undertaken for the LIMS tender and its outcome and provides an economic comparison between the recommended option of a remotely hosted shared LIMS provided by CliniSys Solutions Ltd. and the so-called do-minimum option of retaining three disparate LIMS.

The following documents are enclosed:
1. LIMS FBC_DRAFT_v0.4 – The FBC. Chapter 1 is the executive summary. Each chapter starts with a summary of the changes from the OBC to the FBC. This is the document being recommended to Trust Board for approval.
2. FBC Presentation Summary v0.7 – Key highlights and movements from OBC to FBC

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 25/05/21 (previous version of the FBC) and 22/06/21 (the enclosed version of the FBC)

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
1. To approve the enclosed FBC
2. To confirm whether the Trust Board wishes to receive progress reports on the implementation of the Case (and if so, to confirm the frequency of such reports) or if such reports should be delegated to the Finance and Performance 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

KENT & MEDWAY INTEGRATED CARE SYSTEM – PATHOLOGY PROGRAMME

KENT & MEDWAY PATHOLOGY NETWORK – (SOUTH 8)

Full Business Case (FBC)

Kent and Medway Laboratory Management Information System (LIMS) Replacement

Version: 0.4
June 2021

Document control

Document Information	
Programme	Kent & Medway Integrated Care System: Pathology Programme
Author(s)	Chris Stiff, LIMS Project Manager, Ada Foreman, Deputy Director Strategy Programme and Financial Planning
Version	Draft release v0.4
Document Owner	Malcolm Nudd, Director of Pathology Transformation, Kent & Medway Pathology Network

Version Control			
Version	**Date**	**Amended by**	**Summary of changes**
v0.2	28/04/21	Chris Stiff	Multiple minor changes following peer review
v0.3	28/05/21	Chris Stiff	Multiple minor changes following formal reviews
V0.4	14/06/21	Chris Stiff	Update of appendix F (Project Risks) Update to table 24 in section 2.3.7 re Project Risks Addition of references to VAT risk in sections 1.3.6 and 3.8.3

Document Approval			
Name	**Title**	**Date**	**Signature**

This document is only valid on the day it was printed, please contact the author to confirm this is the most recent version.

Contents

1 Executive Summary

1.1 Introduction

This LIMS Full Business Case (FBC) follows on from the LIMS Outline Business Case (OBC) which was approved by the Pathology Programme Board in December 2019 and subsequently by the Trust Boards and the Kent and Medway CCG Governing body in 2020.

Since the drafting of the LIMS OBC there have been significant impacting factors on pathology services nationally, and none more so that the coronavirus pandemic that is still ongoing at the time of writing. This FBC reflects on how the Kent and Medway Pathology Services have responded to the pandemic and, despite a very effectual response, how the services may have benefited by a modern integrated LIMS shared by all, working in a fully harmonised approach.

Although many of the estimated costs that informed the LIMS OBC were ratified during reviews in preparation for the development of this FBC, the LIMS FBC will show a reduction in overall estimated costs. The uninflated preferred option has reduced from the £30.1m detailed in the OBC to £25.6m in total, as detailed in this FBC.

1.1.1 Structure and Content of the Document

This FBC has been prepared using the approved Five Case Model format, which comprises the following key components:

- The **strategic case** section. This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
- The **economic case** section. This demonstrates that the Network has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM).
- The **commercial case** section. This outlines the content and structure of the proposed procurement arrangements and contractual terms.
- The **financial case** section. This confirms funding arrangements and affordability and explains any impact on the balance sheet of the host Trust – East Kent Hospitals University NHS Foundation Trust (EKHUFT).
- The **management case** section. This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

1.1.2 The Programme Context

This FBC seeks approval to invest in a new Laboratory Information Management System (LIMS) for the whole of Kent and Medway and forms part of a programme of transformational change across the pathology services of Kent and Medway. This FBC succeeds the LIMS OBC, which was developed

alongside the Managed Equipment Services (MES) OBC which, together, detail the proposed investment schemes that will enable the Kent Pathology Programme to achieve its agreed objectives.

The MES OBC focussed on the need to undertake wholesale changes to the provision of the key laboratory equipment, such as the tracked analysers. This will eventually be succeeded by the related FBC in 2022/23. Due to the expected implementation timeline for this project the procurement cannot commence until 2022/23 and in the interim, current contracts have been extended which have provided a saving to the programme.

The LIMS OBC was approved by the four acute Trust Boards and the Kent & Medway CCG in 2020 and was then submitted to NHSEI for approval. Verbal approval has been provided and, as at 27th April 2021, a formal letter of approval is awaited. Letters of support from the acute Trusts and the Kent & Medway CCG were provided in support of the LIMS OBC and appendix A1 and A2 are the draft letters that the same bodies will be asked to sign in support of this LIMS FBC at the outcome of their Board approval process, prior to submission to NHSEI. The letter of support from the CCG makes specific reference to its support for transition funds. The LIMS OBC was also accompanied by the completed *'Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts - Annex 1: Business case core checklist'* and this has been updated to support this FBC. This document can be found in appendix B.

It is recognised that delivering the necessary change at a county-wide scale will inevitably require investment in new equipment and technology. This FBC focuses specifically on the need for a new LIMS to support the other significant changes to Pathology enabled by the MES initiative.

Analyses of other recent LIMS business cases has shown that this business case is typical in establishing that, on its own, the significant investment in a new LIMS will not generate savings. However, a new LIMS will be a key enabler for changes as detailed in the following table:

Table 1: Comparison between new and existing LIMS

New LIMS	Existing LIMS
The ability to harmonise the services across Kent and Medway. Harmonisation means a largely single approach to: Units of measure (tests orderables etc) Test/orderables catalogue Definition of tests, panels etc. Workflows Methods Quality Management System Policies The above will be achievable only via the same, integrated, LIMS or ideally a single shared LIMS. A single shared LIMS enforces standardisation.	Existing disparate LIMS will not support standardisation. It may be possible to standardise the approach to some aspects but physical differences in the design and configuration of existing LIMS will prevent total harmonisation.
Flexibility in the use of resources as all labs will be	Due to the existing LIMS being physically

New LIMS	Existing LIMS
familiar with and have access to the same system.	different systems or, where the same, being configured differently, coupled with different laboratory working practices, the use of resources from other labs cannot be achieved effectively.
New functionality that is not available in the existing LIMS that are around 25 years old.	Technology progresses. Legacy LIMS have been updated since first being installed circa 25 years ago but they do not compare to newer systems available.
The ability to take advantage of emergent technologies such as Digital Pathology and Artificial Intelligence (AI).	Legacy systems will most likely not be able to fully accommodate some emergent technologies and it is unlikely that the supplier will develop the legacy LIMS further due to their development of their next generation LIMS.
Compliance to new mandated standards such as SNOMED-CT and FHIR.	Existing LIMS do not accommodate these standards.

1.1.3 Project Interdependency

As implementing a new LIMS will not generate material savings, funding for the scheme will come in part from the savings achieved by the MES project and other projects, which are detailed in this FBC. MES savings will be delivered within specific organisations from the base year to the new MES implementation, from current contract extensions.

The Programme also includes a project for referred tests and a project for pathology transformation which are all supported by a dedicated Project Management function. The total anticipated savings to year 14 are £19,722. See table 19 in paragraph 1.5.5 for details.

1.2 Strategic Case

1.2.1 The Strategic Context

Around 70% of all diagnoses made in the NHS involve pathology. National demand for pathology is estimated to be around 1.2 billion tests per year with approximately 44% originating from primary care. Year on year increases are being observed by individual laboratories and across Kent and Medway approximately thirty-nine million tests are undertaken annually with continued growth. Activity growth stems from multiple causes; changes in demographic composition of the patient community cohort, for example, will impact pathology testing rates. Appendix C provides further information on population change forecasts for Kent and Medway. It should be noted however, as stated in appendix C, that an increase in the demand for existing pathology services does not directly or linearly impact LIMS. The procured LIMS will, by specification, be able to accommodate year on year activity growth.

In autumn 2017 NHS Improvement (NHSI) announced 29 new pathology networks. NHSI believes these new structures will support high-quality services to patients and facilitate a new generation of investigations, enhance career opportunities for clinical, scientific and technical staff, and deliver efficiencies to the NHS of at least £200m annually. The NHS Long Term Plan also directs for pathology networks to be established by 2021.

The pathology services in Kent & Medway are combined within the 'South 8' network as determined under the NHSI initiative. In October 2020 a vision document was agreed by the Pathology Programme Board, in which an alternative 'alliance' model of networked working was described. In this way the 'South 8' Network will be provided via three independent pathology hub and spoke services working together under the guidance and support of a Director of Pathology Transformation, who was subsequently appointed in December 2020 and started in role in March 2021.

The UK and the wider world is in the grip of a pandemic. At time of writing, there have been 4.38 million recorded cases of Covid-19 disease in the UK, which has led to 127k deaths so far. NHS Pathology services undertake many of the tests that provide the results to support individual case management and the South 8 Network has performed exceptionally during this period. The network however, has been impeded by its poor connectivity across laboratories and despite functioning very well, a single modern LIMS across all services would have added significant benefit. The recent Richards Review, (*Diagnostics Recovery & Renewal, October 2020)*, published during the pandemic, highlighted the importance of increased connectivity, stating:

"Digitisation and IT connectivity across the NHS is currently variable, but will be vital for diagnostic networks to work efficiently."

The implementation of Community Diagnostic Hubs (CDHs) recommended in the Richard's review will require improved digital infrastructure and connectivity, which will be essential for their successful implementation.

In June 2019, NHSEI wrote to all CEOs and Finance Directors emphasising that LIMS deployments must meet the standards for SNOMED-CT (Systematised Nomenclature of Medicine - Clinical Terms), FHIR (Fast Healthcare Interoperability Resources) and guidelines for open access of systems, which the Kent & Medway Pathology Network will only be able to achieve through replacement of the legacy LIMS.

In a reflective article focussing on lessons learnt from pathology consolidation, the Head of Service for Pathology at Queen Elizabeth University Hospital, Glasgow wrote:

"Another significant challenge that we have not yet overcome is dependence on an ageing IT infrastructure. This was highlighted at the time of the proposed merger and although a new LIMS was promised, it was not delivered. Failure to provide adequate laboratory IT has had a significant negative impact on efficiency. Hopefully, this is something we will overcome in the coming years."

The Kent and Medway Sustainability and Transformation Partnership (STP) and the eight CCG's merged in April 2020 into a single Clinical Commissioning Group, Kent and Medway CCG. From 1st In April 2021 the NHS and its partners in Kent and Medway were formally designated an Integrated Care System (ICS). The development of four place-based Integrated Care Partnerships, each

including one of the acute hospital Trusts, and 42 Primary Care Networks is underway. These changes will impact on how direct access pathology services are commissioned and will enable the move of care closer to where people live

The wider planned changes to the Pathology services in Kent and Medway will support this significant change but will be hampered by the digital infrastructure unless the decision to invest in a modern, shared LIMS is made.

1.2.2 The Case for Change

In July 2018, the Kent and Medway Pathology Programme agreed to five strategic objectives linking back to the major challenges set out in the SOC and these formed the investment objectives detailed in the LIMS OBC:

- **Objective 1:** The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative and creative.
- **Objective 2:** Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs.
- **Objective 3:** Creating a workforce that feels valued, involved and owns the single pathology service as partners in the service; and it is a great place to work.
- **Objective 4:** Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential and meets the needs of the client Trusts and Commissioners.
- **Objective 5:** Managing the transition to the new service in a creative and competent manner.

Since the OBC was developed and following agreement on the Kent & Medway Pathology Network's alliance-based model of working, these objectives have been reviewed and only slightly revised to exchange 'service' with network where relevant.

Resulting from the increasing capabilities of modern healthcare IT/digital systems and the rise in new technologies, the legacy LIMS, being disparate and non-integrated, no longer meet the need and will not enable the Pathology Network to achieve the stated objectives. The LIMS OBC considered the best approach for their LIMS infrastructure to achieve these and also facilitate and embrace opportunities that may arise from innovations. This investment scheme should therefore be viewed as an imperative rather than optional.

1.2.3 Equality and Health Inequalities Impact Assessment

A Quality Impact Assessment (QIA) has been completed at programme level and an Equality, Diversity and Inclusion Impact Assessment (EDIIA) has been completed at project level. These can be seen in Appendices U and V. The QIA considers risks across multiple domains, namely: Patient Safety, Clinical Effectiveness, Patient Experience, Staff Experience and Inequalities. The output of the QIA determined that there were no discernible negative impacts across these domains resulting from the Programme. The EHIA considers the impact of the programme on the ten protected

characteristics outlined in the Equality Act 2010 and any other groups which may be impacted positively or negatively

1.3 Economic Case

1.3.1 Critical Success Factors

Aligned to the stated investment objectives, the Kent and Medway Pathology Programme agreed 6 critical success factors (CSFs) against which the project success will ultimately be assessed. These can be summarised under the following headings:

- Addressing clinical priorities and improving outcomes
- Overall costs
- Provide a solution that supports staff
- Timetable
- Ability to meet increasing demand for pathology services
- Technological change

1.3.2 The Short List

The following short list of options that emerged at outline business case is as follows:

Option 1 This is the Do Minimum option. Each Trust would keep their existing LIMS. However, as urgent hardware refreshes are now required for at least two Trusts and the entire LIMS will need to be replaced within the next few years, significant investment will still be required with this option.

Option 2 Keep existing LIMS as per option 1 and additionally integrate through a new common Trust Integration Engine (TIE) and new eMPI (enterprise Master Patient Index). This will see some additional benefits brought about by the integration of the legacy LIMS.

Option 3 Each Trust buys same new LIMS and Integrates them via new TIE and eMPI. (The first option based on a new LIMS implementation that focuses on achieving the Pathology Programme's objectives).

Option 4 One Trust buys new LIMS and hardware on behalf of all Trusts and installs on site.

Option 5 One Trust enters a Managed Service Contract for a new, remotely hosted (in the cloud) LIMS solution on behalf of all Trusts. This option would see the transfer of most of the risk (and control) to the supplier.

The preferred and agreed option at OBC stage was Option 5 and a competitive procurement exercise was undertaken on this option. Hereon the FBC progressed with only two options and as such option 1, is defined as Option A, the do minimum option as the Public Sector Comparator (PSC) and option 5 is defined as Option B, the preferred option.

1.3.3 The Procurement Process

The procurement tender was launched in September 2020 and was concluded in April 2021. The procurement was managed through a mini-competition process using the QE Procurement framework: “Clinical software (and hardware) solutions for use in healthcare”.

The tender process consisted of 5 stages.

Stage 1: Mandatory Questions (Invitation to tender stage)

Stage 2: Initial Proposal

Stage 3: Supplier demonstrations and validation

Stage 4: Reference site visits and validation

Stage 5: Best and Final Offer (BAFO)

Appendix D is the Procurement Outcome Report, which fully details the process that was undertaken to arrive at the recommended bidder; however the process can be summarised as follows:

Stage 1 required prospective bidders to consider a total of 24 criteria and respond by stating whether the company or system either fully complied with each criterion or did not comply. For the prospective bidder to be able to pass through to Stage 2 they must have been able to fully comply with all 24 criteria. At the end of stage 1, two prospective suppliers were invited to tender:

- CliniSys Solutions Limited; and
- Cirdan Imaging limited.

Stage 2 required these bidders to state their level of compliance to the Output Based Specification (OBS) by providing a ‘fully compliant, partially compliant or non-compliant’ response to each criterion and also to provide detailed written responses to associated technical questions.

A team of 30 Subject Matter Experts (SMEs) from all Kent and Medway acute Trusts undertook the evaluation against defined scoring criteria and the rationale for their scores was recorded. The out-come of the evaluation was that both bidders were taken through to Stage 3.

Stage 3 of the tender enabled bidders to facilitate scripted system demonstration sessions in order for the evaluators to validate the scores agreed at Stage 2. Both bidders were invited to progress to Stage 4.

Stage 4 required bidders to arrange a reference site visit with the selected site on a date provided with around 8 weeks’ notice. Unfortunately, Cirdan was unable to arrange the requested visit on the

agreed dates and they were provided with a further two weeks to propose another date, which was eventually agreed.

The CliniSys reference site validation events were completed with one minor delay to one session however Cirdan failed to gain representation from their reference site and all visits were cancelled at their request.

Due to the stage 4 slippage, in order to ensure that the overall tender timeline was not extended, it was decided to run stage 4 and stage 5 in parallel. However, bidders had to successfully complete stage 4 in order to be able to submit a best and final offer.

Cirdan's inability to provide a reference site visit led to them withdrawing from the tender and therefore only one bidder remained at stage 5.

Stage 5 is the BAFO stage during which a fully compliant offer was received from CliniSys. The offer was reviewed with the support of external legal advisors to consider the degree of risk to which the Trusts would be exposed. The advice received was that proposed changes to the draft contract terms and conditions affect the (host) Trust's interests but do not have a material impact on the overall balance of risk and/or are acceptable to the Trust in terms of overall risk transfer.

1.3.4 Economic Appraisal

This section provides a detailed overview of the costs and benefits associated with the CliniSys offer in comparison to the do minimum option as the PSC. In the following sections, the PSC is referred to as Option A and the CliniSys offer that represents Option 5 that the procurement was undertaken against, is referred to as Option B.

The following assumptions and bases have been used to calculate the economic and financial impact of the proposed investment scheme:

Table 2: Economic Appraisal Assumptions

OBC	FBC
Base year (Year 0) is 2019/20	Base year (Year 0) is 2020/21 which includes the costs being at 20/21 pay rates
Contract duration and anticipated system life is 10 years based on historic rate of system development. Within this period a hardware refresh at year 5 is expected to be required and has been included within the costs	Within this period a hardware refresh at year 5 of the operational contract term is expected to be required and has been included within the costs.
All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option 5 and the ASM in all options.	All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option B and the ASM in all options.
Discount factor is 0.035 (3.5%).	Discount factor is 0.035 (3.5%).

OBC	FBC
Effect of inflation has been excluded	Effect of inflation has been excluded
Scheme will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available.	Option A will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available
Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the Treasury green book approach	Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the Treasury green book approach
10% optimism bias has been added to the system capital costs based on the Treasury green book approach	10% optimism bias has been added to the system capital costs based on the Treasury green book approach for option 1 only
The Managed Service Contract term of 10 years for Option 5 is assumed to commence from the date of the first go-live to the new LIMS	The Managed Service Contract term of 10 years for Option B is assumed to commence from the date of the final go-live to the new LIMS
There may be a cash impact caused by any payments to the supplier during the implementation stage but these have not been modelled. These will be identified during the tender.	The total contract term for Option B will reflect the implementation period from contract signature to final go live which results in a contract term of c13 years. The implementation costs of the supplier are reflected where applicable during the implementation period and included in the total costs of Option B.
Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included.	Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included. Plus the TIE as at date of FBC approval for option 1
Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.	Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.
Specific procurement related costs have been included within the implementation team costs, however, work undertaken by Trust-based procurement services are absorbed within business-as-usual (BAU) costs of the Trust and therefore not included within the OBC costs	No additional procurement related costs have been incurred due to the tender being run via a framework and evaluation undertaken by internal subject matter experts. Work undertaken by Trust-based procurement services are absorbed within BAU costs of the Trust and therefore not included within the costs of the FBC.

1.3.4.1 Benefits

Appendix E provides an overview of all the benefits for the two shortlisted options. The table cross-references each identified benefit to the investment objectives. The benefits are shown as either cash-releasing (CRB), non-cash-releasing (NCRB) or Qualitative (Q). Where they can be quantified, the identified cash-releasing benefits specifically relating to the LIMS replacement only have been included within the total financial position detailed within the financial case of this document.

1.3.4.2 Net Present Cost

The undiscounted and discounted values for all options are shown in Table 3 below. The capital and revenue elements for each option are described in section 3.6.4.

The comprehensive investment model (CIA) shown in appendix G was used to calculate the Net Present Costs for each option. The CIA combines the costs, quantified benefits and quantified risks associated with each option.

Table 3: Undiscounted and Discounted values for all options:

From CIA	Undiscounted (£'000)	Net Present Cost (£'000)
Option A – PSC		
Capital	14,898	13,272
Revenue	19,467	15,548
Risk retained	1,385	1,140
Optimism bias (if applicable)	594	541
Total costs	**36,344**	**30,501**
Less cash releasing benefits	0	0
Costs net cash savings	**36,344**	**30,501**
Non-cash releasing benefits	0	0
Total	**36,344**	**30,501**
Option B – Preferred supplier		
Capital	595	555
Revenue	29,602	24,040
Risk retained	382	327

From CIA	Undiscounted	Net Present Cost
	(£'000)	(£'000)
Optimism bias (if applicable)	0	0
Total costs	**30,579**	**25,921**
Less cash releasing benefits	(5,940)	(4,411)
Costs net cash savings	**24,639**	**20,510**
Non-cash releasing benefits	0	
Total	**24,639**	**20,510**

There are no social benefits nor financially quantifiable non-cash-releasing benefits therefore the only economic assessment is on net present costs which considers cash releasing benefits.

Appendix G is the comprehensive investment model which derived the values reflected this table.

1.3.4.3 Economic Appraisal Outcome

The economic appraisal considers revenue and capital expenditure, the cash-releasable benefits delivered by the option and the risk appraisal considered for the capital risks identified through the Green Book risk assessment approach. These costs are based on the cash profile.

The Net Present Costs (NPC) were calculated for the cashflows under the five options. The Department of Health and Social Security (DHSC) template Comprehensive Investment Appraisal (CIA) and the HM Treasury Green Book approach to estimating costs have been applied in this FBC stage.

Table 4: Economic Appraisal Summary

Option	Description	NPC	Cash benefit	Non cash benefit	Cost net cash savings	Costs net all savings	Ranking
		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	
A	Do Minimum	30,501	0	0	30,501	30,501	2
B	Preferred bidder	24,921	(4,411)	0	20,510	20,510	1

The outcome of this economic appraisal is that Option B ranks highest.

Table 5 below shows that Option B has the lowest incremental increase in cost of £10m compared to the BAU cost.

Table 5: Incremental Value for Money Analysis

Evaluation Results Incremental impact	Cost £'000	Benefit £'000	Risk £'000	Total £'000
Option A	19,152	0	1,140	20,293
Option B	14,386	(4,411)	327	10,302

1.3.5 Qualitative Benefits Appraisal

At OBC stage, seven criteria through which to qualitatively evaluate the options were identified, discussed and agreed as outlined above. The criteria are:

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

Because there was only one remaining bidder at the end of the procurement process, these criteria were reassessed at FBC stage and confirmed as still relevant for use in appraising the two remaining options.

At OBC stage, an options appraisal workshop was held. The 8-member panel was comprised of the Pathology Clinical Directors, Pathology General Managers and the Directors of IT at each Trust. The panel undertook an options appraisal using agreed criteria based on benefits, risk and the degree to which the option enabled the achievement of the investment objectives.

The highest-ranking option of the evaluation was the implementation of a remotely hosted single shared LIMS procured through a revenue-based arrangement. In table 6 below this is shown as Option B. Option A is the do minimum PSC option provided for comparison.

Table 6: Summary Qualitative Appraisal Scores

Evaluation Results	Option A	Option B
Qualitative appraisal (%)	23	85
Ranking	**2**	**1**

Because at the end of the LIMS tender process only one bidder remained, as previously stated the logical process to derive a qualitative appraisal outcome at FBC stage was to confirm that the process undertaken and outcome obtained at OBC stage was still pertinent; and to transpose the generic Option 5 for the solution provided by the successful bidder, CliniSys.

To ratify the outcome, the original appraisal criteria, identified benefits and identified risks pertaining to both options were reassessed by the Director of Pathology Transformation and the Chair of the LIMS Project Steering Group (the General Manager of Pathology at Maidstone and Tunbridge Wells NHS Trust (MTW). They concluded that the offer provided by CliniSys aligns to the generic Option 5.

1.3.6 Risk Appraisal

The possible business and service risks associated with the two shortlisted options that were identified at the OBC stage were reviewed by the Director of Pathology Transformation and the Chair of the LIMS Project Steering Group.

Each unquantifiable risk was assessed based on its impact should it occur and the probability of it occurring. The standard risk assessment matrix adopted by the Pathology Programme was used to determine a Risk Priority Number (RPN) by multiplying the impact and probability scores together, therefore the higher the RPN, the higher the risk is perceived to be.

Table 7: Summary Unquantifiable Risk Appraisal Scores

Unquantifiable Risk Evaluation Results	Option A	Option B
Risk Priority Number totalled	88	59
Ranking	**2**	**1**

Appendix G provides a high-level overview of the identified quantifiable risks associated with the two shortlisted options. These are the risks that relate specifically to an option and not the wider project and these were used to calculate contingency costs for both options. Risks were assessed through the whole anticipated contract lifecycle using the CIA. The risk that VAT is not recoverable is deemed to be a contingent liability and is therefore not included in the contingency cost figures.

1.3.7 Options Appraisal Outcome

The results of the combined appraisals are as follows:

Table 8: Summary of total appraisal results

Evaluation Results	Option A	Option B
Economic appraisal ranking	2	1
Qualitative appraisal ranking	2	1
Unquantifiable risk appraisal	2	1
Overall Ranking	**2**	**1**

A cost benefit ratio has been calculated for both shortlisted options in the CIA. The benefit is less than a ratio of 1:1 for both, as this is an investment case to enable the wider Pathology Programme to deliver benefits.

The programme as a whole is expected to yield a benefit ratio of 1.81 when the incremental cost and benefits of all the projects within the programme are taken into consideration. This is presented in table 9 below

Table 9: Incremental net present cost of the pathology programme

Preferred option	LIMS £'000	MES £'000	Transformation £'000	PMO & Referred tests £'000	Total £'000
Incremental Net present cost	14,386	0	0	491	14,877
Cash releasing benefit	(4,411)	(14,104)	(5,796)	(3,276)	(27,587)
Non-cash releasing benefit	0	0	0	0	0
Sub-total	9,975	(14,104)	(5,796)	(2,785)	(12,710)
Risk	327	0	0	0	327
Total net present cost / (benefit)	**10,302**	**(14,104)**	**(5,796)**	**(2,785)**	**(12,383)**
Net benefit to cost ratio	0.30	N/A	N/A	6.67	1.81

1.3.8 Sensitivity Analysis

Sensitivity analysis provides an assessment of the impact on the economic evaluation should the underlying assumptions prove to vary when the preferred option is delivered.

1.3.8.1 Results of Scenario Sensitivity Analysis

The following table summarises the scenario sensitivity analysis:

Table 10: Sensitivity Analysis

	Option A	Option B
Sensitivities	**£'000**	**£'000**
Base NPC	**20,293**	**10,302**
All Capital costs 10% Higher	21,815	10,317
All Capital costs 10% lower	18,771	10,287
Revenue 5% higher	21,447	12,172
Revenue 5% lower	19,139	10,302
Implementation costs 10% higher	20,773	10,703
Implementation costs 10% Lower	19,813	9,902

Note: Sensitivity analysis on identified risks was not undertaken as these were considered immaterial and would not affect the outcome of the result. Equally, sensitivity analysis on benefits was not undertaken as these were considered factual.

1.3.9 The Preferred Option

Based on the options appraisal outcome, Option B is the preferred option as is demonstrably the better option. As the only remaining supplier at the end of the competitive procurement process, CliniSys are the recommended supplier.

1.4 Commercial Case

1.4.1 Required Services

CliniSys, as the recommended supplier, will be required to provide a single remotely hosted multi-disciplinary LIMS accessible to all legitimate users throughout all laboratories via managed service contract.

EKHUFT will host the LIMS contract on behalf of the Kent & Medway Pathology Network. As a result, EKHUFT will be the purchaser of the service on behalf of the Network but will be supported by 'back-to-back' agreements (also referred to as a collaboration agreement) with the other members of the Network to ensure that all Trusts are equally accountable under the terms of the contract with CliniSys.

1.4.2 Agreed Risk Transfer

The general principle is that risks should be passed to 'the party best able to manage them,' subject to value for money.

This section provides an assessment of how the associated service risks during the design, build and operational phases will be apportioned between the Network and the recommended supplier, CliniSys.

Table 11: Agreed Risk Allocation Matrix

Risk Category	Agreed allocation			Related Contract Schedule
	Network	CliniSys	Shared	
1. Design risk			✓	N/A
2. Construction and development risk			✓	N/A
3. Transition and implementation risk			✓	6.1
4. Availability and performance risk		✓		2.2
5. Operating risk	✓			N/A
6. Variability of revenue risks	✓			N/A
7. Termination risks	✓			7.2
8. Technology and obsolescence risks			✓	N/A
9. Control risks	✓			8.1
10. Financing risks	✓			7.1, 7.2, 7.4, 7.5
11. Legislative risks	✓			N/A
12. Other project risks	✓			N/A
13. Price Increase above NHS Inflator			✓	7.1
14. Contract delivery penalties		✓		7.1

1.4.3 Agreed Charging Mechanisms

The contract will run for 10 years from the point of the final go-live, estimated to be November 2024, and will therefore be for approximately 12 years 11 months in total as the full implementation across the three hub laboratory groups will take an estimated 3 years from contract award, which is estimated to be December 2021. The draft contract allows the possibility of the contract length being extended for further periods of up to 5 years.

Ahead of the service being fully operational, the new LIMS must be deployed across all three pathology services. Payments have been agreed for key deployment milestones including hardware build, LIMS configuration, data migrations and each go-live. For each of the milestones a minimum delay payment of £3k has been agreed and is defined in the draft contract.

Only variable operational prices are to be subject to Consumer Prices Indexation (CPI) and therefore indexation will not apply to deployment (milestone) costs. Indexation will be capped at the current CPI rate or 2%, whichever is the higher.

The draft contract requires CliniSys to meet an Operational Service Level (OSL) of 99.98% with Service Credits being applied at 99.91%. Schedule 2.2 of the contract also details the maximum time that CliniSys will be permitted to take in resolving any Service Incidents. Service Incidents are graded between severity level 4, which requires CliniSys to resolve the incident within 80 hours and level 1, which requires CliniSys to resolve the incident within 4 hours. Failure to achieve these targets for each incident recorded will result in Service Credits being applied.

1.4.4 Key Contractual Clauses

The proposed contract for the supply of the LIMS is a variation of the standard services agreement used by the QE procurement framework, which in turn is based on the government's current model services contract. The minor variation from the QE Procurement model followed advice and guidance received from the external legal advisors, DAC Beachcroft.

The draft contract comprises a main terms and conditions document and 28 separate schedules, each detailing specific aspects.

Each schedule is important in its own right however, arguably of key importance, are Schedule 2.1 (Services Description) and Schedule 2.2 (Performance levels). These schedules detail the expectations of the Trusts and the supplier's contractual obligations in meeting those. Appendix H is Schedule 2.1 and appendix I is Schedule 2.2

Schedule 2.2 sets out the standards to which the supplier must deliver the services, the mechanism by which Service Failures will be managed, and the method by which the supplier's performance under this agreement will be monitored.

The mechanisms employed give a well-defined boundary of what must be delivered, together with a fair means to allow the deduction of points where this has failed to occur, and a clear and well-structured process that allows all parties to determine both what has happened, and the reasons and responsibilities where it has not been in line with the expectations of the contract.

1.4.5 Personnel implications (including TUPE)

TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2014) will not apply to this investment.

The proposed investment includes a new post of LIMS System Manager, who will be employed by EKHUFT. The existing Pathology IT Managers employed separately at the individual Trusts will have professional accountability to this person for the support of the LIMS in use at their respective Trusts and sites, whilst continuing to report hierarchically to the Pathology General Managers.

The implementation of the proposed single shared LIMS will not directly impact the employment of other staff at any of Network's Trusts.

1.4.6 Procurement Route and Implementation Timescales

As previously stated, a competitive procurement process using the QE procurement framework was undertaken and the tender concluded with one remaining bidder, CliniSys Solutions Ltd, submitting a compliant best and final offer. CliniSys will be awarded the contract subject to the approval of this full business case by the Boards of the Kent and Medway Trusts, the Kent and Medway CCG and NHSEI.

A representative project plan, which outlines key tasks throughout the implementation and across multiple workstreams is provided in appendix J, however, the definitive project plan will be agreed jointly with CliniSys within 40 working days of the contract being awarded, as stipulated in the draft contract.

It is anticipated that the implementation phase will take approximately 3 years from contract award, assumed to be December 2021, to the final go-live being fully completed in November 2024. The early stage following contract award will include supplier resource mobilisation and the finalisation of the LIMS/Process harmonisation work, which must be completed before the new LIMS can be configured.

1.4.7 IFRS Accountancy Treatment

The contract with CliniSys will be for a remotely hosted solution and the provision of a service. No assets will be for the sole use of the network, so this is assumed to be a service contract and not 'on balance sheet'. This assumption has been reviewed by EKHUFT's external auditors who support this assumption.

1.5 Financial Case

1.5.1 Financial Assumptions

The assumptions detailed in the Economic Case summary in paragraph 1.3.4 apply to the financial case.

1.5.2 Source of Costs

1.5.2.1 Current Costs

Current costs associated with supporting the current LIMS have a collective recurrent operating cost of £868k per annum as shown in Table 12 below.

Table 12: Current Pathology IT Operational Costs

	Total LIMS IT Support				Non-LIMS			Total Pathology IT Support		
Trust	**WTE**	**Pay**	**Non-Pay**	**Total**	**WTE**	**Pay**	**WTE**	**Pay***	**Non-Pay**	**Total**
		£'000	**£'000**	**£'000**		**£'000**		**£'000**	**£'000**	**£'000**
EKHUFT	2.05	109	191	**300**	0.10	5	2.15	114	191	**305**
MFT	0.15	5	81	**86**	0	-	0.15	5	81	**86**
DGT	2.05	97	97	**194**	1.10	37	3.15	133	97	**230**
MTW	2.05	109	179	**288**	0.10	5	2.15	114	179	**293**
Totals	**6.30**	**320**	**548**	**868**	**1.3**	**47**	**7.60**	**367**	**548**	**915**

*Includes both Pathology IT staff and Trust IT staff.

1.5.3 Impact on the Income and Expenditure of the Organisations

The total inflated income and expenditure for the preferred option are shown in Table 13 below. Inflation has not been applied to capital charges or contingency which are now reflected as a revenue cost in table 13 below.

Table 13: Inflated Income and Expenditure for Option B

Income and Expenditure (Inflated)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Yr 14 to Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
Option B	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue, including capital charges	873	1,879	3,132	3,728	3,465	1,439	1,464	1,489	1,517	1,545	1,572	1,562	1,590	1,585	1,103	27,942
Total	**873**	**1,879**	**3,132**	**3,728**	**3,465**	**1,439**	**1,464**	**1,489**	**1,517**	**1,545**	**1,572**	**1,562**	**1,590**	**1,585**	**1,103**	**27,942**
Funded by																
Existing	873	885	893	901	909	917	925	933	942	950	959	968	976	985	994	14,010
Additional	0	995	2,239	2,827	2,556	522	539	555	575	595	613	594	613	600	109	13,933
Total	**873**	**1,879**	**3,132**	**3,728**	**3,465**	**1,439**	**1,464**	**1,489**	**1,517**	**1,545**	**1,572**	**1,562**	**1,590**	**1,585**	**1,103**	**27,942**

Costs will be split proportionally on the basis of the agreed financial principles which is the gross cost of the pathology service as per the NHSI returns 18/19 outturn. Table 14 provides the details of the distribution of investment/savings.

Table 14: Proportionate Split of Additional Revenue Costs

	MTW (£'000)	EKHUFT (£'000)	NKPS (£'000)
Annual Gross Cost	26,039	27,377	26,368
Percentage	33%	34%	33%

(SOURCE: 2018/19 final NHSEI return)

Applying the above proportionate percentages to the total I&E position produces the following costs per organisation.

Table 15: Proportionate Split for all Trusts for Option B inflated revenue

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Yr 14 to Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
Option B	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Investment																
Central funds	475	0	0	0	0	0	0	0	0	0	0	0	0	0	0	475
EKHUFT	0	0	0	0	0	0	0	0	201	0	0	0	0	0	0	201
Total capital investment	**475**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**201**	**0**	**0**	**0**	**0**	**0**	**0**	**676**
Revenue Investment – Inflated																
MTW	0	325	731	923	834	170	176	181	188	194	200	194	200	196	36	**4,547**
EKHUFT	0	341	768	970	877	179	185	191	197	204	210	204	210	206	37	**4,781**
NKPS	0	329	740	934	845	173	178	184	190	197	203	196	203	198	36	**4,605**
Total I&E Impact	**0**	**995**	**2,239**	**2,827**	**2,556**	**522**	**539**	**555**	**575**	**595**	**613**	**594**	**613**	**600**	**109**	13,933

Mitigations have been agreed with the Kent and Medway CCG to 'bridge fund' the adverse impact in the four years from 2021/22 to 2024/25 to manage the phasing of the LIMS investment in order to support the delivery of the pathology service transformation programme.

Should the project not progress to the implementation stage; sunk costs, which have already been incurred and have already been charged to revenue budgets. The purchase of the TIE would be used for alternative projects which would need to fund the capital charge impact. It would also result in no return on investment already incurred.

1.5.4 Impact on Balance Sheet

The capital assets of the TIE and LIMS data archive solution are on EKHUFTs balance sheet and will be depreciated in line with the accounting policies of the Trust. The costs include a server refresh for the TIE during the life of the project.

The contract with CliniSys will be for a remotely hosted solution and the provision of a service. No assets will be for the sole use of the network, so this is assumed to be a service contract and not 'on balance sheet'. This assumption has been reviewed by EKHUFT's external auditors who support this assumption over the standard life of the equipment.

To ensure the liabilities committed by EKHUFT's contract with the supplier, a collaboration agreement will be entered into by all Pathology Network partners as a form of Back-to-Back Agreement to legally bind all parties to their commitment and financial obligations of the contract.

1.5.5 Overall Affordability

The detailed cost of the LIMS (uninflated) is detailed in table 16 below including the share of these costs by pathology Network member.

Table 16: Uninflated Detailed Costs for Option B

Option B: uninflated	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Implementation	0	557	1,985	2,140	1,423	0	0	0	0	0	0	0	0	0	0	6,105
Pay	320	320	320	320	320	320	320	320	320	320	320	320	320	320	320	4,804
Non pay	548	901	571	712	1,038	596	596	596	596	596	596	596	596	596	348	9,485
Contingency	0	8	10	26	18	25	25	25	25	25	25	0	0	0	0	211
Sunk costs	0	0	0	49	35	0	0	0	0	0	0	0	0	0	0	84
MSC	0	0	0	130	598	984	984	984	984	984	984	984	984	984	574	10,155
Depreciation & capital contingency	0	34	124	156	99	80	80	80	80	78	78	66	66	33	0	1,057
Dividend	5	17	17	16	15	12	10	8	9	10	8	5	3	1	0	135
Sub-Total	**873**	**1,837**	**3,027**	**3,550**	**3,546**	**2,017**	**2,016**	**2,013**	**2,014**	**2,013**	**2,011**	**1,972**	**1,969**	**1,934**	**1,242**	**32,036**
Savings-Pay	0	0	0	0	(34)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(48)	(828)
Savings-Non-pay	0	0	0	0	(228)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(320)	(5,480)
Total	**873**	**1,837**	**3,027**	**3,550**	**3,283**	**1,387**	**1,385**	**1,382**	**1,383**	**1,383**	**1,380**	**1,341**	**1,339**	**1,304**	**874**	**25,728**
Funded by:																
Existing	873	873	873	873	873	873	873	873	873	873	873	873	873	873	509	12,735
Additional	0	964	2,154	2,677	2,410	513	512	509	510	509	507	468	465	430	364	12,993
Total	**873**	**1,837**	**3,027**	**3,550**	**3,283**	**1,387**	**1,385**	**1,382**	**1,383**	**1,383**	**1,380**	**1,341**	**1,339**	**1,304**	**874**	**25,728**

Table 17 below identifies the investment required by each organisation to deliver the LIMS project.

Table 17: Investment Requirements per Organisation for Option B

Investment by Organisation	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MTW	0	311	700	870	783	164	164	163	163	163	162	149	149	137	117	**4,196**
EKHUFT	0	325	733	913	821	170	170	169	169	169	168	155	154	142	122	**4,381**
NKPS	0	328	721	894	805	179	178	177	177	177	177	164	163	151	126	**4,416**
Total	**0**	**964**	**2,154**	**2,677**	**2,410**	**513**	**512**	**509**	**510**	**509**	**507**	**468**	**465**	**430**	**364**	**12,993**

Affordability is judged on the outcome of the whole programme which is comprised of a number of projects and schemes. These projects when all implemented will deliver the sustainability and financial benefits. Due to the degree of change required each project is to be fully implemented in turn; however, as the network changes, it is expected that transformation benefits may be realised earlier. These have not been included in order to be prudent.

Table 18 below details the impact of each project to the pathology network

Table 18: Impact of each project on the pathology network

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Baseline (Programme and LIMS)	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	678	16,950
Programme Projects																
COST: Cost PMO	489	547	334	224	92	0	0	0	0	0	0	0	0	0	0	1,685
SAVING: 'send away' CIP estimate	0	(58)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(67)	(1,505)
SAVING Transfor-mation Change - LOW	0	0	0	0	0	0	0	0	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(807)	(9,111)
COST: LIMS Project	873	1,837	3,027	3,550	3,283	1,387	1,385	1,382	1,383	1,383	1,380	1,341	1,339	1,304	874	25,728
SAVING: MES project	(317)	(596)	(596)	(596)	(690)	(1,006)	(1,440)	(1,871)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(958)	(19,570)
Total Pro-gramme costs / (savings)	1,045	1,731	2,649	3,063	2,570	265	(170)	(604)	(2,033)	(2,033)	(2,035)	(2,075)	(2,077)	(2,112)	(959)	(2,772)
Impact of Programme	**(117)**	**569**	**1,487**	**1,900**	**1,408**	**(897)**	**(1,332)**	**(1,766)**	**(3,195)**	**(3,195)**	**(3,197)**	**(3,237)**	**(3,239)**	**(3,274)**	**(1,637)**	**(19,722)**

The alliance agreement details how these costs and benefits are distributed to the Network members of the network and this is shown in table 19 below.

Table 19: Distribution of costs across the pathology network.

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Impact by Organisation																
MTW	(188)	127	427	562	337	(532)	(532)	(533)	(985)	(985)	(985)	(998)	(999)	(1,010)	(504)	(6,799)
EKHUFT	45	97	412	554	417	(362)	(795)	(909)	(1,383)	(1,383)	(1,384)	(1,398)	(1,398)	(1,410)	(703)	(9,601)
NKPS	26	345	648	785	653	(4)	(4)	(324)	(827)	(827)	(828)	(841)	(842)	(853)	(430)	(3,322)
Total	(117)	569	1,487	1,900	1,408	(897)	(1,332)	(1,766)	(3,195)	(3,195)	(3,197)	(3,237)	(3,239)	(3,274)	(1,637)	(19,722)

The Kent and Medway CCG is a member of the Pathology programme Board and is fully committed to this case. Letters of support are included in appendix A. During the first 4 years there is an adverse impact on the network members and the CCG has agreed to provide transitional funding to enable the delivery of the programme. This is detailed in table 20 below.

Table 20: Transitional funding arrangements.

Transition funds to each organisation	Year 0	Year 1	Year 2	Year 3	Year 4
	2020/21	2021/22	2022/23	2023/24	2024/25
	£'000	£'000	£'000	£'000	£'000
MTW	0	(127)	(427)	(562)	(337)
EKHUFT	0	(97)	(412)	(554)	(417)
NKPS	0	(345)	(648)	(785)	(653)
Kent and Medway CCG	**0**	**569**	**1,487**	**1,900**	**1,408**

Year 1 costs reflect the recruitment in advance of full FBC approval of the key members of the Trusts implementation team to enable the timeline to be delivered. These staff will be focused on harmonisation and change strategy.

1.6 Management case

1.6.1 Deliverability

A single shared LIMS implemented across four sovereign Trusts, each with multiple PMI interface requirements and each with disparate electronic order comms system, represents a significant technological and logistical challenge.

The procurement exercise that has led to the selection of CliniSys as the recommended supplier and the approach to deploying the LIMS has taken into consideration this complexity. Stage 1 of the procurement, using specific mandatory criteria, focused on ensuring that only those suppliers that could demonstrate a proven ability to deploy a single shared LIMS in a complex network context were able to be taken forward for detailed consideration at Stage 2 and beyond.

Harmonisation of the four Trusts' processes, test catalogues, methods, test and panel compositions also represent a significant challenge that should not be underestimated. A comprehensive change management strategy and plan coupled with excellent clinical leadership effectively supported from the very highest levels of Trust and Programme governance will be required to drive through this change.

1.6.2 Programme Management Arrangements

The scheme is a key part of the Kent and Medway Pathology Programme, which comprises a growing portfolio of projects for the delivery and development of a Pathology Network, fit for the 21st century. The Programme will be managed within the Kent & Medway Integrated Care System governance framework.

As the Kent & Medway Pathology Network have adopted an alliance model for its organisation, decisions on clinical and technical aspects will remain sovereign to each Trust but some will require consideration at a Network level. To work in this way effectively, some decisions might need to be delegated to proposed Clinical and Technical Design Authorities, which will have representation from all Trusts and other organisations.

To support the Pathology Network, a Director of Pathology Transformation has been appointed. The Director is accountable for the delivery of the whole pathology programme, which includes the new LIMS, the MES project and any other network projects that may arise. The Director has the authority to make decisions where a consensus cannot be reached but would not have line management responsibility for the senior pathology staff. The Director may refer issues for resolution to the Clinical or Technical Design Authorities where they deem it necessary to consult more widely before deciding.

1.6.3 Project Management Arrangements

The project will be managed in alignment with PRINCE 2 methodology. Appropriate strategies and plans will be developed during the initiation phase of the implementation project to ensure that the project is managed and controlled effectively with specific focus placed on quality, scope, schedule and cost.

The project will comprise of multiple workstreams, each led by an experienced and relevant manager. The workstreams will report through a Project Director to a Project Steering Group, which in turn will report through a Programme Team to the Programme Board.

1.6.4 Project Plan

Detailed implementation planning will be undertaken, following authorisation to proceed into Project Initiation, in partnership with CliniSys, and in conjunction with system users. Working with the Trusts, CliniSys will be contractually required to produce a detailed implementation plan within 20 working days of the contract being signed. This plan must be responded to and approved by the Trusts within a further 20 working days. This process will ensure that as soon as practicable a detailed and meaningful plan will be available for baselining.

Appendix I provides the representative implementation plan that milestones and costs detailed in this FBC have been derived from, but should be considered as an estimation of the timescales only. This

indicative plan is based on the Pathology Programme Board's approval in principle, in April 2021, to release business change enablement funds totalling £200k to begin the recruitment of resources to work on process harmonisation tasks ahead of full FBC approval but it having been approved by the Programme Board.

1.6.5 Implementation of Lessons Learnt

The Project Management team will collate lessons learnt as the project progresses.

Lessons from similar projects and programmes have been, and will continue to be, investigated, shared and embedded wherever possible. Lessons from the North Kent Pathology Service consolidation project have been obtained and the above timescales and governance approaches have considered these.

Appendix L is a table containing the NKPS Project lessons learnt and recommendations that are pertinent to the replacement LIMS Project, and explanations on how each lesson has been considered within this FBC.

In addition, key lessons identified from this and previous similar projects include:

- Governance arrangements must be established and fully integrated into respective Trusts' governance structure to ensure key decisions and actions are discharged in a timely manner.
    - The governance arrangements proposed above, including the implementation of the Clinical Design Authority and Technical Design Authority spanning all Trusts and the CCG will help enable effective decision making and support.
- Project management should adhere to PRINCE2 principles with a fully resourced Programme Management Office (PMO).
    - The costs outlined with this OBC include the provision of all key PMO roles to support the LIMS project.
- The need to map existing operational processes and data flows at a detailed level, including those impacting service users such as GP Practices.
    - As-Is processes and current data flows are included within the draft LIMS implementation plan. Costs associated with resources for these are included within this FBC and work is scheduled to start ahead of full FBC approval, once the Programme Board has approved the FBC.
- The need to ensure proactive clinical leadership with a single accountable clinical lead for each discipline.
    - The implementation of a Clinical Design Authority with very senior members from all Trusts and the CCG will support the harmonisation and standardisation work. The appointment of Clinical Leadership is outside of the scope of the LIMS Project.
- The need to define test repertoires and test and panel compositions early, during the service design task.

- The draft LIMS implementation plan includes a significant period of harmonisation work as a precursor to LIMS system design. This work is agnostic of supplier and costs associated with commencing this work ahead of full FBC approval have been included, for approval, within this FBC. A separate recommendations paper outlining the specific up-front costs was presented to the Programme Board in April 2021. The paper recommended the approval of £200k business change enablement funding to begin this work ahead of full FBC approval but having been approved by the Programme Board. The decision of the Programme Board was at their April 2021 meeting was to support this recommendation, plan on the basis of approval of the early funding and detail this within the FBC.

- The need to provide adequate project resources.
  - Costs for an appropriately sized project team are included within this FBC. The team composition and period of engagement have been discussed at workshops with subject matter experts and have been approved by the LIMS Project Steering Group.

- If agreed dates with suppliers slip for key on-site support and works, often the next available will be months away as their diaries to support other areas are planned in advance.
  - Detailed planning with CliniSys, the recommended LIMS supplier, will be undertaken and other key external partners such as Order Comms Systems suppliers and GP systems supplier will be engaged to support this work as required. Schedule 7.1 (*Charges and Invoicing*) contains a list of key milestones that CliniSys must achieve before stage payments will be released and also lists the daily penalty costs for any delays to these milestones caused by the supplier.

- GP systems need to be fully understood, databases cleansed and full engagement in place with primary care to work through the complexities of changing LIMS and the impact on referrers, especially in relation to any changes that affect the ability to review historic trends.

- Data cleaning tasks and integration tasks including GP systems have been included within the draft LIMS implementation plan and costs to support this work have been included within this FBC. Data flow mapping will be undertaken as part of the early integration design work.

1.6.6 Benefits Realisation and Risk Management

The approach to Benefits Realisation Management will be fully detailed within a Benefits Management Strategy, which will be developed during the Initiation Stage of the Project in accordance with the PRINCE2 methodology.

A Benefits Register will be established, benefits will be recorded, categorised and an owner identified. Baseline measurements will be taken for quantitative benefits and improvement targets agreed. During the lifetime of the project, 'in-flight' benefits reporting will be to the Project Steering Group. Arrangements will be made as part of the project closure to ensure Benefits Realisation Management remains a key focus of the operational management team.

The approach to Risk Management will be fully detailed within a Risk Management Strategy, which will be developed during the Initiation Stage of the Project in accordance with the PRINCE2 methodology.

Risks will be recorded in a project risk register and evaluated. The scale of the risk will determine the actions required regarding escalation. All risks will be assigned an owner, who will be responsible for ensuring that mitigation actions are completed in accordance with the management plan.

A management approach will be agreed for all risks and actions to either transfer, tolerate, terminate or treat the risk will be established.

1.6.7 Post Project Evaluation Arrangements

During the closure stage of the project, arrangements will be made to transfer the system and all related artefacts such as the open risk register to the operational management team.

The project closure stage will include the approach to be taken to evaluate the performance of the project against the agreed success criteria, the benefits realisation plan and business case.

The project closure stage will include the completion of a final lessons report, which will compile all lessons identified throughout the life of the project and can be shared as required within and across the organisations and beyond.

It is anticipated that the project will be closed approximately 3 months after the completion of the last Trust/lab deployment, after the final stabilisation period has come to an end.

1.7 Recommendation

The Full Business Case concludes that, strategically and economically, a remotely hosted, single shared LIMS for Kent and Medway provided via a managed service contract by CliniSys Solutions Limited represents the optimal approach.

2 Strategic Case

Why the chapter matters:

This chapter demonstrates that the proposed investment to implement a single shared LIMS for all pathology services in Kent and Medway fits with national and local healthcare priorities. It sets out the case for change and investment objectives for the project, explaining how the proposal fits with Trust and ICS business strategies, providing a compelling case for change.

What this chapter says:

The chapter introduces the impact that Pathology has on clinical decision making and explains the purpose of the LIMS. The case explains the introduction of 29 national Pathology networks, of which the Kent and Medway services have combined as an alliance in November 2020 called the Kent and Medway Pathology Service to form the South 8 Network. The chapter provides information on the current arrangements and the increasing requirement for digitisation and systems interoperability to facilitate a step-change in the use of IT in Pathology. Information on the investment objectives and critical success factors are provided, by which the project's outcome will be measured. The chapter concludes with a view on identified key risks, constraints, and dependencies on aspects external to the project.

Changes since the OBC:

Since the LIMS OBC was first issued in December 2019 the environmental context has changed significantly. In spring 2020 the country, and the wider world, was plunged into a coronavirus pandemic, which has impacted lives in general and has led to a more focused effort by the DHSC on digitising pathology services. This led to the establishment of a fund against which the Pathology Programme successfully secured a bid for £475k capital funding, which has enabled the purchase of a Pathology Trust Integration Engine (TIE) and LIMS Data Archive solution, which were both included in the OBC costs as revenue funded. These purchases and the associated income to fund them are detailed in the Financial case.

The OBC discussed the intention to implement a single pathology service for Kent & Medway under a single management and clinical leadership arrangement. Since then, the Trusts in Kent and Medway have agreed to work within an alliance structure and a shared vision and collaboration agreement was subsequently implemented from November 2020. The change from a single pathology service to an alliance model necessitated the review of the Programme's objectives. Although these have now been updated, they remain fully aligned to those in the SOC and OBC and therefore, for consistency, those cited in those documents have been retained in the LIMS FBC. One of the impacts of the change to an alliance model is on estimated savings. The OBC cited anticipated programme savings of £5.6m per annum compared to 'do minimum with a net saving of £2.8m per annum after all projects have been implemented. This net saving has now increased to £3.2m. Given the changes that have been seen since the OBC was published, a review of the Risks, Constraints and Dependencies has also been undertaken and has informed this case.

2.1 Introduction

This section of the FBC provides the environmental and strategic context for the proposed investment. It sets out the case for change, together with the supporting investment objectives for the scheme.

2.2 The Strategic Context

Pathology is the study of disease and it is estimated that it is involved in 70% of all diagnoses made in the NHS. Pathology services in Kent and Medway provide a crucial role in the local healthcare system, underpinning all clinical services, enabling the effective delivery of care to the community.

Pathology is also a key enabler to other Government health delivery plans including cancer services. In addition to the analyses of patient specimens and the reporting of results and findings, the pathology services across Kent provide expert advice on the appropriateness of tests and the interpretation of often complex and highly-specialist results, contributing hugely to the quality of care provided to patients. To enable this vital role to be performed, the pathology service requires the tools and digital infrastructure to be available and adequate to match the ever-changing clinical context. The backbone of any pathology service is its Laboratory Information Management System or LIMS.

The evolving competitive pathology market introduces both opportunities and threats for Acute Trusts. The Kent and Medway Pathology Programme aims to provide a high quality, robust and sustainable pathology service for the people of Kent and Medway via a network of pathology laboratories working in alliance, supported by effective systems and processes. The Kent & Medway Pathology Network (KMPN) will support the constituent services to thrive and grow within an evolving competitive market environment. The success of this network will be dependent on the introduction of a modern LIMS and its associated infrastructure to support it.

2.2.1 The LIMS

The LIMS is fundamental to pathology laboratories and ultimately the front-line clinical services they support. The system supports all aspects of the service including the management of requests, specimen tracking and storage, laboratory workflows and recording and relaying test results from sample analysers and reporting clinicians, often via other clinical systems such as Order Communications Systems (OCS) and Electronic Patient Records (EPR) systems.

While the volume of testing alone makes a LIMS vital to any service's viability, its purpose extends far beyond simple administrative processing; with numerous interfaces to other healthcare systems and support for complex translation of analyser and patient data into meaningful clinical information at the root of all local and national reporting requirements such as Acute Kidney Injury (AKI) and the Cancer Outcomes and Services Dataset (COSD).

The four Trusts in Kent each have stand-alone, legacy LIMS which are discussed in more detail in the 'Existing Arrangements' section below.

2.2.2 National Context

2.2.2.1 Increasing Demand for Pathology Services

In his 2020 report "Diagnostics: Recovery and Renewal" issued in October 2020, Professor Sir Mike Richards, gave context to the importance and growth of pathology stating:

"Huge numbers of individual pathology tests are done each year (an estimated 1.2 billion p.a.). Around 44% of these originate from primary care. Year on year increases are being observed by individual laboratories"

Across Kent and Medway, approximately thirty-nine million tests are undertaken annually with year-on-year growth, based on historic trends. Activity growth stems from multiple causes; often there are spikes in activity, as has been the case with microbiology PCR (polymerase chain reaction) testing caused by the Covid-19 outbreak (see paragraph 2.2.3). Change in demographic composition of the patient community cohort will also impact pathology testing rates and appendix C provides further information on population change forecasts for Kent and Medway. It should be noted however, as stated in appendix C, that an increase in the demand for existing pathology services does not directly or linearly impact LIMS. The procured LIMS will, by specification, be able to accommodate year on year activity growth.

Any LIMS solution will therefore need to be scalable and adaptable to the advances in screening techniques and new technologies that are often cited as factors in demand growth.

Imperatives such as the Carter Reviews have turned the spotlight on supporting services including pathology, with responsibility to deliver significant savings through bringing services together. While the Kent & Medway Pathology Network is, through its established programme of work, planning for greater collaboration and the development of a new operational delivery model, management and staffing structure and equipment refreshes; these are dependent on the introduction of a shared single, modern LIMS for their successful implementation.

2.2.2.2 National Pathology Networks

In autumn 2017 NHSI announced 29 new pathology networks for England. These networks were to run as hub and spoke models: preserving essential laboratory services relevant to each hospital on site, while centralising both high volume and complex tests. NHSI believes these new structures will support high-quality services to patients and facilitate a new generation of investigations, enhance career opportunities for clinical, scientific and technical staff, and deliver efficiencies to the NHS of at least £200m annually. In the NHS Long Term Plan, it also directs for pathology networks to be established by 2021 (Para 3.60 and 6.17(iii)) with the requirement that pathology networks are faster, more digitally enabled and thus with greater resilience, reduced variation and reduced human error through automation.

The pathology services in Kent & Medway are combined within the 'South 8' network as determined under the NHSI initiative. As outlined in the Strategic Outline Case (SOC) that preceded this FBC and the earlier LIMS OBC, the intention was to develop a single pathology service for Kent and Medway under a single management and clinical leadership structure. In October 2020 a vision document was agreed by the Pathology Programme Board, in which an

alternative 'alliance' model of networked working was described. In this way the 'South 8' Kent & Medway Pathology Network will be provided via three independent pathology hub and spoke services working together under the guidance and support of a Director of Pathology Transformation, who was subsequently appointed in December 2020 and started in role in March 2021.

In his recent diagnostics review (*Diagnostics Recovery & Renewal, October 2020*), Professor Sir Mike Richards underlined the importance of the networks and the need for these to work efficiently. Recommendation 20 of his review states:

"NHS Digital's work on developing and implementing a standardised universal test list across all of diagnostic disciplines (pathology, imaging, endoscopy and cardiorespiratory services) should be accelerated as has been done for the National Genomic Test Directory."

Without a new shared LIMS for the Kent & Medway Pathology Network to help bind the disparate services together under the alliance model, it will be challenging to realise the requirement to standardise due to the existing variation. A singularly configured LIMS, shared by all services in the network, will enable this standardisation. Failure to implement a single shared LIMS risks failure to meet the NHSI network requirements, as directed by NHSI and cited in the Long-Term Plan.

2.2.2.3 The Impact of Covid-19

Since the publication of the LIMS OBC that precedes this business case, the NHS nationally and all health services globally have been battling to cope with the effects of a Coronavirus pandemic. At time of writing, there have been 4.38 million recorded cases of the so-called Covid-19 disease in the UK, which has led to 127k deaths so far. NHS Pathology services undertake many of the tests that provide the results to support individual case management and, as such, have been and continue to be an essential service in the fight against this disease. The South 8 Network has performed exceptionally during this period but has been impeded by its poor connectivity across laboratories. Despite functioning very well, a single modern LIMS across all services would have added significant benefit.

2.2.2.4 Community Diagnostic Hubs and the Need for Interoperability

In his recent diagnostics review, published in October 2020 as the Covid-19 pandemic was ongoing, Professor Richards states:

"Community diagnostic hubs should be established away from acute hospital sites and kept as clear of Covid-19 as possible."

The aim of the Community Diagnostic Hubs (CDHs) is to provide elective diagnostic services outwith acute hospitals. Although the configuration of CDHs will be down to local decision making, the objective is to provide a broad range of services as possible. It is likely that this will include, as a minimum:

- **Imaging:** CT, MRI, ultrasound, plain X-ray.

- **Cardiorespiratory:** echocardiography, ECG and rhythm monitoring, spirometry and some lung function tests, support for sleep studies, blood pressure monitoring, oximetry, blood gas analysis.

- **Pathology:** phlebotomy.

- **Endoscopy:** additional facilities are undoubtedly needed and should be provided in Covid-19 minimal locations. However, these are likely to be better delivered at scale and may therefore only be provided in some CDHs. Some larger endoscopy facilities could also become training academies.

- **Consulting and reporting rooms.**

Improved digital infrastructure and connectivity will be essential for the successful implementation of the CDHs, as underlined by Professor Richards:

"Digitisation and IT connectivity across the NHS is currently variable, but will be vital for diagnostic networks to work efficiently."

The Kent & Medway Pathology Network recognises the vital nature of interoperability in driving service efficiencies. Its absence can have significant repercussions in terms of manual processing and risks to data integrity. This is reinforced by NHSEI's June 2019 letter to CEOs and Finance Directors emphasising that LIMS deployments must meet the standards for SNOMED-CT (Systematised Nomenclature of Medicine - Clinical Terms), FHIR (Fast Healthcare Interoperability Resources) and guidelines for open access of systems, which the Kent & Medway Pathology Network will only be able to achieve through replacement of the legacy LIMSs.

2.2.2.5 Learning from Others Before Us

In July 2017 the Royal College of Pathologists published a paper entitled "Consolidation of Pathology Services - Lessons Learnt" in which several organisations reflected on their recent experiences regarding consolidation.

In a section entitled "Consolidation of cellular pathology in Glasgow - Challenges and how we met them", Dr Gareth Bryson, Head of Service for Pathology wrote:

"Another significant challenge that we have not yet overcome is dependence on an ageing IT infrastructure. This was highlighted at the time of the proposed merger and although a new LIMS was promised, it was not delivered. Failure to provide adequate laboratory IT has had a significant negative impact on efficiency. Hopefully, this is something we will overcome in the coming years."

2.2.3 Organisational Overview

Pathology services are currently provided by the four acute NHS Trusts and Foundation Trusts in Kent from seven sites. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust form

the North Kent Pathology Service (NKPS) under a joint venture which is based at the Darent Valley Hospital site and serves both Trusts and their respective GP practices and other users.

The Network-wide arrangements are currently as follows:

- **Darent Valley Hospital** at Dartford provided by NKPS operates a hub site for cold work to Dartford and Gravesend NHS Trust (DGT) and Medway Foundation Trust (MFT) and the Essential Service Laboratory (ESL) to DGT

- **Medway Maritime Hospital** at Gillingham provided by NKPS operates as the ESL as well as Andrology and Fetal Medicine Unit screening.

- **William Harvey Hospital** at Ashford provided by EKHUFT provides a hub site for hot and cold pathology services including full pathology support to the Kent Cancer Centre. EKHUFT also conduct the majority of immunology work for the region.

- **Queen Elizabeth the Queen Mother Hospital** at Margate provided by EKHUFT operates a traditional ESL with some blood film work.

- **Kent and Canterbury Hospital** at Canterbury provided by EKHUFT operates an ESL with some specialised testing and the haemophilia service.

- **Maidstone Hospital** provided by MTW operates a hub site for full hot and cold laboratory with Blood Sciences, Microbiology and Cellular Pathology. In addition, Cellular Pathology provides the Histology and non-gynae Cytology services for MFT and DGT. The regional Kent Cancer Centre is located and serviced by Pathology here.

- **Pembury Hospital** at Tunbridge Wells provided by MTW operates an ESL with average activity in excess of that at Maidstone hospital.

2.2.4 Business Strategies

The Kent and Medway Sustainability and Transformation Partnership (STP) and the eight CCG's merged in April 2020 into a single Clinical Commissioning Group, Kent and Medway CCG. From 1st In April 2021 the NHS and its partners in Kent and Medway were formally designated an Integrated Care System (ICS). 2021/22 is a transition year from the CCG into a statutory NHS ICS body to oversee NHS functions across the whole system; and a health and care partnership made up of a wider group of organisations that will bring together a wider group of partners to develop overarching plans across health, social care and public health. The development of four place-based Integrated Care Partnerships, each including one of the acute hospital Trusts is underway, and 42 Primary Care Networks have been formed. These changes may impact on how direct access pathology services are commissioned and will enable the move of care closer to where people live.

The inception of the ICS from April 2021 has led to 9 improvement and development priorities for 2021/22 and the function of pathology services in Kent and Medway clearly has a role in supporting some, and in particular:

Priority 1: "Continuing to respond effectively to the Covid-19 pandemic as a cohesive system - with partnership working in places and system co-ordination in the form of a system Incident Command and Control (ICC), system wide programme for recovery, and system oversight of the Covid-19 vaccination programme."

Priority 3: "Working as a system on increasing diagnostic capacity and elective capacity including managing long waits for planned care that have arisen as a result of the pandemic."

Priority 9: "Refreshing the system digital strategy, creating system capability for digital through formalised matrix working and implementing our analytics strategy at pace."

The wider planned changes to the Pathology services in Kent and Medway will support this significant change but will be hampered by the digital infrastructure unless the decision to invest in a modern, shared LIMS is made.

A single shared LIMS will promote integrated working, not just between the Trusts of the Kent & Medway Pathology Network, but to wider organisations throughout the Integrated Care System that use and benefit from the Pathology services. This will be achieved through being able to access test results from across the Network and also through the Network's ability to harmonise working practices and take full advantage of emergent technologies such as Digital Pathology and AI. The quick and easy access to shared results will have some effect on reducing demand on pathology thereby reducing waste and overall costs to the health economy.

This business case is provided for and behalf of the Kent & Medway system and letters of support are provided in appendix A1 and appendix A2.

2.2.5 Local Strategic Priorities

Kent & Medway Strategy Delivery Plan 19/20 to 23/24
Submission to NHS England and NHS Improvement
Our system challenges - Diagnostics

Improving diagnostics in healthcare is a global objective of effective healthcare systems. We need to continuously improve how quickly and accurately we diagnose conditions and illnesses. In Kent and Medway, we have particular challenges affecting our diagnostics capacity and processes associated with both workforce challenges and availability of diagnostic equipment.

In particular, shortages of radiologists impact our diagnostic services. However, our broader workforce challenges impact the availability of our consultants and other clinical professionals to support diagnostics.

In East Kent, our transformation programme is tackling challenges of access to diagnostics. This will also need to be considered as part of the work that needs to be undertaken in other parts of the county as we look at the need to network services between hospitals or to consolidate provision of services. Additionally, within our cancer programme we are implementing a range of improvements to support early diagnosis.

However, the work on diagnostics now needs to span beyond East Kent and cancer to a wider diagnostics review that will encompass both a speciality view and a geographical view.

Options will need to include consideration of networked models as well as the potential major diagnostic centre in the Kent and Medway geography. Digital enablers will need to play a significant role in the transformation of diagnostic services, with increasing levels of automation to speed up processes and free up staff time as well increased use of artificial intelligence to support earlier and more accurate diagnosis.

Strategic Objective 1) – Improving care quality and patient experience
Local care – Access to expert opinion and timely access to diagnostics

The Emergency Department**:** Streamlining processes and ensuring good access to expert opinion and diagnostics.

Planned care: Our performance against referral to treatment times and diagnostic waiting times remains challenged over the five-year period. We intend to re-forecast our diagnostic waiting times projection as part of a dedicated diagnostics review across Kent and Medway, which will drive up performance.

Cancer: Earlier and faster diagnosis, we have a multi-faceted approach including awareness campaigns, a primary care education strategy, reviewing and improving our diagnostic service provision

Strategic Objective 3) – Driving financial balance, efficiency and productivity

In the future, a single pathology service in Kent and Medway will be established with a single Laboratory Information Management System, Managed Service Contract, referred diagnostic contract and standardised operating procedures, which, together with potential efficiency gains through strategic partnership/s and management/workforce redesign.

East Kent clinical strategy:
The East Kent system is currently evaluating two options for acute service reconfiguration:

Option 1 is to have:

- A major emergency centre at WHH.
- An emergency centre at QEQM.
- An integrated care hospital with a 24/7 urgent treatment centre plus an elective care hospital at K&C.

Option 2 is to have:

- A major emergency centre at K&C.

- An integrated care hospital with an 24/7 urgent treatment centre plus an elective care hospital at the WHH.

- An integrated care hospital with an 24/7 urgent treatment centre plus an elective care hospital and a stand-alone midwife-led unit at QEQM.

In order to consult on the options, there must be confirmation that the £420+m required for either option is included in any nationally allocated capital funding streams. Securing a commitment of capital is therefore a critical requirement for the progression of the East Kent transformation work. The East Kent Team and the NHSE/I regional team continue to work with national NHSEI colleagues and DHSC to secure funding for the East Kent Programme, but as things currently stand this is not yet in place, despite the high priority and obvious need for investment. Once we have clarity about a national allocation of capital funding and a finalised and agreed pre-consultation business case (PCBC), the Kent and Medway system will look carefully at the timing for public consultation.

If option 2 is selected as the preferred option the new hospital(s) will not be ready for at least seven years so there will be no impact on the pathology service change for some time. Once the preferred option is agreed however, costing for a new laboratory as part of the new hospital would need to be carried out.

Neither option has a material impact on the provision of LIMS as the number of sites and users remains the same.

2.3 The case for change

2.3.1 Investment objectives

As detailed in the OBC, in July 2018, the Kent and Medway Pathology Programme's steering group agreed to five strategic objectives linking back to the major challenges set out in the SOC:

- **Objective 1:** The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative and creative.

- **Objective 2:** Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs.

- **Objective 3:** Creating a workforce that feels valued, involved and owns the single pathology service as partners in the service; and it is a great place to work.

- **Objective 4:** Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential and meets the needs of the client Trusts and Commissioners.

- **Objective 5:** Managing the transition to the new service in a creative and competent manner.

Since the OBC was developed and following agreement on the Kent & Medway Pathology Network's alliance-based model of working, these objectives have been reviewed and only slightly revised to exchange 'service' with network where relevant. On that basis, the above-listed objectives continue to

be referred to and used within this FBC to ensure continuity with the SOC and OBC. The Trusts in Kent and Medway have agreed a shared vision and collaboration agreement has been implemented, which outlines the mechanics of the alliance.

The legacy LIMSs in their current, disparate and totally non-integrated configurations, do not support or enable any of these objectives. Option 2 detailed in the LIMS OBC and outlined in the Economic Case, builds on the current LIMS and provides a degree of standardisation through the pooling of results and the implementation of an eMPI. Option 3 could meet the needs of the objectives, but it could not be guaranteed due to the separate LIMS instances. For the avoidance of doubt, Option 1, the do minimum option, enables none of the objectives to be realised; however it is the public sector comparator for this case (option A). As demonstrated within the Economic Case, maximum alignment to these objectives and therefore maximum efficacy as an enabler for the wider change is only provided by the provision of a single modern LIMS used by all laboratories in the Network, as detailed within Options 4 (in house provision of a single LIMS) and the preferred option, Option 5 (outsource hosting of a single LIMS).

The five strategic objectives can be translated using the SMART approach as detailed in table 21 below. This approach helps to show how important an efficient and effective LIMS implementation is to their achievement.

Table 21: Translating Investment Objectives, specifically to LIMS

Investment objective	Specific to LIMS	Measurable	Achievable	Realistic	Timely
The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative and creative.	Harmonised test catalogue, methods and processes	One test catalogue with one common set of methods working to one common set of Standard Operating Procedures (SOPs) governed by a single Quality Management System (QMS)	based on best practice approaches, successfully used in other Networks to achieve harmonised ways of working.	Implementing standardisation that is relevant to all sites within the Network.	Implementing in accordance with an agreed, baselined implementation plan
Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs	A modern LIMS that is able to accommodate emergent technologies such as digital Pathology and AI	Implementing the LIMS to the maximum achievable compliance to the agreed specification	Adopting the best fit supplier solution available whilst ensuring value for money.	Based on market offering and agreed budget	Implementing in accordance with an agreed, baselined implementation plan

Investment objective	Specific to LIMS	Measurable	Achievable	Realistic	Timely
Creating a workforce that feels valued, involved and owns the single pathology service as partners in the service; and it is a great place to work.	Enables a flexible pool of resources that can be deployed anywhere within the Network with the ability to use the LIMS in exactly the same way at every site.	Staff being able to work at any site using a common methodology and SOPs governed by a single QMS. Staff feedback through the annual staff survey	based on best practice approaches, successfully used in other Networks to achieve harmonised ways of working.	Implementing standardisation that is relevant to all sites within the Network.	Implementing in accordance with an agreed, baselined implementation plan
Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential and meets the needs of the client Trusts and Commissioners.	Implementation of a modern LIMS solution, harmonised practices across the network and fully trained staff.	A single shared LIMS implemented across all services and configured based on common ways of working.	Procurement and implementation of a single shared LIMS solution based on a specification agreed by all Trusts in the network.	Agreeing a harmonised approach that all Trusts support.	Implementing in accordance with an agreed, baselined implementation plan
Managing the transition to the new service in a creative and competent manner	Effective and efficient implementation of a harmonised LIMS across the Network	Working in accordance with the agreed implementation plan	based on best practice approaches, successfully used in other Networks to achieve harmonised ways of working.	Implementing standardisation that is relevant to all sites within the Network.	Implementing in accordance with an agreed, baselined implementation plan

2.3.2 Critical Success Factors (CSFs)

The CSFs are the attributes essential to the delivery of the transaction against which the project success will be assessed. They have been designed to make sure that the investment objectives, constraints and dependencies which are set out in this Strategic Case can be met.

The Kent and Medway Pathology Programme has identified six critical success factors, which are described in Table 22 below:

Table 22: Project Critical Success Factors

Critical success factor	Description
Addressing clinical priorities and improving outcomes	Supports the clinical pathway by providing consistent quality of results. Interface capability with various GP Order comms currently used. Harmonised test catalogue, methods, tests, panels, and workflow Ability to access and communicate across the different sites.
Overall costs	Ability to facilitate savings and benefits as a result of more effective use of resources.
Provide a solution that supports staff	Effective working Improved workflows Facilitates the retention and recruitment of high-quality staff. Empower staff to deliver positive patient experience. Effective use of skill mix and enabling staff to develop and work at the 'top of their licence'
Timetable	Clear sequencing and project management. Robust delivery programme Maintains continuity of services whilst limiting associated system migration costs.
Ability to meet increasing demand for pathology services	A “future proof” system able to support changes in local and national demand and technology adoption. Scalable to manage variation in demand and use. Increased automation using harmonised rules.
Technological change	UK accredited service Compliant with ISO 15189. Lean process flows. Reduced manual data entry requirements. Able to meet the defined KPIs Ability to move services across sites if required during the life of the contract.

2.3.3 Existing arrangements

The four Trusts currently utilise disparate LIMS provided by the same supplier, DXC Technology. Two of the four use iLab Apex and the other two use iLab Telepath. Both systems were developed in the latter half of the last century and have provided good service over this time, however no longer meet the needs going forward.

iLab Apex was installed at MFT in 1995 and has undergone version upgrades however, unsurprisingly, the technology does not match the specifications of modern systems including the current supplier’s current product. In 2016 MFT updated their iLab Apex LIMS server infrastructure,

meaning it is now approaching end of life. This LIMS is currently only used by the MFT Blood Transfusion service.

Similarly, iLab Apex was installed at EKHUFT in circa 1995 and has also undergone several system upgrades. The EKHUFT server infrastructure was updated in 2014 meaning the hardware is working beyond its useful life. Investment in replacement servers may be required ahead of the completion of the proposed shared LIMS implementation, to reduce the risk of failure.

DGT's iLab Telepath LIMS was installed in circa 1990 and has undergone several system upgrades. The server infrastructure was last refreshed in July 2013 and is currently undergoing a new hardware upgrade.

The iLab Telepath LIMS at MTW was originally installed in circa 1990 and has undergone several upgrades. The hardware was replaced last in circa 2012 and is also currently undergoing a new hardware upgrade.

Table 23 shows the current annual operational costs for running and supporting the four Pathology services and specifically those costs associated with supporting the legacy LIMS.

Table 23: Current LIMS Annual Operational Costs

	Total LIMS IT Support				Non-LIMS			Total Pathology IT Support		
Trust	**WTE**	**Pay**	**Non-Pay**	**Total**	**WTE**	**Pay**	**WTE**	**Pay***	**Non-Pay**	**Total**
		£'000	**£'000**	**£'000**		**£'000**		**£'000**	**£'000**	**£'000**
EKHUFT	2.05	109	191	**300**	0.10	5	2.15	114	191	**305**
MFT	0.15	5	81	**86**	0	-	0.15	5	81	**86**
DGT	2.05	97	97	**194**	1.10	37	3.15	133	97	**230**
MTW	2.05	109	179	**288**	0.10	5	2.15	114	179	**293**
Totals	**6.30**	**320**	**548**	**868**	**1.3**	**47**	**7.60**	**367**	**548**	**915**

*Includes both Pathology IT staff and Trust IT staff. The above costs are based on 2020/21 workforce costed at midpoint.

2.3.4 Business Needs

With the increasing capabilities of modern healthcare systems and the rise in new technologies such as AI and digital pathology; the pathology services must consider the best approach for their LIMS infrastructure to facilitate and embrace opportunities that may arise from these innovations and meet the needs of the wider health service, the users of pathology.

As outlined above, the legacy LIMS' are aged, lacking interoperability, functionality, are totally disconnected from each other, and, in two instances, require a complete hardware refresh, one

urgently. Despite several upgrades over the past years, their age reflects the overall functionality deficits compared to modern LIMS; including the existing supplier's current offering. In reality, all Kent LIMS' have outlived their effective use, although options to enhance what they do offer are considered in the short list of options detailed in the Economic Case, in a 'do minimum' approach.

The blueprint for a modern Pathology Network underpinned by a modern, shared LIMS from the current offering would include characteristics such as the ability to:

- Electronically send and receive requests for tests to and from other laboratories, e.g. to facilitate send-aways to specialist providers or reference laboratories.
- Direct and redirect work across the network seamlessly and electronically.
- Easily move staff from site to site as required, secure in the knowledge that they will have the requisite skills and knowledge to operate the equipment and work to standardised methods, within aligned Quality Management Systems.
- Run reports and provide comparative data with standardised units from anywhere in the Network with the confidence that the data is accurate, transparent and appropriate for the need.
- Easily interface to other healthcare and administrative systems via open application programming interfaces (Open APIs) to ensure that results are integrated into e.g. care records, Chemotherapy ePrescribing and ICU systems; to facilitate safe, high-quality patient care.

The ability to achieve these five points is essential and any solution must enable these; as such they are deemed to represent the Minimum Viable Product of the Project. It is these characteristics and more that the Kent and Medway Pathology Programme is focussed on delivering through their programme of change; but change of this scale can only be fully realised through the investment in a new, modern, pan-Kent LIMS. Maintaining the status quo will not enable the desired change.

As a final consideration to business needs, as detailed in the Economic Case of this document; a contract period of 10 years from the point of the final go-live has been considered appropriate. Given the age of the existing LIMS' across all Trusts and, because the existing supplier has developed and is currently marketing a replacement product, it is deemed likely that within the contract period the supplier will give notice on support arrangements for the current LIMS. As it would be impossible to continue to utilise an unsupported critical clinical system, not just for practical reasons but also in order to maintain ISO 15189:2012 accreditation and MHRA compliance; Trusts would be forced to change LIMS at that stage. This investment scheme therefore should be viewed as an imperative rather than optional.

2.3.5 Potential Business Scope and Key Service Requirements

The scope of the proposed investment includes all aspects that the four legacy LIMS currently accommodate. This includes the facilitation of all pathology core disciplines, adherence to all national and local reporting requirements and the need for appropriate Open API interfaces to other healthcare systems.

The four Trusts comprising the Kent & Medway Pathology Network currently provide the following core disciplines:

- **Blood sciences:** Clinical Biochemistry, Haematology and Blood Transfusion and the specialist services of Immunology and Haemophilia
- **Clinical Microbiology:** bacteriology, serology and virology
- **Cellular Pathology**: Histopathology, non-gynae Cytology, Molecular pathology and mortuary services

2.3.5.1 Out of Scope Services

Whereas Point of Care Testing (POCT) is also provided by all Kent pathology services, normally aligned to Blood Sciences, POCT results are not currently recorded in the legacy LIMS and will not be recorded in any new LIMS as it is deemed that this may have a significant impact on services' UKAS accreditation. However, the procured LIMS must be able to accommodate POCT results effectively should this decision be reversed at a future date and POCT criteria were therefore included within the Output Based Specification (OBS) used during the LIMS tender.

POCT as a service remains within the scope of the Kent and Medway Pathology Programme.

Phlebotomy and mortuary services across Kent and Medway are provided by pathology departments in two of the Trusts and from outside of pathology in the other two Trusts. Specific phlebotomy functionality within the LIMS is excluded from scope as phlebotomy services access requests and results via electronic order comms solutions interfaced to the LIMS. Mortuary services functionality within the LIMS has been included within the LIMS OBS used during the tender.

2.3.6 Benefits

The wider Pathology Programme objectives will enable the delivery of multiple qualitative benefits to patients, staff and service users. In addition, annual cost savings in the region of £3.2m, after all projects delivered, are estimated. Investment in a new LIMS and, in particular, the implementation of a single shared LIMS will contribute towards the programme's outlined benefits through long-term cost savings but, crucially, the LIMS will be one of the key technology enablers that will support the Programme's delivery of wholesale change. Without the new LIMS, benefits such as reducing duplication, managing demand, and crucially the standardisation of tests and methods may not be achievable.

Investment in a new LIMS is not an end in itself but provides a means to an end. A new LIMS will provide minimal independent cost savings, and future cost avoidance, it will also enable them within the wider programme.

The Economic Case of this FBC will discuss the various options considered regarding enhancements to or replacement of the legacy LIMS, which were considered during the OBC stage. The different

options will provide varying qualitative benefits and the alignment of these to the Pathology Programme's objectives form part of the options appraisal approach.

Appendix E provides an overview of the identified benefits relating to the shortlisted options.

2.3.7 Main Project Risks

Table 24 provides an overview of the current risks on the LIMS Project Risk Register. Appendix F is the current risk register.

Table 24: Project Risks

Risk Description & Impact (there is a risk that…leading to…)	Project Stage	Management Actions
BECAUSE of the potential for the delayed approval of key artefacts there is a RISK of a later than scheduled meeting approving RESULTING IN a delay to the project delivery	FBC	Engage and inform early wherever possible – no surprises for members.
BECAUSE the FBC needs approval by four Trust Boards, the CCG and NHSI there is a RISK one or more may not approve RESULTING in delay to the current timeline	FBC	Check and challenge and Gateway Review with CEOs and CFOs to enable review and agreement prior to Trust/CCG Board meetings.
BECAUSE of potential unavailability of sufficient or experienced Trust resource there is a RISK of insufficient resource being available RESULTING IN a delay to the project delivery or adverse impact on quality.	Implementation	Mitigation is dependent on reasons for resource shortage but might include: > Liaise with Pathology GMs to release resources as required > Employ fixed-term staff and/or contractors to either back-fill or work directly on the project
BECAUSE Key PMO members may leave there is a RISK of insufficient handover and resource being available RESULTING IN a delay to the project delivery or adverse impact on quality.	Implementation	Ensure notice period sufficient for recruitment of replacements, Project Team meetings include awareness of each member's role and responsibilities. Consider retention strategy.
BECAUSE Key PMO members may have unplanned absence there is a RISK of insufficient hand over and resource being available RESULTING IN a delay to the project delivery or adverse impact on quality.	Implementation	Secure support from wider Programme Team and/or wider STP team/partner organisations; Project Team meetings include awareness of each member's role and responsibilities; save documents on

Risk Description & Impact (there is a risk that…leading to…)	Project Stage	Management Actions
		shared drive/server.
BECAUSE of potential change fatigue, poor communication or lack of empowerment there is a RISK of a reduction in staff morale RESULTING IN an adverse impact to the pathology service and/or support of the project	Implementation	As part of Project initiation, undertake organisational impact assessment to map stakeholder group and identify the type and degree of change. Develop a detailed communications and organisational development plan and assign communication tasks to leaders. Monitor communications at Project Steering Group and Programme Team/Board meetings.
BECAUSE of the implementation plan is only an estimate there is a RISK of the timeline being underestimated RESULTING IN the total project plan timeline increasing	Implementation	The implementation plan and resource requirements will be discussed with the successful bidder prior to contract award. The plan and resources will be finalised with the supplier shortly after contract award as detailed in the contract terms and conditions.
BECAUSE of the implementation plan is only an estimate there is a RISK that the volume and cost of the resource required has been underestimated RESULTING IN the total cost of the project increasing	Implementation	The implementation plan and resource requirements will be discussed with the successful bidder prior to contract award. The plan and resources will be finalised with the supplier shortly after contract award as detailed in the contract terms and conditions.
Because of the complexity and interdependency with the MES Project there is a risk of project delays resulting in delays to the project delivery and cost over-run	Implementation	Ensure effective Programme and Project management and governance is in place from the commencement of the project
BECAUSE the pathology services will be provided by three separate organisations within the network, there is a RISK that it may not be possible to reach agreement on a fully harmonised LIMS configuration across all services, RESULTING IN a more complexly configured LIMS that takes more time to build, test and implement.	Implementation	1) Obtain a mandate for maximum harmonisation from the highest level in all organisations. 2) define areas of required harmonisation as soon as possible. Work with the preferred bidder to identify critical aspects for system configuration pre-contract award. 3) Ensure governance arrangements

Risk Description & Impact (there is a risk that…leading to…)	Project Stage	Management Actions
		are in place with decision-making / arbitration authority. 4) Appoint the Business Change Manager to implement the Change Management Strategy as soon as funding permits.
BECAUSE they are not currently required and have not been established, there is a RISK that the Clinical and Technical Design Authorities may not be established in time for the LIMS implementation commencement, RESULTING IN the potential for delays in decision-making around process harmonisation.	Implementation	1) Define governance relationship between Design Authorities and Programme Team / Board 2) Define Terms of Reference including membership roles and responsibilities and gain Programme Team and Programme Board approval. 3) Identify individuals for the membership. 4) Initiate the authorities prior to implementation project commencement.
BECAUSE categorical assurance regarding full VAT recoverability cannot be provided there is a RISK that HMRC may challenge the assumption that VAT is recoverable RESULTING in additional costs of up to £2.3m over the life of the contract (12 years and 11 months) if none of the VAT is recoverable.	Implementation	Continue to identify information that enhances the case for recovering VAT including working with other Networks (e.g. South 6) who have also recently encountered the same risk/issue.

2.3.8 Constraints

Constraints, like dependencies carry the potential to disrupt the smooth progress of any project and as such must be identified and managed proactively. The constraints identified for the LIMS Project are detailed in Table 25.

Table 25: Project Constraints

Constraint	Potential Source…	Management Actions
Available budget ultimately	Contributing Trusts	Work closely with the supplier. Manage the approved expenditure

Constraint	Potential Source…	Management Actions
approved to deliver the LIMS		closely and regularly. Avoid additional costs, beyond the budget, by reducing potential for delays by managing dependencies, issues and risks effectively.
Availability of critical resources such as subject matter experts, Clinicians Trust IT Teams, pathology IT Teams, supplier resources and third-party resources. Possible cause may be other significant IT systems projects undertaken at Trust sites	Contributing Trusts. Supplier Third parties	Work closely with all parties contributing resources. Agreements at Programme Management / Trust Executive level will be required to ensure that the project will be supported as a priority. Potential use of new Programme-wide governance forums and action-oriented groups such as Technical Design Authority and Clinical Design Authority to oversee Programme-wide IT systems projects.
The release of laboratory staff for training on any new system or equipment being implemented	Contributing Trusts / laboratory.	Work closely with all parties contributing resources. Agreements at Programme Management / Trust Executive level will be required to ensure that the project will be supported as a priority
The need to comply with the needs of Government IT guidelines.	Technology Code of Practice	Ensure that the project considers and complies with the relevant elements of the 14 domains detailed within the service standard. These will apply throughout various stages of the project's lifecycle and into the system's operational use.
The extent to which Trusts in the Network (working in the alliance model) agree to fully harmonise processes and methods that impact the LIMS configuration across the Network.	All Trusts in the Kent & Medway Pathology Network	Initiate business change activities as soon as funding becomes available. Implement an effective governance arrangement to resolve issues regarding harmonisation before work begins.

2.3.9 Dependencies

Within any complex programme of work, dependencies between projects and workstreams are inevitable and must be closely managed. Failure to identify and manage key dependencies may lead to cost overruns and schedule slippage. Within the Kent & Medway Pathology Network's programme,

the two constituent projects are to some extent dependent on each other. Table 26 illustrates the how the LIMS Project is dependent on the other projects and other bodies.

Table 26: Project Dependencies

Dependency	Dependent on…	Management Actions
Forecast savings to be enabled through the Managed Equipment Services (MES) Project, which will part-fund the LIMS implementation.	The ability to achieve economies of scales through maximisation of standardised equipment and consumables.	Effective agreement of MES project scope and procurement scope.
Appropriate, often dedicated, resources with the prerequisite skills and experience to implement the LIMS.	Trusts releasing staff to resource the project. Ability to recruit resources with specialist skills.	Agreements at Programme Management / Trust Executive level will be required to ensure that the project is appropriately resourced. Resourcing is also a key risk. Proactive recruitment as soon as budget becomes available. Start to identify possible individuals ahead of formal recruitment. Potential use of special agencies to source specialist resources.
Support and input from Trust IT Teams to enable Open API interfaces to downstream healthcare and patient administration systems to be implemented.	Trust IT teams and their sub-contracted providers and system suppliers.	Agreements at Programme Management / Trust Executive level will be required to ensure that the project will be supported as a priority. Potential use of new Programme-wide governance forums and action-oriented groups such as Technical Design Authority
Support and input from GP Practice systems providers to enable Open API interfaces to their systems to be updated as required	GP Practice systems providers. CCG GP IT Team	Close working with the CCG GP IT Teams. Ensure that they are aware of the dependency and ensure that they provide proactive support with managing GP Systems providers. Include CCG IT membership on the Project Steering Group.
Effective system and data architecture design will be fundamental to the success of the project. A successful LIMS implementation is reliant on understanding and planning for the various data flows.	A clear understanding of the current (as-is) and future (to-be) data flows.	Data Architect role should be included within the team structure to support this work. The Data Architect will work closely with the Project Manager to design and implement the specified system.

Dependency	Dependent on…	Management Actions
Fully harmonised processes and methods that impact the LIMS configuration across the Network.	Reaching full agreement on elements that impact configuration of the LIMS. I.e. success of the alliance model to be used across the Kent & Medway Pathology Network in place of a single pathology management structure.	Initiate business change activities as soon as funding becomes available. Implement an effective governance arrangement to resolve issues regarding harmonisation before work begins.

2.3.10 Network Sensitivities

In addition to the identification of Risks, Dependencies and Constraints, it is important to recognise sensitivities to any aspects of the proposed scheme that may exist across the Kent & Medway Pathology Network. Currently, during the life of the programme, there is no intention for the Kent and Medway CCG to tender direct access pathology services however if this position was to change then this could affect the overall affordability of the Network.

DGT and MFT experienced a challenging period during the implementation of their shared Pathology Service, NKPS, and during Network discussions great emphasis has been placed on learning from this episode. Appendix M is a table containing the NKPS Project lessons learnt and recommendations that are pertinent to the replacement LIMS Project and explanations on how each lesson has been considered within this FBC.

2.3.11 Demand and Capacity Impact

Table 27 below details the key movements in activity, workforce and financial. Despite year on year growth in the volume of tests completed across all pathology services there is no material impact on LIMS support and no anticipated need to revise the laboratory configuration significantly.

Table 27: Impact of Growth on LIMS

	21/22	22/23	23/24	24/25	25/26
Laboratory Configuration	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs
Peak Concurrent Log-ins	600	600	600	600	600
WTE LIMS Support Staff	7.3	7.3	4.6	4.6	4.6
Total Investment in LIMS (£'000)	2,546	2,833	3,168	2,005	2,006

Notes:

- Based on an estimated activity growth.
- No significant change in laboratory configuration is anticipated within the next five years.
- the peak concurrent log-ins, which equates to the number of users at any one time, is not anticipated to rise however any increase in users will be accommodated through normal BAU revenue expenditure, where justified, in the form of additional user licences. This is the typical approach with any IT system.
- A single shared LIMS will enable economies of scale and therefore there is an anticipated reduction in support requirements specifically attributable to LIMS.
- Early years incur implementation costs until a new baseline is achieved in 25/26

2.4 Equality and Health Inequalities Impact Assessment

A Quality Impact Assessment (QIA) has been completed at programme level and an Equality, Diversity and Inclusion Impact Assessment (EDIIA) has been completed at project level. These can be seen in Appendices U and V. The QIA considers risks across multiple domains, namely: Patient Safety, Clinical Effectiveness, Patient Experience, Staff Experience and Inequalities. The output of the QIA determined that there were no discernible negative impacts across these domains resulting from the Programme. The EHIA considers the impact of the programme on the ten protected characteristics outlined in the Equality Act 2010 and any other groups which may be impacted positively or negatively.

3 Economic Case

Why the chapter matters:

This chapter provides a comparison of the potential suppliers' costs and quality solution against the baseline 'do minimum' option in order to enable a recommendation on the shortlisted options to be reached.

What this chapter says:

The chapter lists the critical success factors against which the investment will be measured and outlines the various options that were introduced at OBC stage and the preferred option that was taken forward to procurement. The chapter summarises the procurement process and its outcome then continues to provide a comparison between the solution offered by the only supplier that submitted a bid and the do minimum option.

Changes since the OBC:

The LIMS OBC considered options 4 and 5 as equal contenders to be recommended and, therefore, it was decided that during the competitive procurement process, indicative process for supplier solutions based on both of these options were obtained. The indicative prices and then low confidence in the programme's ability to obtain central capital funding led the Pathology Programme Board to select Option 5 as the preferred option as detailed in the OBC. The procurement process concluded with only one bidder remaining in the process to best and final offer based on Option 5. Therefore, the one offer was evaluated against the costs associated with Option 1, the do minimum option (the assumed Public Sector Comparator (PSC)), and the qualitative criteria used to compare the various options at the OBC stage.

3.1 Introduction

This section of the FBC documents the range of options that were considered within the OBC. The chapter details the competitive procurement activities that were undertaken on the recommended option and provides evidence to show that the offer received is economically advantageous, meets our service needs and optimises value for money.

3.2 Investment Objectives

As detailed within the Strategic Case of this document, in its SOC, which was approved by the four Trust Boards during January and February 2019 and by NHS Improvement in April 2019, the Kent and Medway STP detailed five strategic investment objectives:

- Delivery of a clinically and financially sustainable single pathology service based on a viable service that is clinically led, standardised, innovative and creative.

- Delivery of a high-quality diagnostic service for the patients, hospital clinicians and general practitioners that meets their current and future needs.

- Creating a workforce that feels they are valued, involved and own the single pathology service as partners in the service.

- Transforming the service models in pathology in Kent and Medway to deliver technological change to create a more responsive service with increased efficiency. Developing meaningful roles for our staff to maximise their potential and meet the needs of Trust's and commissioners.

- Managing the transition to the single service in a creative, competent manner.

These strategic investment objectives form the anchor point of the business case and have been used as the basis for qualitatively evaluating the identified options detailed below.

3.3 Critical Success Factors (CSFs)

The CSFs are the attributes essential to the delivery of the transaction against which the project success will be assessed. They have been designed to make sure that the strategic objectives, constraints and dependencies which are set out in the Strategic Case can be met.

The Kent and Medway Pathology Programme has identified six critical success factors, which are described in Table 28 below:

Table 28: Project Critical Success Factors

Critical success factor	Description
Addressing clinical priorities and improving outcomes	Supports the clinical pathway, delivering provides consistent quality of results. Interface capability with various GP Order comms currently used. Harmonised test catalogue, methods, tests, panels, and workflow Ability to access and communicate across the different sites.
Overall costs	Ability to facilitate savings and benefits as a result of more effective use of resources.
Provide a solution that supports staff	Effective working Improved workflows Facilitates the retention and recruitment of high-quality staff. Empower staff to deliver positive patient experience. Effective use of skill mix and enabling staff to develop and work at the 'top of their licence'
Timetable	Clear sequencing and project management. Robust delivery programme Maintains continuity of services whilst limiting associated system migration costs.
Ability to meet increasing demand for pathology services	A "future proof" system able to support changes in local and national demand and technology adoption. Scalable to manage variation in demand and use. Increased automation using harmonised rules.

Critical success factor	Description
Technological change	UK accredited service Compliant with ISO 15189. Lean process flows. Reduced manual data entry requirements. Able to meet the defined KPIs Ability to move services across sites if required during the life of the contract.

3.4 Short Listed Options

None of the identified options were discounted therefore all options were taken forward to the short list.

The short-listed options identified at outline business case are as follows:

Option 1 This is the Do Minimum option. Each Trust would keep their existing LIMS however as urgent hardware refreshes are now required for at least two Trusts and the entire LIMS will need to be replaced within the next few years, therefore significant investment will still be required with this option.

Option 2 Keep existing LIMS as per option 1 and additionally integrate through a new common TIE and new eMPI (enterprise Master Patient Index). This will see some additional benefits brought about by the integration of the legacy LIMS.

Option 3 Each Trust buys the same new LIMS and Integrates them via new TIE and eMPI. (The first option based on a new LIMS implementation that focuses on achieving the Pathology Programme's objectives).

Option 4 One Trust buys new single LIMS and hardware on behalf of all Trusts and installs on site i.e. hosted by the Trust.

Option 5 One Trust enters a Managed Service Contract for a new, remotely hosted (in the cloud) single LIMS solution on behalf of all Trusts. This option would see the transfer of most of the risk (and control) to the supplier.

In detail, the short-listed options are:

3.4.1 Option 1 – Do Minimum

When taking a long-term view, it is not viable to actually do nothing, and the two main reasons are:

1) As with all options, server hardware would normally be replaced twice within 10 years. Some Trusts are already using hardware that is beyond its useful life and are being supported on a best of endeavours basis. The aged hardware will need to be replaced however, even if another option is adopted.

2) The current LIMS Supplier, DXC Technology, is developing a new LIMS product that will ultimately replace Apex and Telepath and the likelihood is that within the 10-year period they will cease to support the existing LIMS, thereby forcing Trusts' hands to replace the system.

Since the current LIMS' were designed and implemented, standards across all aspects of pathology have evolved and new standards have emerged. Trusts contemplating implementing such legacy systems now, within a single network, may struggle to meet all regulatory standards including those relating to Blood Transfusion imposed by the MHRA. Should the decision be made to retain the legacy systems, and ultimately replace with disparate, like-for-like systems, then the MHRA may find that the blood transfusion services can no longer be authorised.

When considering the extent to which the option enables the Pathology Programme to achieve its objectives; consider that there will be no direct integration between labs. Beyond any access laboratories may currently have to other laboratories' pathology data, there would be no opportunity to identify linked patient records - those patients proven to be the same person, who have had pathology undertaken at multiple Kent Trusts - as there could be through the use of an eMPI (see option 2 for eMPI).

The disparate LIMS arrangement in Kent would restrict the Network's ability to achieve any of its objectives; and one key reason would be the inability to effectively harmonise test catalogues, test and panel compositions, analytical methods and, equally importantly therefore, the impossibility of a single Quality Management System; often considered as the bedrock of harmonisation and standardisation.

When the LIMS at each Trust is eventually replaced, there may be agreement at that time to coordinate the procurement with the other Trusts in the Network. Agreement might be reached for each to procure the same LIMS or even work through a single Trust and procure a single LIMS, as described by Option 4. This may or may not be via a Managed Service Contract (MSC), as described by Option 5. This then implies that at some point within the next few years, there is a reasonable chance that a procurement option similar to options 3, 4 and 5 will be considered. However, significant opportunity to benefit from the advantages of these options much earlier would have been lost and this may have implications outside of the Network, such as the loss of work to other laboratories.

When considering the eventual need to replace the current LIMS' under this option (and option 2) it is recognised that the current Apex LIMS at MFT would not be replaced and the MFT Blood Transfusion service that uses Apex would be migrated to the new NKPS LIMS. Costs shown within the Economic Case are based on this approach.

3.4.2 Option 2 – Keep existing LIMS but integrate through a new common TIE and new eMPI

The considerations raised for option 1 regarding hardware replacements and the eventual LIMS replacement coupled with the risks outlined regarding MHRA compliance and the inability to enable harmonisation, remain in full for this option. This option would benefit however from the integration of the disparate LIMS through a new common TIE, which would enable results and data to be sent and received from each laboratory.

To ensure that linked patients can be easily identified and the accuracy of patient demographic data optimised; it is envisaged that a dedicated eMPI would be implemented; such that all Trusts' and potentially other organisations' Patient Administration Systems (PAS) could be interfaced, to ensure validated NHS Numbers and high-quality demographic data is accessible by the LIMS. The eMPI utilises logic-based rules and parameters set by the Trusts to check whether patients with similar demographic details presenting at different organisations are in fact the same person; thereby enabling disparate records across Trusts to be linked, and a more holistic account of a patients' pathology to be made available to clinicians with legitimate access.

Although this option represents a significant improvement on Do Minimum, a dedicated eMPI represents a significant investment. Some modern LIMS suppliers have an eMPI integrated within their LIMS, negating the cost of an additional, dedicated eMPI.

3.4.3 Option 3 – Each Trust buys same LIMS and integrates them via new TIE and eMPI

This option would see the implementation of the same new LIMS at all laboratories. Each Trust hosting the pathology service (MTW, EKHUFT and DGT for NKPS) would, following a combined procurement exercise, contract separately with the supplier and implement disparate LIMS on their independent servers.

In order to achieve maximum benefit and enable the Pathology Programme's objectives to be realised, each instance of the LIMS would need to be configured identically, in the same way that a single shared LIMS would only have one configuration. This could only be achieved after significant work to harmonise the test catalogue, test and panel composition, and methods with the other laboratories. To achieve this, the implementation would need to be coordinated across the Network; managed within a Programme of Projects and some key roles will need to be implemented at Programme Level to ensure alignment; for example Solution Architect, Training Manager, Testing Manager, Business Change Manager etc. For the same reasons, these roles also exist in options 4 and 5.

The likelihood of a single supplier having the resource capacity to serve three projects simultaneously is deemed to be low. Pressure would be applied to stagger the deployments, and this may extend the Programme’s implementation timetable significantly. The risk of the LIMS configuration being different, even slightly, may cause issues post deployment given the desire for maximised standardisation across the Kent & Medway Pathology Network.

Because each LIMS instance would be disparate, it is unlikely that an eMPI integrated within the LIMS would be useable in this configuration, therefore an additional dedicated eMPI would be required, adding significant cost to the procurement.

3.4.4 Option 4 – One Trust buys new LIMS and hardware on behalf of all Trusts and installs on site

This option would see the implementation of a single, shared LIMS accessible to all laboratories. One Trust, agreed by the Programme Board as EKHUFT, would procure the LIMS and server hardware on behalf of all Trusts and install on-premise. Trusts would therefore need to agree to share the cost of

the LIMS and annual maintenance and support package. This represents a high capital cost investment depreciated over 10 years and would include a hardware refresh in year 5.

As a single shared system, the option aligns well to the Pathology Programme objectives with fewer risks by comparison to options 1-3. Because the project to implement would be focussed initially on a single system implementation (as opposed to multiple implementations for options 1-3), although a significant investment in time and resources will still be required, it enables a more efficient use of scarce resources, who will need to be released to the project to enable success. These resources can be shared from across all Trusts however, whereas with options 1-3 Trusts will largely be required to resource each implementation separately, from within their own pool of staff. The cost for dedicated resources has been included within the financial considerations for all options.

The responsibility to maintain the server hardware, provide effective business continuity and disaster recovery, backup the system and restore following any failures would fall to EKHUFT as the host Trust. As the system would be installed on-premise; opportunities to hold the LIMS supplier to account for any downtime thereby gaining support credits may be reduced due to disputes as to the cause, i.e. hardware or software.

This option will very effectively facilitate and support standardisation due to the necessity for a single configuration, but will still enable downstream systems at Trust sites and multiple GP Order Comms and results reporting systems to be integrated via the new common TIE.

As a single instance of the LIMS would be implemented, Trusts may be able to take advantage of any eMPI integrated within the LIMS, thereby removing this significant cost.

Resilience to ensure business continuity under this option would be provided in the form of automatic failover servers located in a separate geographic location.

3.4.5 Option 5 - One Trust enters a Managed Service Contract for a new remotely hosted (in the cloud) LIMS solution on behalf of all Trusts

This option provides all of the benefits and the lower risk profile of option 4 and the procurement and contract will also be managed through a single Trust. The main difference is that the option lends itself to the use of a Managed Service Contract (MSC) with the LIMS provider, thereby spreading the cost of the procurement over the life of the contract. All of the project cost will be revenue (operations costs as opposed to capital purchase), and there may be opportunities to recover VAT, however, Trusts will need to be cognisant of potentially changing standards and rules concerning leasing and VAT recovery.

What also separates Option 5 from Option 4 is that the LIMS will be hosted remotely, 'in the cloud', and managed and supported 100% by the supplier and/or their thirty-party hosting partner. This enables the Trust to transfer system hosting risks and hold the supplier to account fully for any and all system outages. This maximises opportunities to gain support credits for deviations outside of the agreed system availability thresholds and any response time breaches.

As the system will be hosted remotely, there is the increased risk of system latency issues meaning some processes may be slower to complete than if the system was hosted locally. The recent

implementation of the HSCN (Health and Social Care Network), replacing the local COIN (Community of Interest Network), however, will counter this.

Resilience to ensure business continuity under this option would be the responsibility of the supplier; as such the procurement stage will assess suppliers' capability to provide this.

3.4.6 The Preferred Option

The preferred and agreed option at OBC stage was Option 5 and a competitive procurement exercise was undertaken on this option.

3.5 The Procurement Process

Appendix D is the Procurement Outcome Report, which fully details the process that was undertaken to arrive at the recommended bidder. The following provides a summary of the process.

A procurement tender was launched in September 2020 and was concluded in April 2021. The procurement was managed through a mini-competition process using the QE procurement framework: "Clinical software (and hardware) solutions for use in healthcare" and consisted of 5 stages.

3.5.1 Stage 1, Mandatory Questions

The stage required prospective bidders to consider a total of 24 criteria and respond by stating whether the company or system either fully complied with each criterion or did not comply. For the prospective bidder to be able to pass through to Stage 2 they must have been able to fully comply with all 24 criteria.

At the start of Stage 1, three companies expressed an interest in tendering, however one was unable to comply with all mandatory criteria and, therefore, two companies were provided with the opportunity to progress to Stage 2 and submit an initial offer. The two companies were:

- CliniSys Solutions Limited (referred to as CliniSys).
- Cirdan Imaging Limited (referred to as Cirdan).

3.5.2 Stage 2, Initial Proposal

Stage 2 of the tender was launched on 23/09/20 with both of the above bidders participating. At the start of this stage, the bidders were provided with a document set including the tender guidance document, draft contract and associated schedules and the OBS with associated technical questions. The OBS contained circa 2,000 individual criteria covering all pathology disciplines, mortuary, IT, Information Governance, security and Quality requirements. Although not scored under the assessment as POCT is out of scope of the project, the OBS also detailed POCT criteria to ensure that the procured LIMS sufficiently met requirements should POCT results be included within the LIMS in the future. Also included within the OBS and considered increasing important during the Covid-19 era, given the propensity for viruses to mutate, is automated alert functionality, which was included as a MUST level criterion.

A team of 30 Subject Matter Experts (SMEs) from all Kent and Medway acute Trusts was established to evaluate the bids received. The team undertook the necessary prerequisite training in order to ensure due process and equity across all bidders.

The stage required bidders to submit their initial proposals by way of stating their degree of compliance to the criteria listed in the OBS and by providing written responses to the technical questions.

The OBS compliance and technical questions were evaluated individually by the SMEs against defined scoring criteria and the rationale for their scores was recorded. Due to the subjective nature of individual scoring, the scores were moderated through discussion, using the recorded rationale as a basis for reaching a consensus score for each criterion and question. Both bidders were taken through to Stage 3.

3.5.3 Stage 3, Supplier Demonstrations and Validation

Stage 3 of the tender enabled both bidders to facilitate two extensive system demonstration sessions. These sessions were scripted and focused on areas that the SMEs wished to see demonstrated in order to validate the moderated scores agreed at Stage 2. Due to the Covid-19 restrictions all sessions were held remotely via Microsoft Team software.

At the end of all four sessions the SMEs came back together via MS Teams to moderate any proposed changes to the scores agreed at Stage 2, based on what had been demonstrated. Both bidders were invited to progress to Stage 4.

3.5.4 Stage 4, Reference Site Visits and Validation

Prior to Stage 4 bidders were provided with approximately eight weeks' notice to arrange a reference site visit with the selected site, which would be required if the bidders were invited to progress to this stage. Unfortunately, Cirdan was unable to arrange the requested visit on the agreed dates and they were provided with a further two weeks to propose another date, which was eventually agreed.

The CliniSys reference site validation events were completed with one minor delay to one session; however, Cirdan failed to gain representation from their reference site and all visits were cancelled at their request.

3.5.5 Stage 5, Best and Final Offer (BAFO)

At the commencement of Stage 5 bidders were presented with the BAFO Guidance Document set. This provided the bidders with all information on any aspects of the requirements that had changed over the course of the tender process. The document also included a list of key elements that must be included in the BAFOs.

Cirdan withdrew from the procurement process the day before the BAFO submission deadline due to their inability to provide a reference site to support bid validation.

CliniSys submitted a fully compliant BAFO and as the only bidder remaining at the end of the tender process no evaluation between bidders was required. The bid was however evaluated against the initial requirements and those detailed in the BAFO Guidance Document and external legal advice was sought to ascertain the degree of risk that the trusts might be exposed to, should they proceed with a contract with CliniSys on the basis of the offer. The advice received was that proposed changes to the draft contract terms and conditions affect the Trust's interests but do not have a material impact on the overall balance of risk and/or are acceptable to the Trust in terms of overall risk transfer.

3.6 Economic Appraisal

This section provides a detailed overview of the costs and benefits associated with the CliniSys offer in comparison to the do minimum option (PSC). In the following sections, the PSC is referred to as Option A and the CliniSys offer that represents Option 5 that the procurement was undertaken against, is referred to as Option B throughout the remainder of this FBC.

3.6.1 Assumptions

The following assumptions and bases have been used to calculate the economic and financial impact of the proposed investment scheme:

Table 29: Economic Appraisal Assumptions

OBC	FBC
Base year (Year 0) is 2019/20	Base year (Year 0) is 2020/21 which includes the costs being at 20/21 pay rates
Contract duration and anticipated system life is 10 years based on historic rate of system development. Within this period a hardware refresh as year 5is expected to be required and has been included within the costs	Within this period a hardware refresh at year 5 of the operational contract term is expected to be required and has been included within the costs.
All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option 5 and the ASM in all options.	All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option B and the ASM in all options.
Discount factor is 0.035 (3.5%).	Discount factor is 0.035 (3.5%).
Effect of inflation has been excluded	Effect of inflation has been excluded
Scheme will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available.	Option A will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available
Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the	Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the

OBC	FBC
Treasury green book approach	Treasury green book approach
10% optimism bias has been added to the system capital costs based on the Treasury green book approach	10% optimism bias has been added to the system capital costs based on the Treasury green book approach for option A only
The Managed Service Contract term of 10 years for Option 5 is assumed to commence from the date of the first go-live to the new LIMS	The Managed Service Contract term of 10 years for Option B is assumed to commence from the date of the final go-live to the new LIMS
There may be a cash impact caused by any payments to the supplier during the implementation stage but these have not been modelled. These will be identified during the tender.	The total contract term for Option B will reflect the implementation period from contract signature to final go live which results in a contract term of c13 years. The implementation costs of the supplier are reflected where applicable during the implementation period and included in the total costs of Option B.
Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included.	Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included. Plus the TIE as at date of FBC approval for option A
Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.	Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.
Specific procurement related costs have been included within the implementation team costs however work undertaken by Trust-based procurement services are absorbed within BAU costs of the Trust and therefore not included within the OBC costs	No additional procurement related costs have been incurred due to the tender being run via a framework and evaluation undertaken by internal subject matter experts. Work undertaken by Trust-based procurement services are absorbed within BAU costs of the Trust and therefore not included within the costs of the FBC.

3.6.2 Benefits

Appendix E provides an overview of all the benefits for the two shortlisted options. The table cross-references each identified benefit to the investment objectives. The benefits are shown as either cash-releasing (CRB), non-cash-releasing (NCRB) or Qualitative (Q).

3.6.3 Cash-Releasing & non-Cash-Releasing Benefits

Where they can be quantified, the identified cash-releasing benefits specifically relating to the LIMS replacement *only* have been included within the total financial position detailed within the financial case of this document. Table 30 below provides an indication of the cash-releasing and non-cash-releasing benefits relating to the benchmark do minimum option and those achievable through the CliniSys contract.

Table 30: Overview of cash-releasing and non-cash-releasing

Benefit Description	Measures	Do Minimum (Option A)	CliniSys (Option B)	Benefit Type
Increased cost efficiency	• Reduction in LIMS support & maintenance costs.	X	✓	CRB
Service Change	• Total pay budget per annum across all pathology IT support services	X	✓	CRB
	• Seamless processes deployed. • Harmonised workflows, catalogues, methods.	X	✓	NCRB
Increased operational Efficiency	• Improved TATs. • Reduction in duplicate testing. • Reduced inter-lab administration. • Local system maintenance tasks passed to supplier. • Reduced system password re-sets (self-service).	X	✓	NCRB
Increased clinical effectiveness	• Ability to see all results. • Less time required by clinicians and healthcare professions chasing results. • Reduction in clinical incidents / increased patient safety and clinical quality. • Improved decision support. • Reduction in clinical admin time. • Improved ward efficiency. • Increased number of patient records with NHS Numbers on LIMS. • Removal of paper results.	X	✓	NCRB

3.6.4 Estimating costs

This section provides a detailed overview of the costs associated with each of the selected options.

Costs fall broadly within the categories of either capital or revenue / operational costs. Each shortlisted option attracts varying capital and revenue costs, and these are detailed in Table 31 in section 3.6.5 below. Note that no decisive unquantified costs or benefits have been identified.

Costs have been associated with each option as follows:

3.6.4.1 Do Minimum Option (Option 1)

- Recurring licence and support costs paid to the existing LIMS supplier - revenue
- Recurring existing IT support staff costs – revenue
- New system purchase and supplier costs* – capital
- New Trust-based system implementation team costs – capital
- Replacement server hardware costs** – capital

3.6.4.2 CliniSys (Option B)

- Recurring supplier costs including system installation and configuration, remote access and system support – revenue***
- Recurring IT support staff costs – revenue
- New Trust-based system implementation team costs – revenue
- New Trust Integration Engine (TIE) purchase and installation costs – capital
- New Trust Integration Engine (TIE) licence and support costs – revenue
- New Open API Interfaces cost (for Trust systems) – revenue
- New LIMS Data Archive system – capital
- New LIMS Data Archive system licence costs - revenue

*These costs have been included on the same implementation timeline as Option B on the basis that, within the next few years, the existing supplier is most likely to remove support for the existing out-dated LIMS', which have been in situ at all Trusts since the mid-1990s; as they have developed the next generation of LIMS and are actively marketing this product. There are currently four LIMS' in use; however, it is recognised that the current Apex LIMS at MFT would not be replaced and the MFT Blood Transfusion service that uses Apex would be migrated to the new NKPS LIMS. These costs are based on this approach.

**These costs have been included on the basis that all server hardware has a planned life of 5 years and are normally amortized over this period; therefore, two hardware replacements have been included for all options including Do Minimum.

***The cost of the LIMS, professional services and annual support package will be achieved via a Managed Service Contract (MSC) with CliniSys. An MSC will enable a significant reduction in the requirement for capital expenditure and will form equal annual payments (normally paid annually in advance) uplifted by an annual inflationary rate such as Consumer Prices Index (CPI).

All existing costs were obtained directly from the three Trusts. All future costs have been estimated.

The Trust-based implementation team costs were estimated following the development of detailed implementation plans for both shortlisted options. The plans were used to identify resource types required to undertake the work. The implementation team costs, and all other non-supplier costs were derived using input from subject matter experts from all Trusts involved via focussed workshops held throughout January and February 2021.

Much of the work will be completed by existing Trust staff and the cost at mid-point rate of the appropriate 2020/21 Agenda for Change (AfC) bands was used for these resources. These costs have been included on the basis that resources will need to be released to the project for the duration and will therefore need to be backfilled on most occasions.

Some Trust-based implementation team resources are deemed specialist and, for these, external contractor rates or the nearest equivalent AfC band rates were used in the calculations.

The TIE and LIMS Data archive system costs are actual costs as these were purchased during 2020/21 If option 1 was selected the TIE would become obsolete so has been charged as a sunk cost in year 1.

3.6.5 Net Present Cost Findings

The undiscounted and discounted values for all options are shown in Table 31 below. The capital and revenue elements for each option are described in section 3.6.4 above.

The CIA model was used to calculate the Net Present Costs for each option. The CIA combines the costs, quantified benefits and quantified risks associated with each option.

Table 31: Undiscounted and Discounted values for all options:

From CIA	Undiscounted (£'000)	Net Present Cost (£'000)
Option A – PSC		
Capital	14,898	13,272
Revenue	19,467	15,548
Risk retained	1,385	1,140
Optimism bias (if applicable)	594	541
Total costs	**36,344**	**30,501**
Less cash releasing benefits	0	0
Costs net cash savings	**36,344**	**30,501**
Non-cash releasing benefits	0	0
Total	**36,344**	**30,501**
Option B – Preferred supplier		
Capital	595	555
Revenue	29,602	24,040
Risk retained	382	327
Optimism bias (if applicable)	0	0
Total costs	**30,579**	**25,921**
Less cash releasing benefits	(5,940)	(4,411)
Costs net cash savings	**24,639**	**20,510**
Non-cash releasing benefits	0	
Total	**24,639**	**20,510**

There are no social benefits or financially quantifiable non-cash-releasing benefits therefore the only economic assessment is on net present costs which considers cash releasing benefits.

Appendix G is the comprehensive investment model which derived the values reflected this table.

3.6.6 Economic Appraisal Outcome

The economic appraisal considers revenue and capital expenditure, the cash-releasable benefits delivered by the option and the risk appraisal considered for the capital risks identified through the Green Book risk assessment approach. These costs are based on the cash profile.

The Net Present Costs (NPC) was calculated for the cashflows under the two options. The DH template Comprehensive Investment Appraisal (CIA) and the HM Treasury Green Book approach to estimating costs have been applied in this FBC stage.

Table 32: Economic Appraisal Summary

Option	Description	NPC	Cash benefit	Non cash benefit	Cost net cash savings	Costs net all savings	Ranking
		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	
A	Do Minimum	30,501	0	0	30,501	30,501	**2**
B	Preferred bidder	24,921	(4,411)	0	20,510	20,510	**1**

The outcome of this economic appraisal is that Option B ranks highest.

Table 33 below shows that Option B has the lowest incremental increase in cost of £10m compared to the BAU cost.

Table 33: Incremental Value for Money Analysis

Evaluation Results Incremental impact	Cost £'000	Benefit £'000	Risk £'000	Total £'000
Option A	19,152	0	1,140	20,293
Option B	14,386	(4,411)	327	10,302

3.7 Qualitative Benefits Appraisal

3.7.1 Methodology

At OBC stage; benefits, risks and potential qualitative evaluation criteria were identified during the development and analyses of each option, and were discussed with stakeholders including all of the Pathology General Managers and Clinical Directors of Pathology from all services through joint or 1:1 meetings. The identified benefits, risks and proposed evaluation criteria were also discussed and agreed through presentations at: The Project Team (now called Programme Team) meeting, Programme Board and Clinical sub-group meeting. The benefits and risks for the preferred option and the associated CliniSys offer have been reviewed and revalidated for the FBC.

3.7.2 Qualitative Appraisal Criteria

At OBC stage, seven criteria through which to qualitatively evaluate the options were identified, discussed and agreed as outlined above. The criteria are:

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

Because there was only one remaining bidder at the end of the procurement process, these criteria were reassessed at FBC stage and confirmed as still relevant for use in appraising the two remaining options.

3.7.3 Qualitative Appraisal Scoring

At OBC stage, an options appraisal workshop was held. The 8-member panel was comprised of the Pathology Clinical Directors, Pathology General Managers and the Directors of IT at each Trust. The panel undertook an options appraisal using agreed criteria based on benefits, risk and the degree to which the option enabled the achievement of the investment objectives.

The highest-ranking option of the evaluation was the implementation of a remotely hosted single shared LIMS procured through a revenue-based arrangement. In table 34 below as this is shown as Option B. Option A is the do minimum PSC option provided for comparison. Appendix W provides further information on the options appraisal including the individual appraisers' scores against each criterion for each option.

Table 34: Summary Qualitative Appraisal Scores

Evaluation Results	Option A	Option B
Qualitative appraisal (%)	23	85
Ranking	**2**	**1**

Because at the end of the LIMS tender process only one bidder remained, as previously stated, the logical process to derive a qualitative appraisal outcome at FBC stage was to confirm that the process undertaken and outcome obtained at OBC stage was still pertinent; and to transpose the generic Option 5 for the solution provided by the successful bidder, CliniSys.

To ratify the outcome, the original appraisal criteria, identified benefits and identified risks pertaining to both options were reassessed by the Director of Pathology Transformation and the Chair of the LIMS Project Steering Group (the General Manager of Pathology at MTW). They concluded that the offer provided by CliniSys aligns to the generic Option 5.

3.7.4 Qualitative Appraisal of Options Conclusions

The qualitative option appraisal produced the following conclusions:

Option A – this option ranks second

Option B – this option ranks first

3.8 Risk Appraisal

3.8.1 Unquantifiable Risks

The possible business and service risks associated with the two shortlisted options that were identified at the OBC stage were reviewed by the Director of Pathology Transformation and the Chair of the LIMS Project Steering Group.

3.8.1.1 Methodology

Risks were assessed based on its impact should it occur and the probability of it occurring. The standard risk assessment matrix adopted by the Pathology Programme was used to determine a Risk Priority Number (RPN) by multiplying the impact and probability scores together.

Table 35 below is the matrix used.

Table 35: Summary of Risk Appraisal Results.

		Impact				
Probability		Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
	Rare 1	1	2	3	4	5
	Unlikely 2	2	4	6	8	10
	Possible 3	3	6	9	12	15
	Very Likely 4	4	8	12	16	20
	Almost Certain 5	5	10	15	20	25

3.8.1.2 Risk Scores

Each risk was assessed based on its impact should it occur and the probability of it occurring. The standard risk assessment matrix adopted by the Pathology Programme was used to determine a Risk Priority Number (RPN) by multiplying the impact and probability scores together, therefore the higher the RPN the higher the risk is perceived to be. Table 36 below summarises the risk appraisal results reviewed by the Director of Pathology Transformation and the Chair of the LIMS Project Steering Group.

Table 36: Summary of Risk Appraisal Results.

			Option A		Option B	
Risk Description	**Risk Category**	**Impact Score**	**Probability**	**RPN**	**Probability**	**RPN**
As it does not meaningfully support the 5 objectives of the STP Pathology Programme, change may be enforced by central government, removing autonomy.	Business	5	3	15	1	5
The incumbent supplier may move towards removing support for the current LIMS, forcing labs to upgrade to re-tender and the eventual implementation of more expensive options than a single LIMS across Kent.	Service	3	3	9	1	3
Legacy LIMS are not compliant with the mandated requirement for LIMS to use SNOMED-CT and the FHIR interoperability standard.	Business	2	5	10	1	2
Implementing a common pathology catalogue across multiple LIMS will be challenging	Service	2	5	10	2	4

			Option A		Option B	
Risk Description	**Risk Category**	**Impact Score**	**Probability**	**RPN**	**Probability**	**RPN**
The ability to manage samples across sites, e.g. sample tracking will be more difficult and less efficient with multiple LIMS	Service	1	4	4	1	1
Annual support costs will remain separate to each Trust and may increase substantially above the cost of supporting a modern LIMS through a single contract.	Business	2	3	6	1	2
Predatory competitor organisations may be able to supply a more holistic technology enabled service at a lower cost and may erode the market share held by the Trusts in Kent and Medway	Business	4	3	12	2	8
The harmonisation of tests, methods and the quality management system to form a common approach to the delivery of pathology services in Kent will be challenging to achieve and may not be fully possible.	Service	2	5	10	2	4
Trusts would be dependent on supplier management of the servers/data centres, security, Disaster Recovery, backups, system upgrades and	Service	2	1	2	5	10

			Option A		Option B	
Risk Description	**Risk Category**	**Impact Score**	**Probability**	**RPN**	**Probability**	**RPN**
patches.						
There may be network latency issues with a remotely hosted (cloud-based) system. This may impact performance e.g. causes issues for the Tracked Analysers management system	Service	2	1	2	3	6
Introducing a new LIMS would require the re-implementation of the existing (or new/alternative) GP Order Comms Systems	Service	1	5	5	5	5
Implementing a new LIMS will require significant data cleansing and data migration	Service	3	1	3	3	9
Total RPN scores				**88**		**59**

As detailed in the above table, with a total Risk Priority Number score of 88, Option A represents a riskier option than Option B as this has a combined Risk Priority Number score of 59.

3.8.2 Unquantifiable Risk Appraisal Conclusions

The unquantifiable risk appraisal produced the following conclusions:

Option A – this option ranks second

Option B – this option ranks first

3.8.3 Quantifiable Risks

Appendix H provides a high-level overview of the identified quantifiable risks associated with the two shortlisted options. These are the risks that relate specifically to an option and not the wider project and these were used to calculate contingency costs for both options. Risks were assessed through the whole anticipated contract lifecycle using the Comprehensive Investment Appraisal model (CIA). Prior to the approval to proceed to contract award and the commencement of the implementation

project, i.e. up to the end of the FBC stage, the Programme Board assumes ownership of all option related risks.

Risks that may prevent the *project* achieving its stated objectives, so called project risks, are listed in section 2.3.7 and are described in detail in Appendix F.

The risk that VAT is not recoverable is deemed to be a contingent liability and is therefore not included in the contingency cost figures.

3.8.4 Options Appraisal Outcome

The results of the combined appraisals are as follows:

Table 37: Summary of total appraisal results

Evaluation Results	Option A	Option B
Economic appraisal ranking	2	1
Qualitative appraisal ranking	2	1
Unquantifiable risk appraisal	2	1
Overall Ranking	**2**	**1**

A cost benefit ratio has been calculated for both shortlisted options in the CIA. The benefit for the LIMS project is less than a ratio of 1:1 for both, as this is an investment case to enable the wider Pathology Programme to deliver benefits.

Once all projects within the pathology transformation programme are delivered there will be a net undiscounted saving of £3.3m p.a. from year eight and a total undiscounted saving of £20.3m by year 14 compared to current baseline. Table 49 in section 5.6 of the financial case provides the detail by project.

3.8.5 Cost Benefit Outcome

Table 38 below shows the discounted incremental impact of each of the schemes and the resulting cost benefit ratio. As previously stated, the ratio for LIMS is below 1 due to the high incremental cost from very old legacy systems, minimal cash releasing benefits and unquantifiable, non-cash-releasing benefits. However, this is only one of the enabler projects supporting the transformation of pathology services.

The change-enabling Managed Equipment Service project will procure a single contract for the whole of the network. The savings assumption, based on benchmarking of the savings achieved by other networks, is forecast to deliver net present savings of £14,104k. Implementation costs are not known at this time however the benchmarked level of saving reflects the lowest of the ranges. The cost of project management is included in the Programme Management Office (PMO) costs which are held

centrally to deliver the programme. A network approved outline business case is currently being reviewed by NHSEI

The transformation change project will deliver sustainable and efficient staffing levels mainly as a result of the non-cash-releasing benefits of the enabler projects. The savings assumption is based on high level modelling of skill mix and WTE by activity. A prudent view with no savings anticipated until the first two projects are fully implemented has been assumed. It is likely that a number of the changes will crystallise earlier, i.e. during implementation of the enabler projects, however until the single operating procedures and harmonisation work is complete, robust savings cannot be determined. Where the level of change is material, this will be supported by a business case.

The final project is the referred test project which relates to a review of tests currently undertaken by laboratories outside of the Kent and Medway Network pathology network. The savings assumption is based on a harmonised price for each test based on the current lowest price procured via a contract from a single supplier. No implementation costs will be incurred and no additional cost for project management as these costs are covered by the PMO and the Trust procurement team. The incremental net present cost of the PMO is reflected here for ease of reference.

Collectively the pathology programme delivers a cost benefit ratio of 1.81

Table 38: Incremental net present cost of the pathology programme

Preferred option	LIMS £'000	MES £'000	Transformation £'000	PMO & Referred tests £'000	Total £'000
Incremental Net present cost	14,386	0	0	491	14,877
Cash releasing benefit	(4,411)	(14,104)	(5,796)	(3,276)	(27,587)
Non-cash releasing benefit	0	0	0	0	0
Sub-total	9,975	(14,104)	(5,796)	(2,785)	(12,710)
Risk	327	0	0	0	327
Total net present cost / (benefit)	**10,302**	**(14,104)**	**(5,796)**	**(2,785)**	**(12,383)**
Net benefit to cost ratio	0.30	N/A	N/A	6.67	1.81

3.9 Sensitivity Analysis

Sensitivity analysis provides an assessment of the impact on the economic evaluation should the underlying assumptions prove to vary when the preferred option is delivered.

3.9.1 Results of Scenario Sensitivity Analysis

The following table summarises the scenario sensitivity analysis:

Table 39: Sensitivity Analysis

	Option A	Option B
Sensitivities	**£'000**	**£'000**
Base NPC	**20,293**	**10,302**
All Capital costs 10% Higher	21,815	10,317
All Capital costs 10% lower	18,771	10,287
Revenue 5% higher	21,447	12,172
Revenue 5% lower	19,139	10,302
Implementation costs 10% higher	20,773	10,703
Implementation costs 10% Lower	19,813	9,902

Note: Sensitivity analysis on identified risks was not undertaken as these were considered immaterial and would not affect the outcome of the result. Equally, sensitivity analysis on benefits was not undertaken as these were considered factual.

3.9.2 Key observations

The sensitivity analysis confirms that whilst any increase in costs would increase the cost, there is no effect on the overall ranking of the shortlisted options based on the above sensitivities.

3.10 Option Constraints and Dependencies

The project constraints and dependencies listed in the Strategic Case in sections 2.38 and 2.39 respectively are largely agnostic to any option and as such are largely relevant to all options that have been shortlisted.

3.10.1 Constraints

- Available budget ultimately approved to deliver the LIMS.
- Availability of critical resources such as subject matter experts, Clinicians Trust IT Teams, pathology IT Teams, supplier resources and third-party resources. Possible cause may be other significant IT systems projects undertaken at Trust sites
- The release of laboratory staff for training on any new system or equipment being implemented
- The need to comply with the needs of Government IT guidelines.

- The extent to which Trusts in the Network (working in the alliance model) agree to fully harmonise processes and methods that impact the LIMS configuration across the Network. (this is not a constraint associated with Option 1)

3.10.2 Dependencies

- Forecast savings to be enabled through the Managed Equipment Services (MES) Project, which will part-fund the LIMS implementation.
- The development of interfaces to existing or new analysers is likely to be on the project's critical path, during the implementation phase.
- Appropriate, often dedicated, resources with the prerequisite skills and experience to implement the LIMS.
- Support and input from Trust IT Teams to enable Open API interfaces to downstream healthcare and patient administration systems to be implemented.
- Support and input from GP Practice systems providers to enable interfaces to their systems to be updated as required.
- Effective system and data architecture design will be fundamental to the success of the project. A successful LIMS implementation is reliant on understanding and planning for the various data flows.
- Fully harmonised processes and methods that impact the LIMS configuration across the Network.

3.11 The Preferred Option

Based on the options appraisal outcome, Option B is the preferred option which is demonstrably the better option. As the only remaining supplier at the end of the competitive procurement process, CliniSys are the recommended supplier.

4 Commercial Case

Why the chapter matters:

This chapter provides information on the required services and how these will be provided. Key details of the commercial arrangements between the recommended supplier and the Trusts are outlined, including the payment mechanism for the supplier and the penalties to be imposed for poor performance.

What this chapter says:

The chapter explains that CliniSys Solutions Limited is the recommended bidder at the end of the competitive tender process. The section provides information on the apportionment of risk between CliniSys and the Trusts, as defined by the terms and conditions set out in the proposed contract. The chapter provides a summary of the contract length and key contractual clauses as well as the impact of the proposed investment on staffing. The chapter concludes with a summary of the implementation timelines and the accountancy treatment under IFRS rules.

Changes since the OBC:

The commercial case of the LIMS OBC was by necessity vague on some aspects of the anticipated procurement as, although it was established that QE procurement's framework would be utilised, work on reviewing and redrafting the standard terms and conditions to suit the Network's needs had not begun. The commercial case of this FBC provides specific aspects of the proposed contract.

Since the OBC was published, it has been defined that a remotely hosted solution provided via a managed service contract will be procured from CliniSys Solutions Ltd. The contract length will be 12 years 11 months with the possibility to extend for periods up to a further 5 years. Specific details regarding payment mechanisms have been included and clarification given that TUPE will not apply to the proposed investment scheme.

4.1 Introduction

This section of the FBC sets out the negotiated arrangements with the recommended supplier, CliniSys Solutions Limited (referred to as CliniSys).

The procurement approach outlined in this Commercial Case is consistent with DHSC policies regarding the mandated establishment of Pathology Networks and the advantages of a single shared LIMS. The procurement approach undertaken was compliant with Public Contracts Regulations 2015 (PCR 2015) and was in total compliance to the procurement strategy described in the LIMS OBC.

The LIMS OBC was reviewed by a 'Gateway Review' panel comprised of the Chief Executive Officers and the Chief Financial Officers from the four acute hospital Trusts in Kent and Medway, in order to ensure that the proposal was commercially feasible and deliverable. Prior to, and during, the procurement process, the proposed supplier contract was reviewed by external legal advisors as was the CliniSys commercial offer following the completion of the tender process.

4.2 Required services

CliniSys, as the recommended supplier, will be required to provide a single, remotely hosted, multi-disciplinary LIMS accessible to all legitimate users throughout all laboratories via managed service contract.

All responsibility for the day-to-day management including backups and system restores following system failures, and all disaster recovery and system security responsibilities, would be the responsibility of CliniSys, irrespective of whether they outsource the actual system hosting aspects.

As agreed by the Pathology Programme Board, EKHUFT will host the LIMS contract on behalf of the Kent & Medway Pathology Network. As a result, EKHUFT will be the purchaser of the service on behalf of the Network but will be supported by 'back-to-back' agreements (also referred to as a Memorandums of Understanding (MoU)) with the other members of the Network, to ensure that all Trusts are equally accountable under the terms of the contract with CliniSys.

4.3 Agreed Risk Transfer

The general principle is that risks should be passed to 'the party best able to manage them,' subject to value for money.

The draft contract terms and conditions set-out the responsibilities delineated between CliniSys and the 'Authority,' EKHUFT, on behalf of the Kent & Medway Pathology Network and managed via the back-to-back agreements.

This section provides an assessment of how the associated service risks during the design, build and operational phases will be apportioned between the Network and the recommended LIMS supplier, CliniSys.

Table 40: Agreed Risk Allocation Matrix

Risk Category	Agreed allocation			Related Contract Schedule
	Network	CliniSys	Shared	
1. Design risk			✓	N/A
2. Construction and development risk			✓	N/A
3. Transition and implementation risk			✓	6.1
4. Availability and performance risk		✓		2.2
5. Operating risk	✓			N/A
6. Variability of revenue risks	✓			N/A
7. Termination risks	✓			7.2
8. Technology and obsolescence risks			✓	N/A

Risk Category	Agreed allocation			Related Contract Schedule
	Network	CliniSys	Shared	
9. Control risks	✓			8.1
10. Financing risks	✓			7.1, 7.2, 7.4, 7.5
11. Legislative risks	✓			N/A
12. Other project risks	✓			N/A
13. Price Increase above NHS Inflator			✓	7.1
14. Contract delivery penalties		✓		7.1

4.4 Agreed Charging Mechanisms

The contract will run for 10 years from the point of the final go-live, estimated to be November 2024, and will therefore be for approximately 12 years 11 months in total as the full implementation across the three hub laboratory groups will take an estimated 3 years from contract award.

4.4.1 Milestone Payments

Ahead of the service being fully operational, the new LIMS must be deployed across all three pathology services. Payments have been agreed for the following key deployment milestones:

- Hardware Build
- LIMS Configuration (low-level design)
- Integration low-level design (separate milestone per go-live)
- Data Migration (partial payment for MTW only, remaining costs for MTW and all costs for EKUHFT and NKPS deferred)
- System Testing (separate milestone per go-live)
- User Acceptance Testing (partial payment for MTW only, remaining costs for MTW and all costs for EKUHFT and NKPS deferred)
- Training
- Go-live (separate milestone per go-live)
- Steady State (separate milestone per go-live)

For each of the above milestones a minimum delay payment of £3k has been agreed and is defined in the draft contract (Schedule 7.1 (Charges and Invoicing)).

4.4.2 Indexation

Only variable operational prices are to be subject to Consumer Prices Indexation (CPI) and therefore indexation will not apply to deployment (milestone) costs. Where costs are subject to indexation the rate will be applied on the first day of the second April following the Operational Service Commencement Date (final go-live) and on the first day of April in each subsequent year.

Indexation will be capped at the current CPI rate or 2%, whichever is the higher.

4.4.3 System Availability and Resolution Time Service Credits

Schedule 2.2 (Performance Levels) of the draft contract requires CliniSys to meet an Operational Service Level (OSL) of 99.98% with Service Credits being applied at 99.91%. The schedule lists the increasing number of Service Credits to be applied for each reduction of system availability by 0.10%.

Schedule 2.2 also details the maximum time that CliniSys will be permitted to take in resolving any Service Incidents. Service Incidents are graded between severity level 4, which requires CliniSys to resolve the incident within 80 hours and level 1, which requires CliniSys to resolve the incident within 4 hours. Failure to achieve these targets for each incident recorded will result in Service Credits being applied. For a single severity level 1 incident breach in one month, 3 service credits will be applied and 6 for every repeat failure.

A single Service Credit is a defined unit, being 0.2% of the monthly Services Charges. The draft contract defines that the cumulative effect of Service Credits each month shall be capped at 40% of the monthly Services Charges invoice; that is an aggregate maximum cap of 200 Service Credits each month may be applied.

4.5 Agreed Contract Length

All costs have been produced and evaluated on the basis of a 10-year contract, from final go-live assumed to be November 2024, with the LIMS supplier. The draft contract allows the possibility of the contract length being extended for further periods of up to 5 years.

4.6 Key Contractual Clauses

The proposed contract for the supply of the LIMS is variation of the standard services agreement used by the QE procurement framework: “Clinical software (and hardware) solutions for use in healthcare”. QE Procurement’s standard agreement is based on the government’s current model services contract. The minor variation from the QE Procurement model followed advice and guidance received from the external legal advisors, DAC Beachcroft.

The draft contract comprises of a main terms and conditions document and 28 separate schedules, each detailing specifc aspects ranging from definitions (Schedule 1) to Charges and Invoicing (Schedule 7.1), Processing Personal Data (Schedule 11) and Standards (Schedule 2.3) that the system and suppliers must meet, such as the *NHS Digital, Data and Technology Standards* and the

supplier's future obligations to comply with this standard as it is updated. Also detailed in schedule 2.3 are the interoperability standards that the supplier must meet, including Open APIs for access to clinical services and patient records support OAuth2 and enabling the use of PQAD (Pathology Quality Assurance Dashboard).

Each schedule is important in its own right; however, arguably of key importance are Schedule 2.1 (Services Description) and Schedule 2.2 (Performance levels). These schedules detail the expectations of the Trusts and the supplier's contractual obligations in meeting those.

Appendix I is Schedule 2.1 and appendix J is Schedule 2.2. As stated in paragraph 4.4.3 above, Schedule 2.2 sets out the standards to which the supplier must deliver the services, the mechanism by which Service Failures will be managed, and the method by which the supplier's performance under this agreement will be monitored. The service level agreement details the following:

- Service Levels and Service Credits;
- Supplier System Maintenance;
- Performance Monitoring; and
- Service Incident Reporting and Recording

The principles of the mechanisms employed are to give a well-defined boundary of what must be delivered, together with a fair mechanism to allow the deduction of points where this has failed to occur; and a clear and well-structured process that allows all parties to determine both what has happened, and the reasons and responsibilities where it has not been in line with the expectations of the contract.

Since the development of the specification used during the tender process, national requirements on pathology services have continued to evolve and features and functions that would have been criteria included within the specification have emerged. During the period between tender completion (and award subject to FBC approval) and contract award, the PMO will work with CliniSys to ensure that any new requirements are included within the scope of the contract, where possible. Examples include the need for Trusts to return daily reports to comply with the Covid-19 Hospitalisation in England Surveillance System (CHESS) and Pathology Laboratory Activity & Capacity Electronic System (PLACERS), which CliniSys have already confirmed are accommodated within or by their WinPath Enterprise LIMS.

During the Covid-19 pandemic, a link between specific patient demographic factors, such as ethnicity, and the impact of Covid-19 was established. The impact of Covid-19 on certain ethnic groups was disproportionately higher than other demographic groups. This has led to the realisation that patient demographics must be available alongside results to inform clinical decision-making and reporting datasets must also account for these factors. Again, as the tender specification pre-dates the findings during the Covid-19 pandemic, these requirements will be addressed with CliniSys, who have confirmed that these additional requirements will not pose an issue, during pre-award discussions.

4.7 Personnel implications (including TUPE)

TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2014) will not apply to this investment.

The proposed investment includes a new post of LIMS System Manager, who will be employed by EKHUFT. The existing Pathology IT Managers employed separately at the individual Trusts will have professional accountability to this person for the support of the LIMS in use at their respective Trusts and sites, whilst continuing to report hierarchically to the Pathology General Managers.

Reducing from four LIMS to a single shared LIMS will enable a reduction in the LIMS support required by Pathology IT staff. However, due to the ever-increasing adoption of new systems and Pathology IT staff involvement in IT projects managed outside of pathology but impacting pathology, no decrease in total Pathology IT resource is expected.

The implementation of the proposed single shared LIMS will not directly impact the employment of other staff at any of Network's Trusts.

4.8 Procurement Route and Implementation Timescales

As stated in paragraph 4.6 above, a competitive procurement process using the QE procurement framework and supported by the EKHUFT Procurement Team was undertaken. The tender concluded with one remaining bidder, CliniSys, submitting a compliant best and final offer. Appendix D is the Procurement Outcome report, and a summary of the process undertaken is provided in paragraph 3.5 in the Economic Case.

CliniSys Solutions Ltd. will be awarded the contract subject to the approval of this full business case by the Boards of the Kent and Medway Trusts, the Kent and Medway CCG and NHSEI.

A representative project plan, which outlines key tasks throughout the implementation and across multiple workstreams is provided in Appendix K, however, the definitive project plan will be agreed jointly with CliniSys within 40 working days of the contract being awarded, as stipulated in Schedule 6.1 (Implementation Plan). The project plan will be based on the agreed implementation approach of 3 go-lives.

It is anticipated that the implementation phase will take approximately 3 years from contract award, assumed to be December 2021, to the final go-live being fully completed November 2024. The early stage following contract award will include supplier resource mobilisation and the finalisation of the LIMS/Process harmonisation work, which must be completed before the new LIMS can be configured.

4.9 IFRS Accountancy Treatment

The contract with CliniSys will be for a remotely hosted solution and the provision of a service. No assets will be for the sole use of the network, so this is assumed to be a service contract and not 'on balance sheet'. This assumption has been reviewed by EKHUFT's external auditors who support this assumption.

5 Financial Case

Why the chapter matters:

This chapter provides the total cost of the recommended option (Option B) including the impact of VAT and return of investment both before and after assessment of the impact of inflation. It also provides the financial impact on each of the network members and the Kent and Medway System as a whole.

What this chapter says:

The chapter provides the details of assumptions used when compiling the costs. The uninflated and inflated costs of option B together with the impact to each of the Network members to their Income and Expenditure and balance sheet (where applicable). This chapter also provides the detail of the impact of the project on the Kent and Medway system and how affordability is being addressed.

Changes since the OBC:

The financial model has been updated following a review of the assumptions, costs and timeline. The baseline has moved on a year and is now 2020/21. Following the LIMS OBC, the network has agreed a formal alliance arrangement and, as part of that process, the baseline costs were reviewed to determine the contribution split. The FBC therefore uses the contribution split as agreed in the alliance agreement.

5.1 Introduction

The purpose of this section is to set out the forecast financial implications based on the proposed contract with the recommended Supplier, CliniSys Solutions Ltd (referred to as CliniSys), following the outcome of the competitive tender.

The financial model was quality assured via internal peer review which is in line with the National Audit Office (NAO) framework. The peer review was via a ‘check and challenge’ session whose membership consisted of the Deputy Directors of Finance for each acute Trust and the Operations lead for each of the pathology organisation in Kent and Medway.

5.2 Assumptions

As stated in the Economic Case, the following assumptions have been used to calculate the economic and financial impact of the proposed investment scheme:

Table 41: Financial Assumptions

OBC	FBC
Base year (Year 0) is 2019/20	Base year (Year 0) is 2020/21 which includes the costs being at 20/21 pay rates.
Contract duration and anticipated system life is 10 years based on historic rate of system development. Within this period a hardware refresh as year 5is expected to be required and has been included within the costs	Within this period a hardware refresh at year 5 of the operational contract term is expected to be required and has been included within the costs.
All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option 5 and the ASM in all options.	All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable except the Managed Service Contract in Option B and the ASM in all options.
Discount factor is 0.035 (3.5%).	Discount factor is 0.035 (3.5%).
Effect of inflation has been excluded	Effect of inflation has been excluded
Scheme will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available.	Option A will be funded by Public Dividend Capital (PDC) funds should they become available as no internal funds are available
Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the Treasury green book approach	Risk assessed contingencies (revenue and capital) have been added based on a financial impact assessment of identified risks using the Treasury green book approach
10% optimism bias has been added to the system capital costs based on the Treasury green book approach	10% optimism bias has been added to the system capital costs based on the Treasury green book approach for option A only
The Managed Service Contract term of 10 years for Option 5 is assumed to commence from the date of the first go-live to the new LIMS	The Managed Service Contract term of 10 years for Option B is assumed to commence from the date of the final go-live to the new LIMS
There may be a cash impact caused by any payments to the supplier during the implementation stage but these have not been modelled. These will be identified during the tender.	The total contract term for Option B will reflect the implementation period from contract signature to final go live which results in a contract term of c13 years. The implementation costs of the supplier are reflected where applicable during the implementation period and included in the total costs of Option B.
Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included.	Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included. Plus the TIE as at date of FBC approval for

OBC	FBC
	option A
Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.	Anticipated cash-releasing benefits within the wider Pathology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a single shared LIMS as detailed in section 3.6.3.
Specific procurement related costs have been included within the implementation team costs however work undertaken by Trust-based procurement services are absorbed within BAU costs of the Trust and therefore not included within the OBC costs	No additional procurement related costs have been incurred due to the tender being run via a framework and evaluation undertaken by internal subject matter experts. Work undertaken by Trust-based procurement services are absorbed within BAU costs of the Trust and therefore not included within the costs of the FBC.

5.3 Source of Costs

5.3.1 Current Costs

Current costs associated with supporting the current LIMS have a collective recurrent operating cost of £868k per annum as shown in Table 42 below.

All current LIMS' would either individually or collectively need to be replaced within the medium term. At least two of the four Trust systems requiring hardware replacements for their LIMS', as identified in the Strategic Case.

It is recognised that the pathology service will still require the same amount of Pathology IT resources to support the whole service across all sites so no overall reduction in this cost is expected; indeed, the programme has highlighted the need to increase resource which will be funded from the ad-hoc projects of which they support the implementation. However, as there will be a reduction from four current LIMS to a single shared LIMS, it is assumed that the Pathology IT staff costs that relate specifically to LIMS support will reduce, by 1.7wte. The staffing costs included within the I&E tables in section 5.4 below relate only to the LIMS support element of the Pathology IT support staff costs.

As demand for pathology services increase then the number of concurrent LIMS users may increase to facilitate the processing of requests, testing and reporting. However, there is no direct, linear correlation between growth in demand and an increase in the LIMS support workforce.

Table 42: Current Pathology IT Operational Costs

Trust	Total LIMS IT Support				Non-LIMS		Total Pathology IT Support			
	WTE	Pay	Non-Pay	Total	WTE	Pay	WTE	Pay*	Non-Pay	Total
		£'000	£'000	£'000		£'000		£'000	£'000	£'000
EKHUFT	2.05	109	191	**300**	0.10	5	2.15	114	191	**305**
MFT	0.15	5	81	**86**	0	-	0.15	5	81	**86**
DGT	2.05	97	97	**194**	1.10	37	3.15	133	97	**230**
MTW	2.05	109	179	**288**	0.10	5	2.15	114	179	**293**
Totals	**6.30**	**320**	**548**	**868**	**1.3**	**47**	**7.60**	**367**	**548**	**915**

*Includes both Pathology IT staff and Trust IT staff.

5.3.2 Estimating Costs

All existing costs were obtained directly from the three Trusts. All future costs have been estimated.

Supplier costs have been taken from the best and final offer received from the recommended supplier, CliniSys.

The Trust-based implementation team costs were estimated following the development of detailed implementation plans based on the CliniSys approach to deployment. The plans were used to identify resource types required to undertake the work and stakeholders from all Trusts were engaged in this work.

5.3.3 Overview of Non-recurrent Costs

During the implementation phase of the LIMS project, the current, legacy LIMS' will need to be maintained post the go-live date for each Trust. As noted above, the current cost of the systems across the three Pathology Services is £548k per annum. It is assumed these costs will cease after the implementation of the final lab go-live. A dedicated LIMS data archive solution has been purchased and will be populated with all data not migrated to the new LIMS. Data migration will occur as each lab goes live.

In addition, a largely dedicated project team will be required for the implementation. It has been assumed that the team will mostly consist of back-filled subject matter experts from the operational teams as well as new specialist resources brought in to support the deployment. The estimated Trust-based implementation team cost is £4.398m, spread over years 1 to 4. Supplier costs associated with data migration are £1.707m spread over years 2 to 4, making a total of £6,105m as shown in table 47 below. Appendix L provides the breakdown of the Trust-based implementation team costs.

5.4 Impact on the Income and Expenditure of the Organisations

The total uninflated income and expenditure for the preferred option are shown in Table 43 below

Table 43: Uninflated Income and Expenditure for Option B

Payment Stream (Uninflated)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Yr 14 to Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
Option B	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital (cash phased)	475	0	0	0	0	0	0	0	201	0	0	0	0	0	0	676
Revenue	873	1,837	3,027	3,516	3,214	1,318	1,316	1,313	1,315	1,316	1,314	1,275	1,272	1,270	874	25,052
Total	**1,348**	**1,837**	**3,027**	**3,516**	**3,214**	**1,318**	**1,316**	**1,313**	**1,516**	**1,316**	**1,314**	**1,275**	**1,272**	**1,270**	**874**	**25,728**
Funded by																
Existing	1,348	873	873	873	873	873	873	873	1,074	873	873	873	873	873	509	13,411
Additional	0	964	2,154	2,642	2,341	444	443	440	442	443	441	401	399	397	364	12,316
Total	**1,348**	**1,837**	**3,027**	**3,516**	**3,214**	**1,318**	**1,316**	**1,313**	**1,516**	**1,316**	**1,314**	**1,275**	**1,272**	**1,270**	**874**	**25,728**

Note that the above table assumes savings would not start to be seen until the system has been fully implemented and considers that some existing LIMS supplier contracts may remain in place for up to a year longer.

The total inflated income and expenditure for the preferred option are shown in Table 44 below. Inflation has not been applied to capital charges or contingency which are now reflected as a revenue cost in table 44 below.

Table 44: Inflated Income and Expenditure for Option B

Income and Expenditure (Inflated)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Yr 14 to Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
Option B	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue, including capital charges	873	1,879	3,132	3,728	3,465	1,439	1,464	1,489	1,517	1,545	1,572	1,562	1,590	1,585	1,103	27,942
Total	**873**	**1,879**	**3,132**	**3,728**	**3,465**	**1,439**	**1,464**	**1,489**	**1,517**	**1,545**	**1,572**	**1,562**	**1,590**	**1,585**	**1,103**	**27,942**
Funded by																
Existing	873	885	893	901	909	917	925	933	942	950	959	968	976	985	994	14,010
Additional	0	995	2,239	2,827	2,556	522	539	555	575	595	613	594	613	600	109	13,933
Total	**873**	**1,879**	**3,132**	**3,728**	**3,465**	**1,439**	**1,464**	**1,489**	**1,517**	**1,545**	**1,572**	**1,562**	**1,590**	**1,585**	**1,103**	**27,942**

Costs will be split proportionally on the basis of the agreed financial principles which is the gross cost of the pathology service as per the NHSI returns 18/19 outturn. Table 45 provides the details of the distribution of investment/savings.

Table 45: Proportionate Split of Additional Revenue Costs

	MTW (£'000)	EKHUFT (£'000)	NKPS (£'000)
Annual Gross Cost	26,039	27,377	26,368
Percentage	33%	34%	33%

(SOURCE: 2018/19 final NHSEI return)

Applying the above proportionate percentages to the total I&E position produces the following costs per organisation.

Table 46: Proportionate Split for all Trusts for Option B inflated revenue

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Yr 14 to Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
Option B	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Investment																
Central funds	475	0	0	0	0	0	0	0	0	0	0	0	0	0	0	475
EKHUFT	0	0	0	0	0	0	0	0	201	0	0	0	0	0	0	201
Total capital investment	**475**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**201**	**0**	**0**	**0**	**0**	**0**	**0**	**676**
Revenue Investment – Inflated																
MTW	0	325	731	923	834	170	176	181	188	194	200	194	200	196	36	**4,547**
EKHUFT	0	341	768	970	877	179	185	191	197	204	210	204	210	206	37	**4,781**
NKPS	0	329	740	934	845	173	178	184	190	197	203	196	203	198	36	**4,605**
Total I&E Impact	**0**	**995**	**2,239**	**2,827**	**2,556**	**522**	**539**	**555**	**575**	**595**	**613**	**594**	**613**	**600**	**109**	**13,933**

Mitigations have been agreed with the Kent and Medway CCG to 'bridge fund' the adverse impact in the four years from 2021/22 to 2024/25 to manage the phasing of the LIMS investment in order to support the delivery of the pathology service transformation programme.

Should the project not progress to the implementation stage, sunk costs, which have already been incurred, are within revenue budgets. This would also result in no return on investment.

5.5 Impact on Balance Sheet

The capital assets of the TIE and LIMS data archive solution are on EKHUFTs balance sheet and will be depreciated in line with the accounting policies of the Trust. The costs include a server refresh for the TIE during the life of the project.

The contract with CliniSys will be for a remotely hosted solution and the provision of a service. No assets will be for the sole use of the network, so this is assumed to be a service contract and not 'on balance sheet'. This assumption has been reviewed by EKHUFT's external auditors who support this assumption over the standard life of the equipment.

To ensure the liabilities committed by EKHUFT's contract with the supplier, a Memorandum of Understanding will be entered into by all Pathology Network partners as a form of Back-to-Back Agreement to legally bind all parties to their commitment and financial obligations of the contract.

5.6 Overall Affordability

The detailed cost of the LIMS (uninflated) is detailed in table 47 below including the share of these costs by pathology Network member.

Table 47: Uninflated Detailed Costs for Option B

Option B: uninflated	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Implementa-tion	0	557	1,985	2,140	1,423	0	0	0	0	0	0	0	0	0	0	6,105
Pay	320	320	320	320	320	320	320	320	320	320	320	320	320	320	320	4,804
Non pay	548	901	571	712	1,038	596	596	596	596	596	596	596	596	596	348	9,485
Contingency	0	8	10	26	18	25	25	25	25	25	25	0	0	0	0	211
Sunk costs	0	0	0	49	35	0	0	0	0	0	0	0	0	0	0	84

Option B: uninflated	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MSC	0	0	0	130	598	984	984	984	984	984	984	984	984	984	574	10,155
Depreciation & capital contingency	0	34	124	156	99	80	80	80	80	78	78	66	66	33	0	1,057
Dividend	5	17	17	16	15	12	10	8	9	10	8	5	3	1	0	135
Sub-Total	**873**	**1,837**	**3,027**	**3,550**	**3,546**	**2,017**	**2,016**	**2,013**	**2,014**	**2,013**	**2,011**	**1,972**	**1,969**	**1,934**	**1,242**	**32,036**
Savings-Pay	0	0	0	0	(34)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(48)	(828)
Savings-Non-pay	0	0	0	0	(228)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(548)	(320)	(5,480)
Total	**873**	**1,837**	**3,027**	**3,550**	**3,283**	**1,387**	**1,385**	**1,382**	**1,383**	**1,383**	**1,380**	**1,341**	**1,339**	**1,304**	**874**	**25,728**
Funded by:																
Existing	873	873	873	873	873	873	873	873	873	873	873	873	873	873	509	12,735
Additional	0	964	2,154	2,677	2,410	513	512	509	510	509	507	468	465	430	364	12,993
Total	**873**	**1,837**	**3,027**	**3,550**	**3,283**	**1,387**	**1,385**	**1,382**	**1,383**	**1,383**	**1,380**	**1,341**	**1,339**	**1,304**	**874**	**25,728**

Table 48 below identifies the investment required by each organisation to deliver the LIMS project.

Table 48: Investment Requirements per Organisation for Option B

Investment by Organisation	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MTW	0	311	700	870	783	164	164	163	163	163	162	149	149	137	117	**4,196**
EKHUFT	0	325	733	913	821	170	170	169	169	169	168	155	154	142	122	**4,381**
NKPS	0	328	721	894	805	179	178	177	177	177	177	164	163	151	126	**4,416**
Total	**0**	**964**	**2,154**	**2,677**	**2,410**	**513**	**512**	**509**	**510**	**509**	**507**	**468**	**465**	**430**	**364**	**12,993**

Affordability is judged on the outcome of the whole programme which is comprised of a number of projects and schemes. These projects when all implemented will deliver the sustainability and financial benefits. Due to the degree of change required each project is to be fully implemented in turn however as the network changes it is expected that transformation benefits may be realised earlier. These have not been included in order to be prudent.

Table 49 below details the impact of each project to the pathology network

Table 49: Impact of each project on the pathology network

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Baseline (Programme and LIMS)	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	1,162	678	16,950
Programme Projects																
COST: Cost PMO	489	547	334	224	92	0	0	0	0	0	0	0	0	0	0	1,685
SAVING: 'send away' CIP estimate	0	(58)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(67)	(1,505)
SAVING Transfor-mation Change - LOW	0	0	0	0	0	0	0	0	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(807)	(9,111)
COST: LIMS Project	873	1,837	3,027	3,550	3,283	1,387	1,385	1,382	1,383	1,383	1,380	1,341	1,339	1,304	874	25,728
SAVING: MES project	(317)	(596)	(596)	(596)	(690)	(1,006)	(1,440)	(1,871)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(958)	(19,570)
Total Pro-gramme costs / (savings)	1,045	1,731	2,649	3,063	2,570	265	(170)	(604)	(2,033)	(2,033)	(2,035)	(2,075)	(2,077)	(2,112)	(959)	(2,772)
Impact of Programme	**(117)**	**569**	**1,487**	**1,900**	**1,408**	**(897)**	**(1,332)**	**(1,766)**	**(3,195)**	**(3,195)**	**(3,197)**	**(3,237)**	**(3,239)**	**(3,274)**	**(1,637)**	**(19,722)**

The alliance agreement details how these costs and benefits are distributed to the Network members of the network and this is shown in table 50 below.

Table 50: Distribution of costs across the pathology network.

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Impact by Organisation																
MTW	(188)	127	427	562	337	(532)	(532)	(533)	(985)	(985)	(985)	(998)	(999)	(1,010)	(504)	(6,799)
EKHUFT	45	97	412	554	417	(362)	(795)	(909)	(1,383)	(1,383)	(1,384)	(1,398)	(1,398)	(1,410)	(703)	(9,601)
NKPS	26	345	648	785	653	(4)	(4)	(324)	(827)	(827)	(828)	(841)	(842)	(853)	(430)	(3,322)
Total	(117)	569	1,487	1,900	1,408	(897)	(1,332)	(1,766)	(3,195)	(3,195)	(3,197)	(3,237)	(3,239)	(3,274)	(1,637)	(19,722)

The Kent and Medway CCG is a member of the Pathology programme Board and is fully committed to this case. Letters of support are included in appendix A. During the first 4 years there is an adverse impact on the network members and the CCG has agreed to provide transitional funding to enable the delivery of the programme. This is detailed in table 51 below.

Table 51: Transitional funding arrangements.

Transition funds to each organisation	Year 0	Year 1	Year 2	Year 3	Year 4
	2020/21	2021/22	2022/23	2023/24	2024/25
	£'000	£'000	£'000	£'000	£'000
MTW	0	(127)	(427)	(562)	(337)
EKHUFT	0	(97)	(412)	(554)	(417)
NKPS	0	(345)	(648)	(785)	(653)
Kent and Medway CCG	**0**	**569**	**1,487**	**1,900**	**1,408**

Year 1 costs reflect the recruitment in advance of full FBC approval of the key members of the Trusts implementation team to enable the timeline to be delivered. These staff will be focused on harmonisation and change strategy.

5.7 Sensitivity Analysis

Sensitivity analysis on the relevant variables that may impact on the overall commissioning plan has been undertaken. Since only two costs are being impacted by the change, which are a small staffing/skill mix reduction for Pathology IT staff and the cessation of current LIMS system costs, there is no sensitivity outcome. Also, to mitigate the risk of the Trust implementation cost movement, the revenue costs include a contingency derived from the Green book risk assessment. All other costs have been fixed by the outcome of the procurement of the system.

5.8 Demand and Capacity Impact

Table 52 below details the key movements in activity, workforce and financial. Despite a small estimated annual combined growth of in tests across all pathology services there is no material impact on LIMS support and no anticipated need to revise the laboratory configuration significantly.

Table 52: Impact of Growth on LIMS

	21/22	22/23	23/24	24/25	25/26
Laboratory Configuration	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs	3x Hubs 4x ESLs
Peak Concurrent Log-ins	600	600	600	600	600
WTE LIMS Support Staff	7.3	7.3	4.6	4.6	4.6
Total Investment in LIMS (£'000)	964	2,154	2,677	2,410	513

Notes:

- Based on an estimated activity growth.
- No significant change in laboratory configuration is anticipated within the next five years.
- The peak concurrent log-ins, which equates to the number of users at any one time, is not anticipated to rise; however, any increase in users will be accommodated through normal BAU revenue expenditure, where justified, in the form of additional user licences. This is the typical approach with any IT system.
- A single shared LIMS will enable economies of scale and therefore there is an anticipated reduction in support requirements specifically attributable to LIMS.
- Early years incur implementation costs until a new baseline is achieved in 2025/26.

6 Management case

Why the chapter matters:

This chapter provides assurance that the project has in place a robust structure to deliver the preferred option and in doing so appropriately identify and control project risks and to identify and deliver project benefits.

What this chapter says:

The chapter outlines the proposed project management arrangements to ensure effective control and benefits delivery. The chapter details how change will be managed, and issues escalated to specialist decision-making bodies. It provides details on the resources required to undertake the implementation of the LIMS and the key milestones to which the team will be working. Arrangements for benefits realisation management during the life of the implementation project as well as post-project are discussed.

Changes since the OBC:

Since the LIMS OBC was developed and approved, as discussed in the Strategic Case, the Trusts forming the Kent & Medway Pathology Network have agreed to work in an alliance-based structure. To ensure the success of this and to provide cohesion between the disparate pathology services, the role of Director of Pathology Transformation has been introduced. This chapter provides clarity on the impact of that role on decision support for the business change tasks that are so important to the project's success.

The management case of the LIMS OBC assumed a two-phase deployment with 2 go-lives. Following the tender process, it has been agreed that the deployment will be based on 3 go-lives with each hub laboratory and its associated essential services laboratories 'going-live' together.

The Project management structure detailed in the LIMS OBC included the role of the Project Board. Whereas this function remains in the proposed structure and is detailed in this FBC the Board has been redefined as a Project Steering Group. There have also been some minor changes to the membership of the implementation project team and most relevant is the recognition of the importance of the team's leader, which has changed from Senior Project Manager to Project Director. This chapter now also includes a paragraph detailing the function of the Programme Team, which sits between the Steering Group and the Programme Board in the hierarchy.

There is an increased focus of the important roles of the Business Change Manager and the Training Manager in the FBC whereas the procurement resources section of the OBC has been removed as this is not relevant to the FBC.

With the change from a 2-stage deployment to a 3-stage deployment the key milestones table has been updated accordingly. Further detail is provided on change management and contract management approaches.

6.1 Introduction

This section of the FBC addresses the 'achievability' of the scheme. Its purpose, therefore, is to build on the SOC and OBC by setting out in more detail the actions that will be required to ensure the successful delivery of the scheme in accordance with best practice.

There will be little impact on the organisation and culture of the allied Trusts within the Kent & Medway Pathology Network following the implementation of a single shared LIMS. The most significant change will result from the need to harmonise, as far as reasonably practicable, the tests, methods and processes that the configuration of the single shared LIMS will require.

6.2 Deliverability

A single shared LIMS implemented across four allied sovereign Trusts, each with multiple PMI interface requirements, and each with disparate electronic order comms system, represents a significant technological and logistical challenge.

The procurement exercise that has led to the selection of CliniSys as the recommended supplier and the approach to deploying the LIMS has taken into consideration this complexity. Stage 1 of the procurement, using specific mandatory criteria, focused on ensuring that only those suppliers that could demonstrate a proven ability to deploy a single shared LIMS in a complex network context were able to be taken forward for detailed consideration at Stage 2 and beyond.

During Stage 2, the procurement process considered prospective suppliers' proposed approach to deployment in order that the Network can be satisfied that they are appropriate and take into account the complexities regarding process harmonisation and systems integration. The outcome of this work led to the refinement of the deployment approach and plan upon which this FBC is based. The OBC considered a two-stage deployment whereas this FBC proposes a three-stage approach.

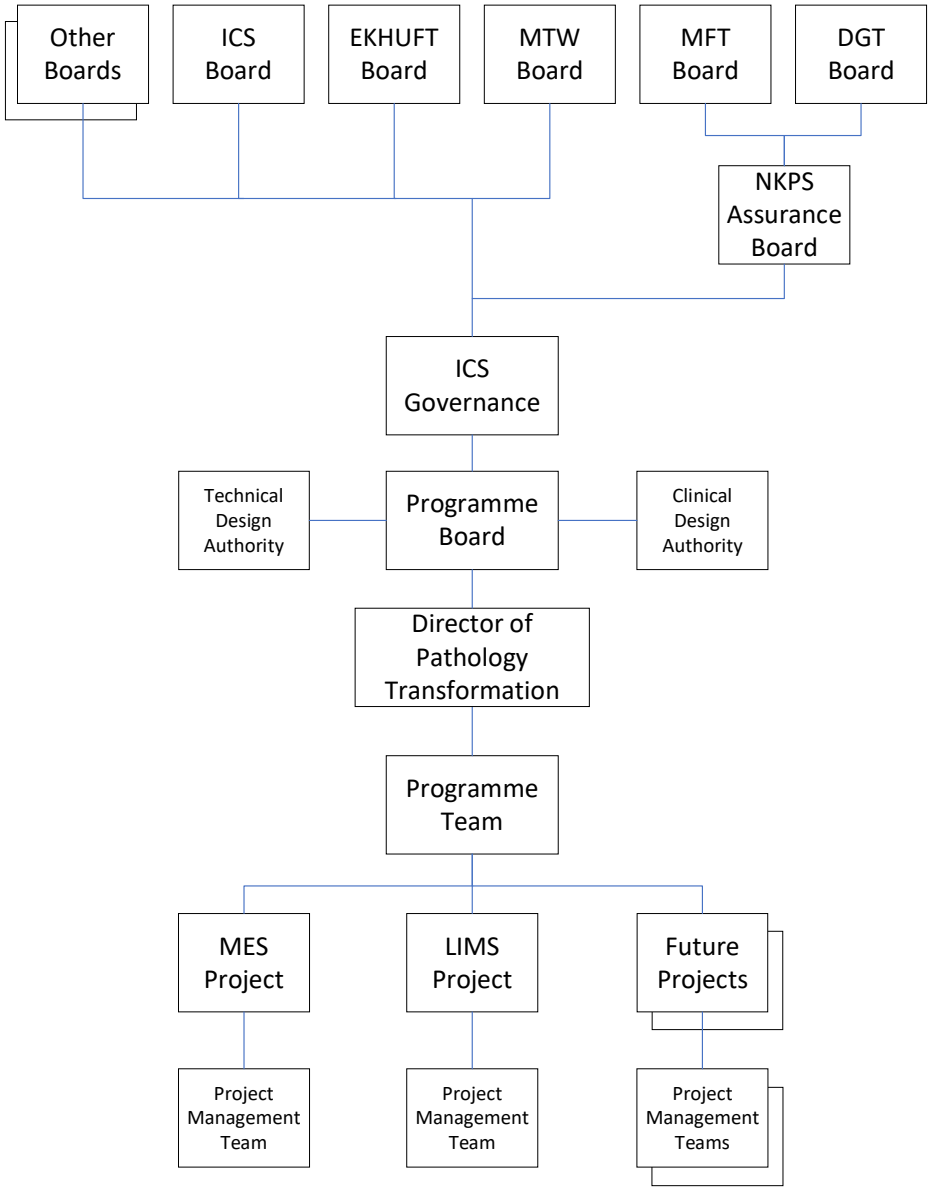
Harmonisation of the four Trusts' processes, test catalogues, methods, test and panel compositions also represent a significant challenge that should not be underestimated. A comprehensive change management strategy and plan coupled with excellent clinical leadership, effectively supported from the very highest levels of Trust and Programme governance, will be required to drive through this change.

6.3 Programme Management Arrangements

The scheme is a key part of the Kent and Medway Pathology Programme, which comprises a growing portfolio of projects for the delivery and development of a Pathology Network, fit for the 21st century. The earlier identified projects were detailed within the Strategic Outline Case (SOC), which was approved by the four Trust Boards and STP Board during January and February 2019 and submitted to NHS Improvement in April 2019. Since the approval of the SOC and with the growing recognition of the role that pathology plays in healthcare decision making and support, brought into sharp relief by the Covid-19 pandemic, greater focus on electronic order communications, digital pathology and AI has emerged.

The Programme will be managed within the Kent & Medway Integrated Care System governance framework. Figure 1 shows the agreed arrangement for the Programme's high-level governance.

Figure 1: Programme Governance Arrangements



6.3.1 Technical and Clinical Design Authorities

As the Kent & Medway Pathology Network have adopted an alliance model for its organisation, decisions on clinical and technical aspects will remain sovereign to each Trust but some will require consideration at a Network level. To work in this way effectively, some decisions might need to be delegated to a body that has representation from all Trusts and other organisations and others may be referred to the Director of Pathology Transformation as outlined in paragraph 6.3.2 below.

As the name implies the Clinical Design Authority would focus on the standardisation of pathology services where LIMS is impacted, e.g. the harmonisation of tests and methods and as other projects such as the MES project, electronic order comms and digital pathology are initiated within the programme, the work of this group may expand to also encompass issues referred to them for decision support from those projects.

The Technical Design Authority will consider all aspects of the system architecture and data flows. As the LIMS will be hosted remotely however, the server infrastructure will be at the discretion of CliniSys and their hosting partner, although the infrastructure arrangements must ensure that the requirements of the service level agreement defined in schedule 2.2 (*Performance Levels*) of the proposed contract are consistently achievable. The flow of demographic and electronic requests data (orders) to the LIMS and results data from the LIMS to third-party systems will be defined and managed by the Trusts. Oversight of data flows, particularly data moving beyond and between organisational boundaries, must be closely managed in accordance with GDPR requirements.

Each body will maintain a change control process to ensure that no unforeseen and undesirable outcomes arise from uncontrolled changes to agreed diagnostic methods or system configurations. Where changes may result in contractual changes, these will be managed in accordance with the LIMS Contract Change Management Process defined in schedule 8.2 (*Change Control Procedure*) of the draft Contract. The Clinical and Technical Design Authorities will advise the LIMS Project Steering Group and Programme Board as required.

The Design Authorities will maintain an overview of all significant IT and Clinical projects and initiatives being undertaken across the whole health economy to ensure that risks and issues do not arise from aspects such as resource clashes and IT change freezes etc.

6.3.2 Director of Pathology Transformation

The Director of Pathology Transformation is accountable for the delivery of the new single shared LIMS, also the outcome of the MES project and any other network projects that may arise. The Director will lead on all network projects and has the authority to make decisions where a consensus cannot be reached but would not have line management responsibility for the senior pathology staff. The Director of Pathology Transformation may refer issues for resolution to the Clinical or Technical Design Authorities where they deem it necessary to consult more widely to before deciding.

During the period following the end of the procurement phase to the contract award phase, the Director will, in conjunction with the LIMS Project Director, EKHUFT Procurement team and other key stakeholders, participate in the finalisation of the contract with CliniSys, ahead of contract award.

Whilst the three services will retain separate management structures, the Director of Pathology Transformation should facilitate the services to prepare for a time in the future where a single management structure may emerge.

6.3.3 Other Authorities

In addition to the Technical and Clinical Design authorities and the role of the Director of Pathology Transformation, specialist knowledge required on an ad-hoc basis will be accessed at every level from Programme Board to Project Steering Group. For example, advice and guidance on Information

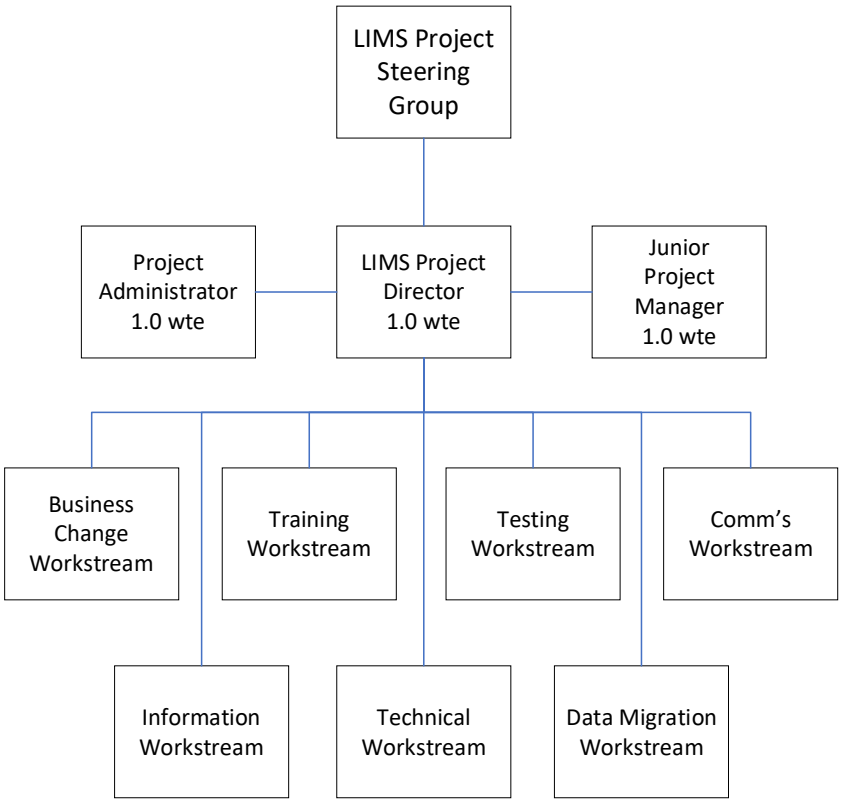
Governance and adherence to the requirements of the GDPR will be sought from the Information Governance Manager. In addition, GDPR compliant, over-arching Information Governance policies and evidential information will be implemented where required such as the Data Protection Impact Assessment (DPIA) shown in Appendix N.

6.4 Project Management Arrangements

The project will be managed in alignment with PRINCE 2 methodology. Appropriate strategies and plans will be developed during the initiation phase of the implementation project to ensure that the project is managed and controlled effectively with specific focus placed on quality, scope, schedule and cost.

6.4.1 Project Reporting Structure

Figure 2: Project Reporting Structure



6.4.2 Project Roles and Responsibilities

6.4.2.1 The Programme Board

The Programme Board is an existing, programme specific, decision-making body, and its membership includes executive representation from all Trusts; from clinical, scientific and operational management; IT and HR director representatives, NHSEI representatives and CCG/GP representative. This ensures effective governance and the interests of all parties being considered.

The Programme Board retains overall responsibility for the delivery of the programme of projects and the single accountable person is the Programme's Senior Responsible Owner (SRO), currently the Chief Executive Officer of MTW, who chairs the Programme Board. The main function of the Programme Board in relation to the LIMS and other Projects is to:

- Act on behalf of the Trusts and wider health economy stakeholders.
- Monitor progress on quality, scope, cost and time against baselined plans for all projects.
- Approve or reject change requests that have been escalated by the Project Steering Groups.
- Provide the final point of arbitration and support the management of escalated risks.
- Monitor progress of any benefits scheduled to be realised during the life of the projects.
- Monitor and approve progress against the programme's strategic objectives.
- Facilitate the flow of information to and from the constituent Trusts and other senior stakeholders.

The Terms of Reference and the membership for the Programme Board are provided in appendix O.

6.4.2.2 The Programme Team

The Programme Team is also already in existence. It is an operationally focused group led by the Director of Pathology Transformation. The Programme Team receives information and recommendations from the Projects within the Pathology Programme and channels supported recommendations to the Programme Board for approval. The team is comprised of the three Clinical Directors of Pathology, the three General Managers/Associate Director of Operations, and all members of the Programme Management Office (PMO). The main function of the Programme Team in relation to the LIMS and other projects is to:

- Act on behalf of the Kent & Medway Pathology Network's pathology stakeholders.
- Monitor progress on quality, scope, cost and time against baselined plans for all projects via monthly project highlight reports and summarise in a Programme level highlight report for the Programme Board.
- Consider change requests that have been escalated by the Project Steering Groups and where supported, recommend approval to the Programme Board.
- Manage Programme-level risks, ensuring that each has an identified owner and effective mitigation plan. Escalate High scoring risks to the Programme Board for consideration.
- Monitor progress of any benefits scheduled to be realised during the life of the projects.

- Monitor progress against the projects' objectives and provide advice and guidance to the Steering Groups.

- Facilitate the flow of information to and from the Project Steering Groups and the Programme Board.

The Terms of Reference and the membership for the Programme Team are provided in appendix P.

6.4.2.3 The Project Steering Group

The Project Steering Group was established in June 2020 and has overseen the LIMS tender process. The composition of the group reflects that of the Programme Team and Programme Board in that it includes representatives from all Trusts from clinical and operational management fields as well as IT, Finance and GP IT representation.

The Project Steering Group retains overall responsibility for the delivery of the LIMS project and the single accountable person will be the chair the Project Steering Group who is a member of the Programme Team. The main function of the Project Steering Group is to:

- Monitor progress on quality, scope, cost and time against baselined plans through regular highlight reports containing performance against agreed indicators.

- Authorise progression to the next project stage when required.

- Approve or reject change requests.

- Ensure that risks are proactively managed and that all risks have an owner and meaningful mitigating actions are identified and implemented.

- Support the management of escalated risks and escalate higher and/or wider, through other governance bodies as required.

- Monitor progress of any benefits scheduled to be realised during the life of the project.

- Monitor progress against the project's objectives and provide advice and guidance to the LIMS Project Director.

- Facilitate the flow of information to and from the Programme Board.

- Act as critical friend to the Project Management Team, provide advice and guidance but hold them to account for the successful delivery of the project.

The Terms of Reference and the membership for the Project Steering Group is provided in appendix Q.

6.4.2.4 The LIMS Implementation Project Team

A largely dedicated, full-time, project team will be required for the implementation of the LIMS and key roles are detailed in the following paragraphs. The team will mostly consist of back-filled subject matter experts from the current operational pathology and IT teams as well as new specialist resources brought in to support the deployment. The estimated Trust-based implementation team cost, included within the revenue costs shown within the Financial Case, is £4.398m, spread over 4 years from 2021/22. Appendix L provides the breakdown of the Trust-based implementation team costs.

6.4.2.5 The LIMS Project Director

As illustrated in figure 4, the project will be led by an experienced Project Director, who will be engaged full time and in post for the duration of the project. The Project Director will have day-to-day responsibility for the successful delivery of the overall project and will report to the Project Steering Group. They will be the main point of contact for the Project Steering Group and will represent the Project Management Team on the Project Steering Group. The Project Director will be PRINCE2 qualified to ensure that they can deliver the project aligned to these standards. Appendix R is the approved job description for role of Project Director.

During the period following the end of the procurement phase to the contract award phase, the LIMS Project Director will, in conjunction with the Director of Pathology Transformation, EKHUFT Procurement team and other key stakeholders, participate in the finalisation of the contract with CliniSys, ahead of contract award.

6.4.2.6 Workstream Leads

The work of the project team will be managed and completed within focussed workstreams as detailed in figure 2. Each workstream will be led by an appropriately skilled and knowledgeable manager who will have the necessary experience to ensure that all work undertaken by the workstream meets the required quality criteria. Work will be described in detail within work packages, following detailed planning, in which the supplier, system users and workstream leads will be fully involved. The work packages will contain all necessary information including quality expectations, reporting arrangements, agreements on timescales and risk management thresholds. Workstream Leads will be responsible for all the work within the workstream and will agree the work packages on behalf of the workstream.

6.4.2.7 Specialist Resources

Within the project's resource structure, but omitted from Figure 4 for clarity, there will be several resources reporting directly to the Project Director who will potentially work across multiple workstreams. These include: Data Architect, Business Change Manager, Training Manager, Testing Manager, Junior Project Manager and Project Administrator. The responsibilities of these roles will be more fully defined during the Initiation stage of the project, once approval to proceed to Initiation has been achieved. Specialist resources are likely to be dedicated, full time, to the project as required but are unlikely to be required for the whole project duration. A summary of the responsibilities of these roles is detailed in table 53.

Two key roles from amongst this group of specialists are the Business Change Manager and the Training Manager. The implementation of any new or replacement IT system normally involves significant change in practices and processes. The implementation of a single shared LIMS across three allied but separate pathology services represents a scale of change of the highest order, which must be carefully planned and managed. A detailed change management strategy will be developed and approved by the Programme Board ahead of the LIMS implementation project commencing and the Business Change Manager will deliver against this strategy. Likewise, the change in LIMS requires a significant effort to ensure that all LIMS users are fully trained and are deemed competent to use the new system. The training strategy and associated plans will be developed by the Training Manager to ensure that all staff are ready to use the new LIMS ahead of each go-live.

Table 53: Specialist Implementation Team Resources

Role	Main Responsibilities
Data Architect	Has overall responsibility for the detailed integration work. Defines the data flows to and from the LIMS and establishes the necessary messaging standards and contents. These will include multiple electronic order comms and GP systems.
Business Change Manager	Develops the change management plan in accordance with the change management strategy. Oversees and supports all business change activity including process development and business continuity planning.
Training Manager	Defines the training strategy, coordinates and plans all training activities including materials creation, user training and system support staff training.
Testing Manager	Defines the testing strategy, coordinates and plans all testing activities including test script creation and defect management and resolution.
Junior Project Manager	Supports the Project Director in the day-to-day management of the project.
Project Administrator	Supports the Project Management Team with all administration tasks.

6.4.2.8 Leadership Responsibilities

As with any significant project, success or failure is dependent on multiple factors. Strong and supportive leadership by those clinical, scientific and management representatives tasked with delivering a new single shared LIMS for the Kent & Medway Pathology Network must accept their role willingly and demonstrate the values that will enable a successful implementation. Descriptions for each of the key roles will be developed and those invited to take-up these roles will be asked to sign these in order to affirm their commitment.

6.4.3 Project Plan

Detailed planning for the implementation stage of the LIMS Project will be undertaken following authorisation to proceed into Project Initiation and in partnership with CliniSys, the recommended

LIMS supplier, and in conjunction with system users. Schedule 6.1 (*Implementation Plan*) of the draft contract states the requirements of the implementation plan. Working with the Trusts, CliniSys will be contractually required to produce a detailed implementation plan within 20 working days of the contract being signed. This plan must be responded to and approved by the Trusts within a further 20 working days. This process will ensure that as soon as practicable, a detailed and meaningful plan will be available for baselining and approval by the Project Steering Group, Programme Team and Programme Board.

Given the county-wide nature of the project; the LIMS implementation enabling all users in all laboratory sites to access the system and to enable pathology service users to request tests and access reports will be large in scale, and the implementation time will be commensurate with the project's scale. A Project Initiation Document (PID), sometimes referred to as a Management Control Plan, will be developed during the Project Initiation stage of the implementation project. The PID will detail the approach to managing the implementation project and effectively form a contract between the Project Steering Group and the Project Director and their Team. The PID will contain the multiple management strategies, such as Communications Management, Risk Management, Configuration Management and Benefits Management strategies.

Work on harmonising the Network's methods, workflow, test catalogue and other key elements required to enable the single shared LIMS to be used effectively and to support the Network's objectives can be undertaken ahead of supplier engagement. As such the project plan assumes that work will start ahead of supplier engagement and business change resources will be recruited once the FBC has been approved by the Programme Board. This approach would enable the implementation to be completed in the shortest time but also represents a risk to the Trusts of sunk costs at the run-rate of £66k per month, should the FBC not be fully approved by all necessary bodies. This indicative plan is based on the Pathology Programme Board's approval in principle, in April 2021, to release business change enablement funds totalling £200k to begin the recruitment of resources to work on process harmonisation tasks ahead of full FBC approval but it having been approved by the Programme Board.

The LIMS tender provided a useful and effective means of establishing how prospective suppliers would approach the implementation phase of the contract. Using a draft plan received from CliniSys during the procurement tender, a draft implementation plan that is aligned to and closely matches the CliniSys proposal was developed and has informed this FBC including costs and cost phasing. Following verbal feedback from NHSEI on the LIMS OBC, an overview of the timeline and approach was discussed with a neighbouring network, who are ahead of South 8 and they felt that the plan was broadly in line with their expectations. Table 54 provides an overview of the key milestones and the indicative timescale in months based on the CliniSys approach to deployment, however, as stated above, a detailed implementation plan will be agreed with CliniSys after the contract has been awarded. The approach described in Table 54 assumes that the LIMS will be configured based on a common, harmonised, set of processes, test catalogue, test composition etc to enable as much change and configuration as possible will be completed concurrently for all organisations leaving only service-specifc data migration, testing and training to be completed ahead of each successive go-live. A 'stabilisation period' of approximately 6 months between cutovers is planned however this period will be used to train users at the next laboratory/organisation and collate lessons learnt ahead of the next go-live. Effective training on the use and support of the single shared LIMS is considered

essential to a successful deployment and as such assurance that all necessary staff including clinicians have been sufficiently trained and competency assessed prior to go-live will form part of the cutover planning arrangements and approval to go-live. A new system will undoubtedly introduce new features and training will be tailored to maximise benefits of these. Where learning from the Covid-19 pandemic can be applied, this will be accommodated in the training. An example would be where a patient's demographic data, available when reviewing results, may inform decision making or reporting, which would have been helpful to identify Black, Asian and minority ethnic (BAME) patients who may be more susceptible to Covid-19.

Given the scale and complexity of the implementation project, any tasks on the critical path will be very closely monitored and it is proposed that tasks with long durations will be decomposed into shorter, smaller tasks where possible, with short durations to enable better control over planning and to avoid slippage. Any task on the critical path that has slipped will be reported as an Issue to the Project Steering Group.

Appendix K provides the representative implementation plan that the milestones were derived from but should be considered as an estimation of the timescales only. As mentioned above, detailed planning for the implementation stage will be undertaken in partnership with CliniSys and others.

Table 54: Milestone Plan

Milestone Activity (Tasks are not all sequential, many are concurrent)	**Month No.**
Preferred bidder identified	-6
LIMS FBC complete and peer reviewed	-6
LIMS FBC approved by the Programme Board	-4
Approval to proceed and begin recruitment of Business Change resources	-4
LIMS FBC approved by Trust Boards and the CCG	-3
Business Change resource recruitment complete (identification of candidates may start pre-approval)	-1
LIMS FBC approved by NHSEI	0
Project Initiation complete	1
High-level Service Design (standardisation and harmonisation) complete	3
As-Is process mapping complete	3
Data migration work (Hub 1) starts	5
Hardware build complete	5
To-Be process mapping complete	6
High level solution and Hub 1 integration design complete	7
Test Strategy complete	9

Milestone Activity (Tasks are not all sequential, many are concurrent)	**Month No.**
SOPs revised / drafted	11
Low level solution & Hub 1 integration design complete	14
Test Script development complete	15
Hub 1 Data migration work complete (minus delta load)	15
Validation and Hub 1 integration & E2E testing complete	16
Hub 2 Data migration work starts	17
To-Be Processes finalisation complete	20
Main User Acceptance Testing starts (3 rounds) complete	20
Hub 1 Cutover, Go-live & Delta migration starts	22
Hub 1 User Training complete	22
Hub 1 Go-live	**23**
Hub 1 Early life support & Stabilisation period starts	23
Hub 1 Cutover, Go-live & Delta migration complete	24
Hub 3 Data migration work starts	24
Hub 2 Data migration work complete (minus delta load)	26
Hub 1 Early life support & Stabilisation period ends	27
Hub 2 integration & end to end testing complete	28
Hub 2 User Acceptance Testing complete	29
Hub 2 Cutover, Go-live & Delta migration starts	30
Hub 2 User Training complete	30
HUB 2 Go-live	**31**
Hub 2 Early life support & Stabilisation period starts	31
Hub 2 Cutover, Go-live & Delta migration complete	32
Hub 3 Data migration work complete (minus delta load)	32
Hub 3 integration & end to end testing complete	34
Hub 2 Early life support & Stabilisation period ends	35
Hub 3 User Acceptance Testing complete	35
Hub 3 Cutover, Go-live & Delta migration starts	36
Hub 3 User Training complete	36
HUB 3 Go-live	**37**
Hub 3 Early life support & Stabilisation period starts	37

Milestone Activity (Tasks are not all sequential, many are concurrent)	Month No.
Hub 3 Cutover, Go-live & Delta migration complete	38
Hub 3 Early life support & Stabilisation period ends	41
Project Closure commences	41

In the table above, month 0 is defined as the month in which the LIMS FBC has obtained full approval from NHSEI estimated to be November 2021.

6.5 Implementation of Lessons Learnt

Lessons from similar projects and programmes have been and will continue to be investigated, shared and embedded wherever possible. Lessons from the North Kent Pathology Service consolidation project have been obtained and the above timescales and governance approaches have considered these. Lessons identified during the course of the project will be captured in a lessons log and will be reported on a monthly basis via the Project Highlight Report. During the project closure stage, a lessons report will be compiled and once approved will be shared within the Network and across external organisations.

Appendix M is a table containing the NKPS Project lessons learnt and recommendations that are pertinent to the replacement LIMS Project and explanations on how each lesson has been considered within this FBC.

In addition, key lessons identified from this and previous similar projects include:

- Governance arrangements must be established and fully integrated into respective Trusts' governance structure to ensure key decisions and actions are discharged in a timely manner.
    - The governance arrangements proposed above, including the implementation of the Clinical Design Authority and Technical Design Authority spanning all Trusts and the CCG will help enable effective decision making and support.
- Project management should adhere to PRINCE2 principles with a fully resourced Programme Management Office (PMO).
    - The costs outlined with this OBC include the provision of all key PMO roles to support the LIMS project.
- The need to map existing operational processes and data flows at a detailed level, including those impacting service users such as GP Practices.
    - As-Is processes and current data flows are included within the draft LIMS implementation plan. Costs associated with resources for these are included within this FBC and work is scheduled to start ahead of full FBC approval, once the Programme Board have approved the FBC.
- The need to ensure proactive clinical leadership with a single accountable clinical lead for each discipline.

- The implementation of a Clinical Design Authority with very senior members from all Trusts and the CCG will support the harmonisation and standardisation work. The appointment of Clinical Leadership is outside of the scope of the LIMS Project.

- The need to define test repertoires and test and panel compositions early, during the service design task.

  - The draft LIMS implementation plan includes a significant period of harmonisation work as a precursor to LIMS system design. This work is agnostic of supplier; and costs associated with commencing this work ahead of full FBC approval have been included, for approval, within this FBC. A separate recommendations paper outlining the specific up-front costs was presented to the Programme Board in April 2021. The paper recommended the approval of £200k business change enablement funding to begin this work ahead of full FBC approval but having been approved by the Programme Board. The decision of the Programme Board at their April 2021 meeting was to support this recommendation and plan on the basis that approval of the early funding will be provided and detail this within the FBC.

- The need to provide adequate project resources.

  - Costs for an appropriately sized project team are included within this FBC. The team composition and period of engagement have been discussed at workshops with subject matter experts and have been approved by the LIMS Project Steering Group.

- If agreed dates with suppliers slip for key on-site support and works, often the next available will be months away as their diaries to support other areas are planned in advance.

  - Detailed planning with CliniSys, the recommended LIMS supplier, will be undertaken and other key external partners such as Order Comms Systems suppliers and GP systems supplier will be engaged to support this work as required. Schedule 7.1 (*Charges and Invoicing*) contains a list of key milestones that CliniSys must achieve before stage payments will be released and also lists the daily penalty costs for any delays to these milestones caused by the supplier.

- GP systems need to be fully understood, databases cleansed and full engagement in place with primary care to work through the complexities of changing LIMS and the impact on referrers, especially in relation to any changes that affect the ability to review historic trends.

  - Data cleaning tasks and integration tasks including GP systems have been included within the draft LIMS implementation plan and costs to support this work have been included within this FBC. Data flow mapping will be undertaken as part of the early integration design work.

6.6 Arrangements for Change Management

The approach to Change Management will be fully detailed within two strategies: Change Management Strategy and the Configuration Management Strategy. The Change Management Strategy will be developed ahead of the implementation project commencement. The Configuration Management Strategy will be developed during the initiation stage of the Project in accordance with the PRINCE2 methodology.

In principle however, the approach to Change Management can be described as follows:

6.6.1 Harmonisation and Process Design

Reporting to the Project Director, the Business Change Manager will lead on all aspects of business change. A Change Management Plan will be developed in accordance with the requirements of the Change Management Strategy. The plan will detail the tasks associated with identifying all relevant operational processes undertaken at the three pathology services, identifying existing synergies and divergences and developing proposals for harmonised approaches. It is anticipated that processes will be aligned to the new single shared LIMS and not the other way around. This will ensure the maximum benefits available from the LIMS are realised.

Any formally approved clinical artefact, e.g. test catalogue, test and panel compositions, test methods etc must be subjected to a formal agreement and change control process. The Clinical Design Authority will be responsible for the change control processes and will advise and inform the Project Steering Group of decisions to be enacted.

6.6.2 Project Artefacts – Configuration Management

Any formally approved project product or artefact, e.g. project plan, Project Initiation Document etc. must be subjected to a formal change control process. The Project Steering Group will be responsible for the change control process for all project artifacts.

6.6.3 Systems Design – Configuration Management

Any formally approved systems artefact, e.g. design/configuration specification, interface specification etc. must also be subjected to a formal change control process. The Technical Design Authority will be responsible for the change control processes and will advise and inform the Project Steering Group of decisions to be enacted.

6.7 Arrangements for Benefits Realisation

The approach to Benefits Realisation Management will be fully detailed within a Benefits Management Strategy, which will be developed during the initiation stage of the Project in accordance with the PRINCE2 methodology.

In principle however, the approach to Benefits Realisation Management can be described as follows:

6.7.1 Benefits Identification

In the economic case of the document the recommended option (Option B) and do minimum options (Option A) were discussed and high-level benefits and risks of each were identified. Appendix E provides an overview of the benefits identified for these options. This followed various analyses of current arrangements and possible approaches and numerous discussions with senior stakeholders and subject matter experts at OBC stage. During this process, consideration was given to how non-cash-releasing benefits (NCRBs) could be quantified. The outcome of these discussions was that the effort required to quantify NCRBs in financial terms would cost more than any notional saving and as such it was agreed that, where possible, measurable benefits would be recorded without financial values.

Identified measurable benefits that specific to the preferred option, have been recorded and detailed in the Benefits Register, which builds on the outline information contained in Appendix E. The Benefits Register can be found at Appendix S and is summarised in table 55 below. The Benefits Register is used to associate each benefit with specific Pathology Programme objectives, establishes the means by which benefits will be measured, the owner of the benefit and any current baseline performance data. Once baseline data is known, improvement targets can be set and associated with the relevant benefit.

Table 55: Summary of the Benefits Register.

Benefit ID	Benefit Category	Benefit Description	Benefit Monitoring Process	Benefit Owner
LIMS-B001	CRB	Reduction in cost of LIMS support services	Budget reports	Pathology GMs
LIMS-B002	CRB	Reduction in LIMS supplier support & maintenance costs.	Budget reports	Pathology GMs
LIMS-B003	NCRB	Reduction in the number of passwords reset by Path IT staff thereby enabling time to work on other priorities.	Number of passwords reset by Path IT staff.	LIMS Systems Support Manager
LIMS-B004	NCRB	Harmonised processes, catalogues, methods across all pathology services to enable a standardised way of working using a single shared LIMS	completion of the harmonisation process	Business Change Manager
LIMS-B005	Q	Reduction in test turnaround times, measured by time taken from sample being taken to results available.	LIMS TAT reporting	Pathology GMs
LIMS-B006	Q	Improved use of NHS numbers - increase in the number of patient records with verified NHS numbers on LIMS	LIMS reports	LIMS System Support Manager
LIMS-B007	NCRB	Reduction in number or duplicate tests through the availability of results across all pathology services	LIMS reports	Pathology GMs

Benefits can be identified at any stage of a project and a significant number are often defined during the business change analyses, where current processes are investigated in detail. The benefits register will be updated as emergent benefits arise and will be monitored by the LIMS Project Steering Group, Programme Team and Programme Board.

6.7.2 Benefits Reporting

The Benefits Register details measurement points to evaluate progress against the target. As measurements are taken, reports will be submitted by the Benefit Owner to the relevant governance body. During the lifetime of the project, 'in-flight' benefits reporting will be to the Project Steering Group. Arrangements will be made as part of the project closure to ensure Benefits Realisation Management remains a key focus of the operational management team, post-project. It is best practice for benefits to be owned by an Operational Manager from the point of identification to ensure a true sense of ownership and embed the benefits management approach.

6.8 Arrangements for Risk Management

The approach to Risk Management will be fully detailed within a Risk Management Strategy, which will be developed during the initiation stage of the Project in accordance with the PRINCE2 methodology. Where applicable costs will be attributed to risks. Risks associated with the recommended and do minimum options are shown in Appendix H. Costs attributed to these risks are detailed within the CIA and have been used to calculate the contingency costs.

In principle however, the approach to Risk Management can be described as follows:

- The Project Director will retain overall responsibility for the identification, assessment and management of risks within the project.

- Risks are recorded in a project risk register and evaluated using agreed Likelihood (Probability) Vs Impact matrix to derive a risk priority number. The scale of the risk, determined by the risk priority number, will help determine the actions required regarding escalation. Aspects such as proximity (when will the risk most likely occur) and opportunities to manage the risk will be established. Appendix F is the current project Risk Register.

- All risks will be assigned to a relevant Risk Owner and one or more actions will be assigned to relevant Risk Actionees. The Risk Owner will be responsible for ensuring that mitigation actions are completed in accordance with the management plan.

- A management approach will be agreed for all risks; actions will form one of the following:

    - Transfer the risk. Sometimes thought of as risk sharing, this is usually to or with a third party who is better able or equipped to manage the risk. In many cases risks cannot be transferred and in others the cost of transferring a risk would far outweigh the potential cost of impact.

    - Tolerate the risk. This is effectively a do minimum / do nothing option, which accepts that the risk exists but that there is no realistic alternative plan that can be put in place. It will be managed as part of everyday project/programme management.

    - Terminate or eliminate the risk – this would be done by removing the risk from the project by, for example, deleting a non-essential activity.

    - Treat or manage the risk. Is this case an action plan is drawn up to ensure that a set of actions are put in place to ensure that the likelihood or impact of the risk is contained within an acceptable level.

6.9 Arrangements for Contracts Management

The Procurement Department of EKHUFT, as host Trust, will be responsible for the establishment and initiation of contract with CliniSys; however, as detailed in the commercial case, a 'back-to-back' agreement between EKHUFT and the other members of the Network to ensure that all Trusts are equally accountable under the terms of the contract with CliniSys.

Contract monitoring arrangements are defined in Part C (*Performance Monitoring*) of schedule 2.2 (*Performance Levels*) and in Schedule 8.1 (*Governance*). These schedules include aspects such as performance review meeting frequency and attendance requirements, and also the reporting requirements ahead of the performance review meetings.

During the implementation phase of the contract, it is expected and defined in schedule 8.1 (*Governance*) that the supplier will have a seat or seats on the LIMS Project Steering Group. The supplier and Trust representatives will also initiate a LIMS Design and Change Management Group. This group will provide oversight of the functional and technical design used in the LIMS and ensuring that functional and technical design choices are made to maximise the long-term value of the Supplier System. This group will assess the impact and, working in collaboration with the LIMS Project Steering Group, will approve or reject all Change Requests pertinent to the LIMS.

Following the full implementation of the LIMS, after the operational service commencement date, a Contract Management Group shall be established as defined in schedule 8.1 (*Governance*). The purpose of this group will be to provide oversight of the performance of the supplier and escalate any issues.

Changes to any contractual agreement will be managed via the EKHUFT Procurement Department in accordance with any pre-established contract change notification procedure defined in schedule 8.2 (*Change Control Procedure*).

6.10 Arrangements for Post Project Evaluation

During the closure stage of the project, arrangements will be made to transfer the system and all related artefacts such as the open risk register to the operational management team.

The project closure stage will be planned as per any other project stage; and such plans will include the approach to be taken to evaluate the performance of the project against the agreed critical success factors, the benefits realisation plan and the business case.

6.10.1 Project Implementation Review

Although the implementation project activity will cease soon after the final stabilisation period has ended, it is anticipated that the project will be formally closed approximately 3 months beyond this date to allow the collation of any monitoring data. At the formal project closure stage, the Project Implementation Review (PIR) will be undertaken. This will include the completion of a final lessons report, which will complete the compilation of all lessons identified throughout the life of the project so this can be shared as required within and across the organisations to benefit other projects.

6.10.2 Post-Evaluation Review

Prior to the formal project closure and by no later than the PIR, the first Post-Evaluation Review (PER) will be planned to take place within 6 to 12 months following the end of the project. This will provide an opportunity to review progress against any benefits realisation milestones that were projected forward, beyond the end of the implementation project. The operational management teams undertaking the PER will agree the frequency of any future meetings to review any benefits that may be realised beyond the initial 6 to 12-month period from the project's closure.

6.11 Gateway Risk Potential Assessment

A Gateway Risk Potential Assessment (RPA) was completed at Programme level. The RPA, which is shown in Appendix T, is used to assess the strategic risk potential of projects and programmes. The outcome of the assessment determined that the consequential risk was *very low*.

6.12 Equality and Health Inequalities Impact Assessment

A Quality Impact Assessment (QIA) has been completed at programme level and an Equality, Diversity and Inclusion Impact Assessment (EDIIA) has been completed at project level. These can be seen in Appendices U and V. The QIA considers risks across multiple domains, namely: Patient Safety, Clinical Effectiveness, Patient Experience, Staff Experience and Inequalities. The output of the QIA determined that there were no discernible negative impacts across these domains resulting from the Programme. The EHIA considers the impact of the programme on the ten protected characteristics outlined in the Equality Act 2010 and any other groups which may be impacted positively or negatively.

6.13 Contingency plans

In the event that this project fails, the following arrangements are in place for continued delivery of the required services and outputs:

- No legacy LIMS will be removed from live use until the cutover to new LIMS has successfully completed. Business continuity will be maintained.
- Immediately following the point at which the project is deemed to have failed and has been stopped, an urgent review of the reasons for failure will be ascertained. Depending on the cause and how far the project has progressed, appropriate actions will be taken. Action might include:
    - A review of the business case to establish if a viable project remains and, if so, what remedial action is required to bring the failed project back on track.
    - Decisions to change the project's scope and or approach.
    - The approval of additional funding if deemed appropriate.
    - The appointment of additional or replacement project management resources.
    - A further review of the original options to ascertain if anything has changed since the decision to proceed with the recommend option and suppler was made.

7 Appendices

The following appendices are included within this section:

- **Appendix A1-A2:** Letters of Support
  - Please refer to the separate pdf file entitled: Appendix A1_letter of support_CCG DRAFT
  - Please refer to the separate pdf file entitled: Appendix A2_letter of support_Trusts DRAFT
- **Appendix B:** Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts - Annex 1: Business case core checklist.
  - Please refer to the separate pdf file entitled: Appendix B_LIMS KM Pathology Investment Checklist.docx
- **Appendix C:** Population Growth Analysis
  - Please refer to the separate pdf file entitled: Appendix C_Population Growth Analysis.
- **Appendix D:** Procurement Outcome Report
  - Please refer to the separate zipped file entitled: Appendix D_Procurement Outcome Report.
- **Appendix E:** Benefits Overview – all options
  - Please refer to the separate pdf file entitled: Appendix E_Benefits Overview
- **Appendix F:** LIMS Project Risk Register
  - Please refer to the separate pdf file entitled: Appendix F_LIMS Project Risk Register
- **Appendix G:** Comprehensive Investment Appraisal (CIA)
  - Please refer to the separate Microsoft Excel file entitled: Appendix G_LIMS CIA
- **Appendix H:** Risks Associated with Options
  - Please refer to the separate pdf file entitled: Appendix H_Options Risks Overview
- **Appendix I:** Schedule 2.1 (Services Description)
  - Please refer to the separate pdf file entitled: Appendix I_Schedule 2.1 (Services Description)
- **Appendix J:** Schedule 2.2 (Services Description)
  - Please refer to the separate pdf file entitled: Appendix J_Schedule 2.2 (Performance Levels)

- **Appendix K:** Representative Implementation Plan
    - Please refer to the separate pdf file entitled: Appendix K_ Representative Implementation Plan
- **Appendix L:** Trust-based Implementation Team costs
    - Please refer to the separate pdf file entitled: Appendix L_Trust Based Implementation Team Costs
- **Appendix M:** NKPS Lessons Learnt Log
    - Please refer to the separate pdf file entitled: Appendix M_ NKPS Lessons Learnt
- **Appendix N:** LIMS Data Protection Risk Assessment (DPIA)
    - Please refer to the separate pdf file entitled: Appendix N_LIMS DPIA
- **Appendix O:** ToR Programme Board
    - Please refer to the separate pdf file entitled: Appendix O_ToR Programme Board
- **Appendix P:** ToR Programme Team
    - Please refer to the separate pdf file entitled: Appendix P_ToR Programme Team
- **Appendix Q:** ToR LIMS Project Steering Group
    - Please refer to the separate pdf file entitled: Appendix Q_ToR LIMS Project Steering Group
- **Appendix R:** LIMS Project Director CV
    - Please refer to the separate pdf file entitled: Appendix R_LIMS Project Director JD
- **Appendix S:** LIMS Project Benefits Register
    - Please refer to the separate pdf file entitled: Appendix S_LIMS Benefits Register
- **Appendix T:** Gateway Risk Potential Assessment (RPA)
    - Please refer to the separate pdf file entitled: Appendix T_LIMS Project Risk Potential Assessment Form
- **Appendix U:** Quality Impact Assessment
    - Please refer to the separate pdf file entitled: Appendix U_Pathology Programme QIA
- **Appendix V:** Equality, Diversity and Inclusion Impact Assessment (EDIIA)
    - Please refer to the separate pdf file entitled: Appendix V_Equality Diversity and Inclusion Impact Assessment
- **Appendix W: Qualitative Options Appraisal**

- Please refer to the separate Microsoft Excel file entitled: Appendix W_Options Appraisal

Kent and Medway Laboratory Management Information System (LIMS) Replacement

Full Business Case (FBC)

Key Take-aways

- The LIMS OBC detailed a total cost of £30.1m.
- The LIMS FBC details a total cost of £25.7 delivering a net reduction in estimated costs of £4.3m, over the life of the contract.
- Estimated savings have increased from £2.8m to £3.2m per annum after all projects within the Pathology Programme have been implemented.
- The SOC and the OBC that precedes this FBC have been approved by all Trust Boards, the CCG and NHSEI.

Objectives

- The **Programme's strategic objectives** were defined in the OBC as the investment objectives. These were retained for the FBC:
  - Delivery of a clinically and financially sustainable single pathology service* based on a viable service that is clinically led, standardised, innovative and creative.
  - Delivery of a high-quality diagnostic service* for the patients, hospital clinicians and general practitioners that meets their current and future needs.
  - Creating a workforce that feels they are valued, involved and own the single pathology service* as partners in the service.
  - Transforming the service models in pathology in Kent and Medway to deliver technological change to create a more responsive service with increased efficiency. Developing meaningful roles for our staff to maximise their potential and meet the needs of Trust's and commissioners.
  - Managing the transition to the single service* in a creative, competent manner

*The word 'Service' has been replaced with 'network' following a review of the objectives.

Drivers for Change

- The Pathology Network requires much-improved digital infrastructure and connectivity.
- During the pandemic pathology services performed despite the level of connectivity, not because of it.
- Demand for, and complexity of, pathology is increasing.
- The health environment is changing, move to implement Community Diagnostic Hubs (CDH's), Digital Pathology, Artificial Intelligence (AI) and a common GP Order Comms system.
- New standards are being introduced like FHIR (Fast Healthcare Interoperability Resources), SNOMED-CT, and automated alerts.
- Drive for efficiency requires processes to be leaner and work to be smarter, which will be achieved in part through standardisation.
- Age of the legacy LIMS (circa 25 years) and vendor support.
- Demand from NHSEI to develop effective Pathology Networks.
- The single shared LIMS is a key enabler of the NHS Long Term Plan.
- The single shared LIMS will be a key enabler of change.

Benefits Summary

Detailed information regarding the relevance of each benefit to the options can be found in appendix E of the LIMS FBC

Benefit Description	Measures	Do Minimum (Option A)	CliniSys (Option B)	Benefit Type
Increased cost efficiency	• Reduction in LIMS support & maintenance costs.	X	✓	CRB
Service Change	• Total pay budget per annum across all pathology IT support services	X	✓	CRB
	• Seamless processes deployed. • Harmonised workflows, catalogues, methods.	X	✓	NCRB
Increased operational Efficiency	• Improved TATs. • Reduction in duplicate testing. • Reduced inter-lab administration. • Local system maintenance tasks passed to supplier. • Reduced system password re-sets (self-service).	X	✓	NCRB
Increased clinical effectiveness	• Ability to see all results. • Less time required by clinicians and healthcare professions chasing results. • Reduction in clinical incidents / increased patient safety and clinical quality. • Improved decision support. • Reduction in clinical admin time. • Improved ward efficiency. • Increased number of patient records with NHS Numbers on LIMS. • Removal of paper results.	X	✓	NCRB

Source: Table 29, Economic Case, LIMS FBC

Evolution from OBC to FBC

Description	Total OBC Cost (£'000)	Total FBC Cost (£'000)	Variance (£'000) (+ is Cost Increase)		Notes Ref
Trust Implementation team costs	3,622	4,398	776		1
Pay	3,386	3,976	590		2
Non pay	6,536	4,680	(1,856)		3
Supplier costs	16,533	11,862	(4,671)		4
Depreciation and capital charges	0	811	811		5
TOTAL	**30,077**	**25,728**	**(4,349)**		

1. Mainly extended time line for 3 'go lives' and Pathology IT resource – OBC assumed no need for back fill.
2. Mainly the increased baseline for NKPS & longer implementation timeline.
3. Capital LIMS data archive solution cheaper and reduced sunk costs
4. Final procured price including supplier implementation costs
5. Central funding for the Trust Integration Engine (TIE), which will be the core element to enable connectivity across Trusts' systems to maximise data access and accuracy and also the LIMS data archive solution capital provided 2020/21.

Meeting the Milestones

- The draft implementation plan included in the FBC is based on feedback from bidders received during the LIMS tender and reduces the risk of slippage by moving from 2 go-lives (OBC) to 3, with stabilisation periods of around 6-7 months between each.
- The draft planned go-lives are: Sept 2023, May 2024, Nov 2024.
- The resource plan to deliver the project was developed with Pathology and IT SMEs.
- Appointment to the role of LIMS Project Director made (subject to references etc.)
- Business change work starts ahead of contract award in December and recruitment is due to commence Q2 2021/22.
- The risk of slippage due to the need for pathology resources has been captured and mitigations are being developed.
- The PMO will work with CliniSys ahead of contract award to map-out the timeline in detail and the final plan will be contractually baselined within 40 working days of contract award.
- Milestones payments to CliniSys are matched by delay payment penalties of around £2k-£3k per day.

Impact of Pathology Programme

- The following shows the impact of each project in the programme to the Pathology Network, in comparison to the OBC.
- LIMS investment has reduced from £17.8m to £13m which is a saving of £4.8m. This is as a result of the £4.3m reduced cost and £0.5m baseline now 2019/20.
- Total savings from the programme have increased from £16.4m to £19.7m

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14 Q3 only	Total
	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
LIMS Investment at OBC	1,736	1,699	1,986	2,321	1,158	1,159	1,159	1,159	1,156	1,156	1,145	1,145	859	-	-	17,838
LIMS investment at FBC	**0**	**964**	**2,154**	**2,837**	**2,077**	**478**	**477**	**474**	**475**	**475**	**472**	**433**	**430**	**395**	**359**	**12,992**
Movement to FBC	(1,736)	(735)	168	356	1,252	(646)	(647)	(650)	(646)	(647)	(638)	(677)	(394)	430	364	(4,846)
Programme Projects at LIMS FBC																
COST: Net cost PMO	200	258	45	(65)	(197)	(289)	(289)	(289)	(289)	(289)	(289)	(289)	(289)	(289)	(169)	(2,529)
SAVING: 'send away'/referred tests	0	(58)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(115)	(67)	(1,505)
SAVING Transformation Change - LOW	0	0	0	0	0	0	0	0	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(807)	(9,111)
SAVING: MES project	(317)	(596)	(596)	(596)	(690)	(1,006)	(1,440)	(1,871)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(1,917)	(958)	(19,570)
Total Programme costs/ (savings) at LIMS FBC	(117)	(395)	(667)	(776)	(1,002)	(1,410)	(1,844)	(2,275)	(3,705)	(3,705)	(3,705)	(3,705)	(3,705)	(3,705)	(2,001)	(32,715)
Impact of Programme at LIMS FBC	**(117)**	**569**	**1,487**	**1,900**	**1,408**	**(897)**	**(1,332)**	**(1,766)**	**(3,195)**	**(3,195)**	**(3,197)**	**(3,237)**	**(3,239)**	**(3,274)**	**(1,637)**	**(19,722)**
Impact of Programme at LIMS OBC	**1,229**	**812**	**910**	**1,186**	**(287)**	**(636)**	**(1,895)**	**(3,060)**	**(3,063)**	**(3,063)**	**(3,074)**	**(3,074)**	**(2,378)**	**0**	**0**	**(16,393)**

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve the Trust's Quality Accounts, 2020/21 **Chief Nurse**

Please find enclosed the Trust's Quality Accounts for 2020/21. The Trust's response to the Covid-19 pandemic and how this has affected the quality governance agenda is a theme throughout the Quality Accounts, where relevant. A number of the Quality Priorities set last year have not been delivered due to the pandemic and have since evolved and carried over to this year; in some cases with amendments.

The Quality Accounts in draft were submitted, reviewed and agreed at the 'Main' Quality Committee meeting on the 12th May 2021. Following amendments the Quality Accounts were circulated to the Trust's main external stakeholders at the end of May. Responses from the stakeholders are included in this final version, which is being submitted to Board for review and approval.

The deadline for publication of Quality Accounts on the NHS website is 30th June 2021.

Which Committees have reviewed the information prior to Board submission?
- 'Main' Quality Committee, 12/05/21

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

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Quality accounts

2020-2021

Part **one**

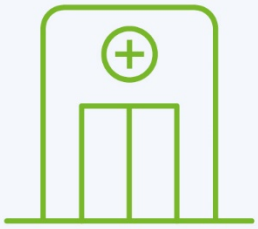
Our year on a page

108

different nationalities are represented in our diverse staff

520,000

outpatient attendances – **40%+ delivered virtually**



10

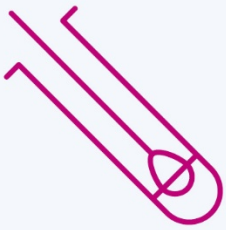
Our emergency departments are consistently in the **top 10 performing Trusts**

18,314

operations carried out

5547

babies born



165,290

lab processed PCR **Covid-19 swabs**

3,580

participants recruited to **76 research projects**

3

All three national **cancer performance targets met**

30,300+

Covid-19 **vaccinations administered**

Contents

Quality Accounts - Introduction

Maidstone and Tunbridge Wells NHS Trust aims to be a caring, sustainable and improvement-driven organisation. These aims encompass the Trust's three core quality objectives to create a safety-focused culture, to continuously improve patient and staff experience with clinically effective services and to learn lessons from our care delivery within a just culture. Providing safe, high quality health services to ensure the best overall experience for our patients, staff and public is at the heart of everything we do at the Trust.

A requirement of the Health Act 2009 is for all NHS healthcare providers in England to produce an annual report that includes a review of the standard and quality of services from the last financial year and sets out the quality priorities for the coming year.

The Quality Accounts focus on the quality of the Trust's services so that the public, patients and anyone with an interest in healthcare will be able to understand the following:

- Where the Trust is doing well
- Where improvements in service quality are needed and how these have been prioritised
- How the Trust Board has reviewed our improvement in the quality of care during the year and what we have prioritised for 2021/22.

'High Quality Care for All' (2008) stated that quality within the context of the NHS should include three aspects. These are:

- Patient Safety – we do no harm to patients and ensure all steps are taken to reduce avoidable harm and risks to individuals.
- Patient Experience – seeking, analysing and understanding patient feedback to assess the compassion, dignity and respect with which patients are treated.
- Clinical Effectiveness – understanding the success rates from different treatments and conditions via a range of measures of clinical improvement including the views of patients.

The three elements of quality within the NHS are used as a framework for this report.

Department of Health. (2008*) High Quality Care for All. NHS Next Stage Review Final Report. Available at:*

https://assets.publishing.service.gov.uk › uploads › file
PDF

About Us

Maidstone and Tunbridge Wells NHS Trust (MTW) is a large acute hospital Trust in the South East of England. We provide a full range of general hospital services and some aspects of specialist complex care to around 590,000 people living in the south of West Kent and the north of East Sussex. The Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital and provides a large number of single-bedded en suite accommodation. We provide specialist cancer services to around 1.8 million people across Kent and East Sussex via the Kent Oncology Centre, which is sited at Maidstone Hospital. We also provide outpatient clinics across a wide range of locations in Kent and East Sussex. We have a team of nearly 6,000 full and part-time staff.

The Tunbridge Wells Hospital at Pembury is the first NHS hospital in England to provide en suite, single rooms for all inpatients; most of which have woodland views. The hospital provides a range of complex and routine surgical and medical services. It has a Trauma Centre, an Emergency Department, Orthopaedic Centre and Women and Children's Centre; all of which provide care for patients from across Maidstone and Tunbridge Wells. The hospital is seen, nationally, as an example of best practice in the design of patient-safe facilities and has attracted widespread international interest.

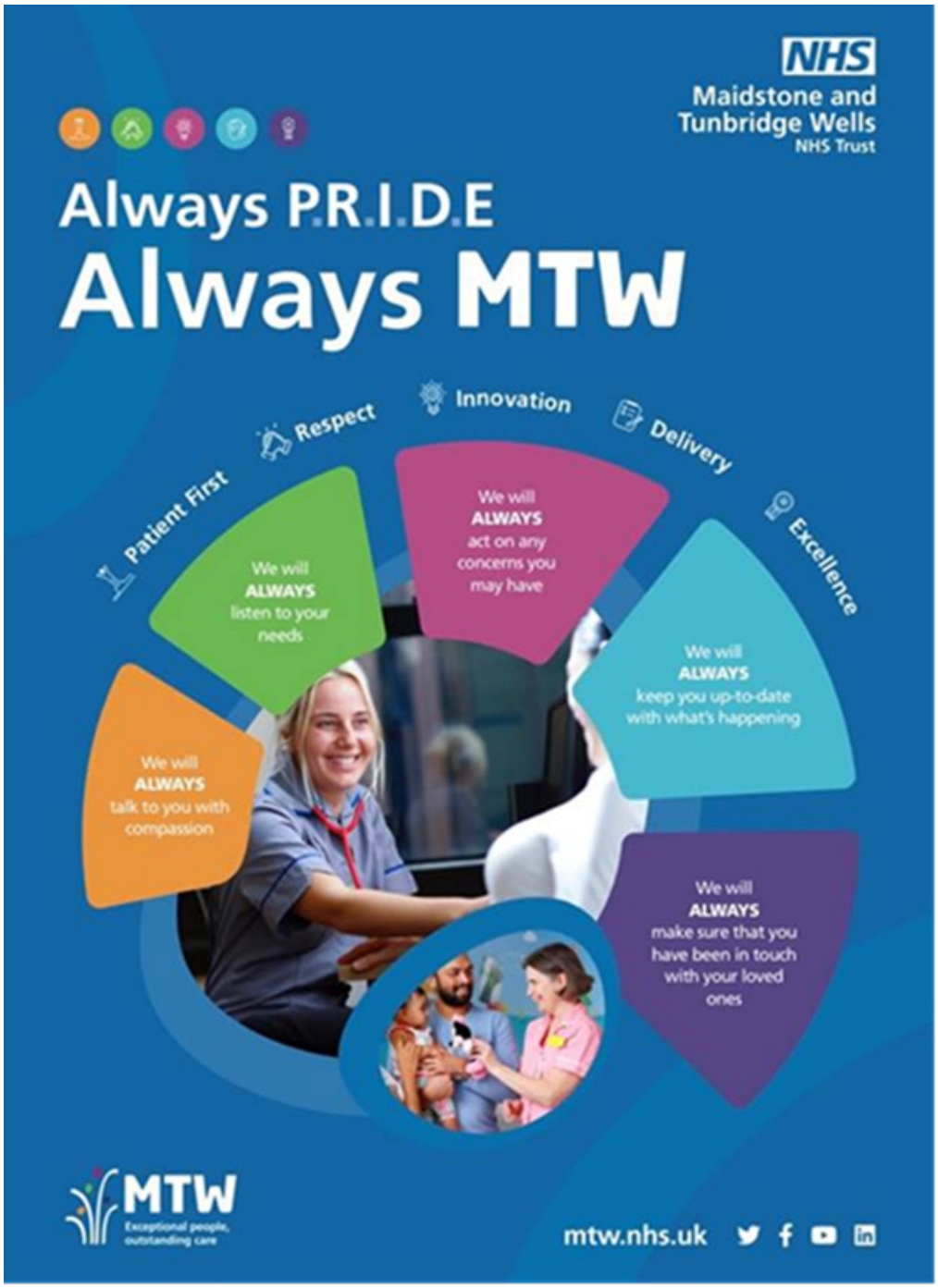
Maidstone Hospital provides a wide range of complex and routine surgical and medical services. It also has the latest in diagnostic facilities. Maidstone Hospital is the base for the Kent Oncology Centre, which provides complex radiotherapy and chemotherapy for patients throughout Kent and North East Sussex.

Our Mission, Vision and Objectives

The Trust's mission is:
To be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community.

The vision of the Trust is:
Outstanding hospital services delivered by exceptional people – 'Exceptional People, Outstanding Care'.

The objectives of the Trust are:
- To be recognised as a caring organisation
- To provide sustainable services
- To be improvement-driven across all areas



Working with Others

Maidstone and Tunbridge Wells is part of the Kent-wide Integrated Care System (ICS). The ICS brings health and social care together across Kent, so that we are providing the best possible care for our population in the most appropriate place. This will mean working more closely than ever with our colleagues from the county, district and borough councils to ensure that we are working holistically across Kent.

There are four Integrated Care Partnerships (ICPs) in the Kent-wide ICS; MTW is within the West Kent ICP. We are working towards a model of integrated care based on population health needs and holistic, individual personal care. This model will cover both planned and unplanned care for physical and mental illness via integrated pathways across primary, secondary and social care. The emphasis will be on prevention and care in the community.

Chief Executive's Statement

On behalf of the Trust Board and staff working at Maidstone and Tunbridge Wells NHS Trust welcome to our Quality Accounts for 2020/21.

The Quality Accounts give us an opportunity to reflect on our achievements, share our performance and learning, and look forward to the next year.

MTW is a family of exceptional people providing outstanding care and I hope that as you read this account it is clear that our patients are at the heart of everything our staff do.

Their dedication has led to some significant achievements but the Covid-19 pandemic has had a major impact on our services, led to different and innovative ways of working and changes to patient pathways. This has also meant we were unable to deliver all our quality priorities for 2020-21 and a number of these are included in our priorities for 2021-22.

Quality improvement continues to drive our work and despite all the challenges of the last year there were a number of key achievements. The Trust tripled intensive care capacity, has continued to deliver the 62 days cancer access standard and is consistently one of the top performing Trusts in the country for Emergency Department performance.

Our ambitious reset and recovery programme continues at pace and significant progress has been made on reducing the number of our patients who have been waiting for treatment , increasing theatre and outpatient activity, and maximising new technology to support patient and staff safety and improve flow around our hospitals.

Staff welfare has been a priority over the last 12 months and the annual staff survey, carried out in the middle of the pandemic, showed increased staff engagement rates. The successful 'One Team Runners' and 'Tele-tracking' schemes were introduced and additional support for staff was provided by a host of initiatives, the 'Wobble Rooms' and Project Wingman being two examples of these.

Over the next year we are implementing an ambitious Exceptional Leaders training programme and rolling out Strategy Deployment and Divisional Objective Setting. This will enable our staff to build and own the goals of the organisation, making quality improvement everyone's business, with the continual aim of delivering outstanding care to our patients.

We continue to work within our Integrated Care System (ICS) on the formation of a system quality group to engage and share intelligence on quality across the ICS and developing an agreed way to measure quality, using key quality indicators.

As we continue to safely restore our services and care for our patients and staff, our goal is to take MTW to Outstanding. We know we have more work to do but with the hard work and dedication of our teams I am confident we will achieve this.

We welcome your feedback and will use it to shape our quality improvements over the next year. So please do share your thoughts and tell us how we are doing and what we can do better.

Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions you can contact us in the following ways:

Follow us on
Twitter: www.twitter.com/mtwnhs
Instagram:
LinkedIn
Facebook: www.facebook.com/mymtwhealthcare

Miles Scott
Chief Executive

Part **two**

Quality Improvement Priorities for 2021/22

This section of the report will outline the quality improvement priorities we have identified for 2021/22 to further develop the quality of our services.

	SUMMARY		
	PATIENT SAFETY	**PATIENT EXPERIENCE**	**CLINICAL EFFECTIVENESS**
AIM	**To sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.**	**To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.**	**To improve the management of our patient journeys through the utilisation of evidence-based practice.**
2021/22 Quality Priorities	Embedding a safety culture within the Trust through ongoing implementation of the National Patient Safety Strategy. Continue to develop a downward trend in avoidable healthcare associated infections. Increased focus on reducing the number of hospital-acquired deep tissue injuries (DTI) and Category 2 pressure ulcers. Focus on reducing the number of inpatient falls resulting in harm. Improve the outcomes of our expectant parents and their babies. Improve the recognition and escalation of the deteriorating patient with specific focus on NEWS2, sepsis and diabetes.	Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'. The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process. Sustain improvement in the timely completion of Duty of Candour* notifications as part of a wider commitment to improve patients' and their carers' experience of adverse incidents and complaints. Embedding safeguarding practices in all aspects of clinical care. Implementation of the Dementia Strategy 2021-2024. Implementation of the Delirium agenda. Improving communications with community pharmacies to improve access to medicines for patients. Improve the experience of our expectant parents and their babies.	Improving the flow of patients into and out of our wards and departments.

**The Duty of Candour is a statutory duty to be open and honest with patients or their families when something goes wrong that appears to have caused or could lead to significant harm in the future.*

Patient Safety

Maidstone and Tunbridge Wells NHS Trust are committed to providing safe, good quality and effective care. Our patients need to feel at ease to tell us about their experiences and if the care they receive falls short of their expectations. MTW staff need to feel empowered to raise concerns and report incidents. By providing our colleagues and patients with a compassionate and inclusive patient safety service we can encourage open and honest reporting.

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. We support our staff to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm.

In July 2019 NHS England and NHS Improvement published 'The NHS Patient Safety Strategy, Safer culture, safer systems, safer patients', which outlined several proposals relevant to the Trust. How these are embedded and sustained, in addition to continuous improvement in patient safety culture, is instrumental to the ongoing development in the quality of care we provide. The delivery of the Culture and Leadership programme, Exceptional People, Outstanding Care is therefore an essential component in making this happen.

Aim/goal

To sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.

Areas for focus and improvement during 2021/22 **Key objectives will include: -**	
1) Embedding a safety culture within the Trust through ongoing implementation of the National Patient Safety Strategy.	
a) Further improve the quality and timeliness of incident investigations to support the learning lessons agenda.	Increase in achievement of 60-day key performance indicator (KPI) in 2021/22 based on 2020/21 compliance figures
	Decrease in numbers of incidents breaching 45-day closure timeline, based on 2020/21 numbers
b) Development of performance dashboards and reports that provide meaningful data to support departments and divisions.	Every ward to have a performance dashboard in place on Datix (the Trust's incident reporting system)
	Development of actions module (to monitor compliance with open actions from investigations) on Datix to drive performance and timely learning
c) Supporting all staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety.	Develop virtual root cause analysis (RCA) training
	Design a qualitative process to evaluate staff experience of incident reporting and being involved in the Serious Incident process

2) Continue to develop a downward trend in avoidable healthcare associated infections, in particular.	
a) To continue excellent practice in infection prevention and control (IPC) measures during the remobilisation of services as we move out of the COVID-19 pandemic.	Flexible and responsive systems in place for infection prevention and control of COVID-19 in line with national guidance
	Performance against the national IPC board assurance framework is reviewed with evidence made available to the Trust Board
	Compliance of self-assessment with the Code of Practice of the Health and Social Care Act 2015 (the Hygiene Code) to be monitored through the Infection Prevention and Control Committee with periodic reports to Trust Board
b) Gram negative bloodstream infections.	To achieve a year on year reduction of gram negative bacteraemia (whilst acknowledging national 5 year target of 50% reduction across the healthcare system by 2024/25)
3) Increased focus on reducing the number of hospital-acquired deep tissue injuries (DTI) and Category 2 pressure ulcers.	
10% decrease in number of hospital-acquired avoidable DTIs and Category 2 pressure ulcers by year end, based on 2020/21 numbers.	
4) Focus on reducing the number of inpatient falls resulting in harm.	
5% reduction in number of falls resulting in harm (moderate, serious and death) compared with 2020/21 figures.	
5) Improve the outcomes of our expectant parents and their babies through:	
a) Delivery of the ten key elements of the maternity transformation plan, with specific focus on the Continuity of Carer's directive.	Continue to implement and embed the maternity transformation plan.
b) Aim to make measurable improvements in safety outcomes for women, their new-borns and families in maternity and neonatal services, as set out in Better Births, the Ockenden report and the Transforming Perinatal Safety publication.	Aim to reduce the rate of stillbirths, maternal and neonatal deaths and neonatal brain injuries occurring during or soon after birth by 50% by 2025 through benchmarking against Saving Lives Care Bundle v2, ATAIN and Maternal and Neonatal Safety Collaborative (MatNeo).
	To achieve the 'halve it' ambition we need to improve care for the populations more at risk of poor outcomes and safety champions can help drive this.
	Effective use of Perinatal Mortality Review Tool (PMRT) process in all eligible cases.
6) Improve the recognition and escalation of the deteriorating patient with specific focus on:	
a) The correct use of NEWS2 and escalation algorithm.	To achieve 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+ having a NEWS 2 score, time of escalation and time of clinical response recorded. 90% of data recorded meeting Trust policy for escalation and clinical response timeframes.

b) Sepsis.	Undertake quarterly audit of 50 sets of notes to assess screening for and treatment of sepsis
	Report findings on a quarterly basis to the Sepsis Committee
	Committee to propose required actions as a result of audit findings
c) Diabetes.	Undertake an audit of Blood Glucose Monitoring and Hypoglycaemia guideline to assess use of blood glucose monitoring form and algorithm
	Complete the implementation of blood glucose monitoring connectivity meters and associated staff training
	Assessment of training levels for clinical staff in relation to diabetes and E-learning for Safer Use of Insulin
	Continue quarterly audits of prescription charts focusing on insulin prescribing and administration with identification of learning and action plans

Executive Lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation Lead: Aoife Cavanagh, Deputy Director Quality Governance
Monitoring: Quality Committee

Patient Experience

Engaging with our patients and service users to gain feedback on their experiences and ensuring the patient's voice is heard when planning improvements and re-design to our services is central to the Trust's plans for becoming outstanding in delivery of care.

The quality priorities listed below are the areas we consider will result in maximum improvements to patient experience during 2021/22.

Aim/goal

To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.

Areas for focus and improvement during 2021/22 **Key objectives will include: -**
1) **Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'**
a) Make the Patient Experience Lead role a substantive post to lead on the strategy.
b) Review the Patient Engagement and Experience Strategy in light of learning from the pandemic and amend if indicated.
c) Monitor implementation and delivery of the strategy quarterly at the Patient Experience Committee (PEC).

d) Design a qualitative process to evaluate patients' and families' experience of our Serious Incident Process.	
e) Re-design and re-launch the complaints satisfaction survey to enable improved understanding of the experience of making a complaint and assess effectiveness in meeting the needs of complainants.	
2) **The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process**	
a) Continue to undertake the Trust bereavement survey and maintain consistently good results.	
b) Improvement in the national End of Life Care survey results, based on most recent results.	
c) Improvement in completion of individualised care plans for End of Life based on last audit results.	
d) Implementation of the AMBER Care Bundle across adult wards to improve communication (among clinicians, patients and their families) where recovery is uncertain and facilitate advance care planning and increased use of the treatment escalation plan (TEP), (audited as part of ICP audit and national EoLC audit).	
3) **Sustain improvement in the timely completion of Duty of Candour notifications as part of a wider commitment to improve patients and their carers' experience of adverse incidents and complaints**	
a) Refine reporting to capture all three elements of Duty of Candour – verbal notification, written notification and sharing the findings of the investigation.	
b) Improved compliance, based on 2020/21 figures.	
c) Develop Duty of Candour dashboard on Datix.	
4) **Embedding safeguarding practices in all aspects of clinical care**	
a) Embed use of the tool developed last year to enable practitioners to ensure that mental capacity assessments are documented appropriately.	Audit use of the tool at a minimum annually
	Report uptake of redesigned MCA level 2 and 3 training to the Safeguarding Committee on a quarterly basis
b) Demonstrate the involvement of the patient and their representatives in decision making in relation to safeguarding.	Annual re-audit to be undertaken assessing involvement of the patient and their representatives
	Results to be shared with relevant wards and any necessary actions put in place
	Audit results, learning and action plans to be presented at the Safeguarding Committee
c) Ensure that all Deprivation of Liberty Safeguard applications are supported by a documented assessment of capacity.	Audit to be undertaken assessing involvement of the patient and their representatives
	Results to be shared with relevant wards and any necessary actions put in place
	Audit results, learning and action plans to be presented at the Safeguarding Committee

5) **Implementation of the Dementia Strategy 2021-2024**	
a) Monitor ward moves for people with dementia to ensure appropriate admission to the most appropriate bed first time where possible.	Monitor via dashboard and results to be reviewed at Dementia Strategy Group and actions identified
b) Develop Patient Partners for people with dementia in collaboration with the Patient Experience Lead, to enable the ability to receive feedback directly from people with dementia.	Patient Partners for people with dementia to be developed and feedback reviewed
c) Develop a proposal / business case for a multi-disciplinary peripatetic team to provide an activity programme for people with dementia.	Proposal / business case to be developed in collaboration with multi-disciplinary team
6) **Implementation of the Delirium agenda**	
a) Recruit a Delirium Nurse Facilitator for 1-year pilot.	Monitor business case KPIs once post holder recruited and report to Dementia Strategy Group
7) **Improving communication with community pharmacies to improve access to medicines for patients.**	
a) Introduce remote dispensing of outpatient prescriptions.	
8) **Improve the experience of our expectant parents and their babies**	
a) The Patient Experience Midwife and Maternity Voices Partnership (MVP) working together to co-produce local maternity services.	
b) Employing the use of patient advocates where appropriate.	

Executive Lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation Lead: Judy Durrant and Gemma Craig, Deputy Chief Nurses, Aoife Cavanagh, Deputy Director Quality Governance
Monitoring: Patient Experience Committee

Clinical Effectiveness

Efficient and effective clinical care drives improvements in both quality and performance. Ensuring our patient pathways throughout the organisation flow as effectively as possible is critical to the delivery of quality services; ensuring patients are cared for in the right environment, by the right staff at the right time. This needs to be applied from initial contact with our organisation through to discharge and beyond.

The quality priorities listed below are the areas we consider will have the greatest impact on delivery of quality patient care during 2021/22.

Aim/goal

To improve the management of our patient journeys through the utilisation of evidence-based practice.

Areas for focus and improvement during 2021/22 **Key objectives will include: -**	
1) Improving the flow of patients into and out of our wards and departments by: -	
a) Increasing the effectiveness of ambulance handovers.	Ambulance handover targets Over 60 mins = 0 Over 30 mins = 3% Over 15 mins = 25% by end Sept (phased approach to decrease by 5% each month from 45% in May)
b) Early assessment of patients attending the Emergency Department	(*To be determined as local targets for the national ED standards have not yet been set*)
c) Improving the timeliness of discharge of patients from Intensive Care (ICU).	Improve performance with regard to ward-based discharge (within 4 hours), based on 2020/21 numbers
	Decrease number of night-time discharges from the Intensive Care Unit (10pm-7am), based on 2020/21 numbers
d) Ensuring all necessary support is in place to allow patients to leave hospital when it is planned for them to do so.	Improved communication with patients and families, measured by a reduction in complaints and PALS contacts
	Improve processes for discharge medications by the use of computers on wheels (COWs) and Omnicell (automated pharmacy management system) to expedite ward based dispensing
e) Increasing the number of video clinics (currently using the Attend Anywhere platform).	10% of all outpatient activity to be carried out as video appointments
f) Ensure there is sufficient MRI capacity to cater for rapid diagnostics for our emergency, cancer and elective patients.	Develop and progress a fully managed MRI Service in line with the broader Trust needs linking in with external partners Ensuring high quality service provision and reporting in a timely manner

g) Work to consolidate a high quality, timely and effective therapies service supporting both inpatient and outpatient activity.	Review and consider the changing needs of the Trust patient-base and expectations in terms of delivery of service Ensure all patients are seen within required timeframe and receive high quality and consistent support
2) Working towards the development of site-specific centres of excellence for Digestive Diseases and Stroke; concentrating on new and improved ways of working, which will support best practice and the opportunities for new roles.	
a) Work to review the best practice diagnostic pathway for colorectal cancer patients in line with broader directional change.	Work with surgery and cancer teams to ensure robust diagnostic radiological pathway for cancer pathway patients in line with national changes to avoid unnecessary delays
b) Development of a Digestives Diseases Unit on the TWH site.	
c) Development of stroke services in preparation for the Hyper-Acute Stroke Unit (HASU) focusing specifically on the provision of stroke rehabilitation.	

Executive Lead: Sean Briggs, Chief Operating Officer
Board Sponsor: Sean Briggs, Chief Operating Officer
Implementation Lead: Lynn Gray, Deputy Chief Operating Officer
Monitoring: Quality Committee

We will monitor our progress against these objectives through our Divisional and Trust-level governance structures. This report and assurance of our progress against it will be presented regularly throughout 2021/22 at Quality Committee and Trust Management Executive (TME).

In the following section we report on statements relating to the quality of the NHS services provided as stipulated in the regulations.

The content is common to all providers so that the accounts can be comparable between organisations and provides assurance that the Maidstone and Tunbridge Wells NHS Trust Board has reviewed and engaged in national initiatives, which link strongly to quality improvement.

Statements relating to the quality of NHS services provided as required within the regulations

The Trust is registered with the Care Quality Commission (CQC) to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre).
- Surgical procedures (at both hospital sites).
- Termination of pregnancies (at Tunbridge Wells Hospital only).
- Treatment of disease, disorder or injury (at both hospital sites).

No conditions or enforcement actions were applied to the registration during 2020/21.

The Nominated Individual for the Trust's Registration is Claire O'Brien, Chief Nurse.

During 2020/21 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County Council and NHS England. The Trust has subcontracted services to the Independent Sector Providers as part of the Prime Provider Model for elective care and in response to the COVID-19 pandemic for emergency admissions. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed for quality purposes in 2020/21 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing Standards

To ensure that we are consistently providing services to the required standards the Trust usually supports a number of external reviews of its services. The COVID-19 pandemic has changed the way in which certain external visits are undertaken, with an increase in those carried out remotely or virtually. The following reviews took place in 2020-21:

- 2019/20 Annual Finance External Audit; Grant Thornton – completed May 2020
- Virtual engagement event with the CQC – 10th June 2020
- General Medical Council – Trainee and Trainer Survey – July 2020

- Counter Terrorism Security Advisers inspection on management of radiation safety - September 2020
- Environment Agency inspection on management of radiation safety – September 2020
- United Kingdom Accreditation Service (UKAS) accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – remote visit September 2020
- Virtual engagement event with the CQC – 9th September 2020
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – remote visit November 2020
- Virtual engagement event with the CQC – 2nd November 2020
- Virtual engagement event with the CQC – 21st December 2020
- HM Revenue and Customs – VAT compliance review of contracted out services – concluded January 2021
- Caspe Healthcare Knowledge Systems (CHKS) (ISO 9001, CQC, Peer Review, TSR and Francis Rec.) Radiotherapy, Medical Physics (including E.M.E. Services), Chemotherapy, Clinical Trials, Oncology Outpatients, Clinical Haematology, admin and clerical – February 2021
- Environmental Health, Maidstone Hospital kitchen – February 2021 (the review of the Tunbridge Wells Hospital kitchen is due in August 2021)
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – a visit was due in November 2020 but has been postponed to May 2021
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) - Blood Sciences – a visit was due in January 2021 but has been postponed to July 2021

In addition our internal auditors, TIAA, undertook a range of audits to review the internal control environment at the Trust. TIAA undertook 14 assurance reviews, 10 of which provided reasonable assurance and 4 provided limited assurance. There were no reviews with substantial assurance or no assurance. TIAA made 88 recommendations following the reviews – 11 urgent, 39 important and 38 routine.

Internally we have a range of reviews to assess the quality of service provision within MTW. However, the impact of the COVID-19 pandemic meant these reviews had to either be suspended or adapted:

- Internal assurance inspections (based on the CQC methodology) with participation from our patient representatives and Quality Leads from West Kent and Sussex Alliance CCG's – these inspections were suspended due to the pandemic and the need to reduce footfall in our clinical areas.
- Internal PLACE (Patient-Led Assessments of the Care Environment) reviews – these reviews were also suspended due to the pandemic and the need to reduce footfalls in our clinical areas.

- Infection control reviews, including hand hygiene audits – these reviews were partially undertaken. The Infection Prevention and Control team also undertook regular observations of practice in clinical areas and provided support to clinical teams in terms of feedback and advice.
- Trust Board member "walkabouts" – these were suspended due to the pandemic and the need to reduce footfall in clinical areas.
- Matron's Quality Checks – these continued where possible but were briefly stood down in the critical phase of the second COVID-19 wave.

Usually the outcomes of these assessments are included within our triangulation process to review clinical areas and identify any areas where additional support and actions are required to maintain standards. Action plans are developed locally and, alongside the associated reports are scrutinised in the Quality Improvement Committee, within our governance structure and monitored accordingly.

During 2020/21 the results of the Matron Quality Checks and other intelligence from sources such as management teams, PALS and patient safety incidents were used to identify any areas where additional support and actions were required in clinical areas during the pandemic. A 'Heat Map' was also developed during the year to assist in identifying areas requiring support or intervention in the absence of the other reviews and inspections. The 'Heat Map' displays in one spreadsheet data from a range of sources for all inpatient clinical areas. The data is grouped under four themes – patient safety, infection control, patient experience and staff management. Some but not all of the elements of the 'Heat Map' are colour coded (RAG – red, amber, green) and the colours have scores, which lead to an overall score for each clinical area.

Clinical areas were visited throughout the pandemic by members of the Corporate Nursing and Quality Governance teams to provide support, listen to staff and patients and to identify where any further actions were indicated.

Clinical Audit

This section of the Quality Accounts provides information about the Trust's participation in clinical audit. Identified aspects of care are evaluated against specific criteria to ascertain compliance and quality. Where indicated, changes are implemented and further monitoring is used to confirm improvement in healthcare delivery. Participation in national clinical audits, national confidential enquires and local clinical audit is mandated and provides an opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

COVID-19 has had a major impact on the Trust's 2020/21 Clinical Audit Programme. Whilst participation in data submission to National Audits has not been mandated during 2020/21, local clinical audits have also been scaled down to allow our clinical colleagues to focus on front line clinical care.

In spite of COVID-19, MTW still participated in **100%** of relevant confidential enquiries and **82%** (45/55) of all relevant national clinical audits in 2020/21 (data for 2 audits was not submitted due to software issues; data for another audit was not submitted following a Directorate decision; data for 7 audits was not submitted due to COVID-19). During the same period, MTW staff successfully completed **114** clinical audits of the **144** due to be completed (local and national) to action plan stage of the **334** audits on the programme to be undertaken during the year. The

remaining audits are at various stages of completeness and will be monitored through to completion.

In response to COVID-19, Clinical Audit registered and supported 12 clinical audits that addressed both COVID-19 care pathways as well as the impact of COVID-19 on the standard of care of patients with other conditions. These were a mixture of local, national and international studies.

We also registered and supported 23 COVID-19 service evaluations that looked at a wide range of topics connected to COVID-19. Although local studies dominated, the Trust also participated in several national and international service evaluations.

Many of these national and international studies are now publishing their findings and some local study reports have also been received. Taking part in these important studies on COVID-19 will help the Trust to learn from the pandemic and plan for the future.

Some of the national and local clinical audits and COVID-19 studies that Maidstone and Tunbridge Wells NHS Trust worked on during 2020/21 to improve the quality of patient care are outlined below:-

Theatres and Critical Care: National Emergency Laparotomy Audit (NELA)

The Maidstone and Tunbridge Wells NHS Trust Emergency Laparotomy Team continues to deliver excellent care. The team assesses all patients' risk of death and morbidity prior to sending the patient into theatre, with Consultant Surgeon and Consultant Anaesthetist presence and almost all patients go to our Intensive Care Unit postoperatively. Our mortality (9.7%) and length of stay (12 days) figures are in line with our Academic Health Services Network and national results. The NELA Team continues to work on maintaining their high level of compliance with national standards.

Children's Services: The National Paediatric Diabetes Audit (NPDA) report received in March 2020 showed that Tunbridge Wells Hospital was an outlier for the adjusted mean HbA1c. "HbA1c is a marker of overall diabetes blood glucose levels over the preceding six to eight weeks and is associated with lifetime risk of microvascular complications... good diabetes management in childhood tracks into adulthood with a lower risk of developing vascular complications and early mortality in the future" - NPDA core report: Care Processes and Outcomes 2018/19.

A set of robust and comprehensive actions were developed to address the outlier status including:

1. Increasing support for technology-led monitoring such as Libre Flash Glucose monitoring by identifying the patients who would most benefit from the system due to impact of diabetes on quality of life.
2. Building a new amber alert pathway to include clinic appointments every 2 months and individualised plans in the High HbA1c policy.

In March 2021, we were advised that Tunbridge Wells Hospital is no longer an outlier for the adjusted mean HbA1c, which should result in a better outlook for our paediatric patients as they transition to adult services.

Rheumatology: The National Early Inflammatory Arthritis Audit's first national report was published in October 2019 (NEIAA). Maidstone and Tunbridge Wells NHS Trust was identified as a negative outlier for quality statement (2) "People with suspected persistent synovitis are assessed in a rheumatology service within three weeks of referral".

The Rheumatology Team reviewed the service and developed a set of actions to increase clinic capacity to enable patients with early synovitis to be seen on time including:

1. Obtain approval from the General Manager to add extra clinics slots.
2. Ensure extra clinic slots are reserved for early synovitis patients.
3. Add a new weekly synovitis clinic run by a Consultant to the clinic schedule.

In January 2021, the NEIAA published its second report and Maidstone and Tunbridge Wells NHS Trust is no longer identified as an outlier for quality statement (2) meaning that patients presenting with early synovitis are now seen in a timely manner.

Pharmacy: Are new, stopped or changed medications clearly documented on discharge summaries? In 2017, the Pharmacy Team conducted an audit with the aim to assess if new, stopped or changed medications have been documented clearly on discharge summaries generated by Maidstone and Tunbridge Wells NHS Trust to aid in continuity of care post-discharge. The results were disappointing with three of the four standards not being met and the fourth standard being partially met. Two recommendations were made:

1. Include more precise directions around documenting medications on the discharge summary in the MTW Clinical Procedures Policy.
2. Develop a learning initiative such as “learning at lunch” to ensure all staff are informed of the changes to the policy.

In September 2020, the re-audit was completed. Significant improvements were noted for all standards with only one standard remaining as “not met”; two standards are now “partially met” and one standard is now “fully met”. Additional actions have been developed to improve results further including protected time for Pharmacy staff to read the Standard Operating Procedure “Discharge Medication Preparation and Standard Practice” so that individual clinical staff can improve their compliance.

Breast Care Team: B-MaP C study (a national audit) Breast Cancer Management Pathways during the COVID-19 pandemic. Our Breast Care Team submitted data into this important study aiming to determine alterations to breast cancer management during the peak transmission period of the UK COVID-19 pandemic, and the potential impact of these treatment decisions. The study group published their findings in the British Journal of Cancer[1] in March 2021, which concluded that “The majority of ‘COVID-19 altered’ management decisions were largely in line with pre-COVID-19 evidence-based guidelines, implying that breast cancer survival outcomes are unlikely to be negatively impacted by the pandemic. However, in this study, the potential impact of delays to breast cancer presentation or diagnosis remains unknown[1].”

Neurology: A qualitative and quantitative study to explore the impact of COVID-19 on community-dwelling adults with Parkinson’s Disease. This local service evaluation looked at how the COVID-19 pandemic had disproportionally affected and distorted the lives of people living with long term conditions, including Parkinson’s disease (PD). The study explored the impacts of the pandemic and what matters the most to PD patients.

The study observed a trend of deterioration including anxiety, social isolation, fear of contracting COVID-19 and physical deterioration. This had a profound negative impact on our patients’ wellbeing as well as an exponential effect on carer burden. Many PD patients felt that human interactions within medical consultations are very important and were very much missed during

the pandemic. This study again reinforces the benefits of exercise groups on wellbeing and delaying disease progression in Parkinson's disease.

The national clinical audits and national confidential enquiries relevant to Maidstone and Tunbridge Wells NHS Trust are listed in the table below and our participation in these clinical audits during 2020/21 is also presented:

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	MGH - 270 TWH - 479	100%
Antenatal and newborn national audit protocol 2019 to 2022	Y	2	100%
BAUs Urology Audits: Renal Colic Audit (Snapshot)	Y	27	100%
BAUs Urology Audits: Cytoreductive Radical Nephrectomy Audit	Y	0	100%
BAUs Urology Audits: Female Stress Urinary Incontinence Audit	Y	0	100%
Cardiac Rhythm Management (CRM)	Y	MGH - 248 TWH - 143	100%
Cardiac Rhythm Management (CRM) – Cardiac Electrophysiology	Y	MGH - 31	100%
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement	Y		Submission data not yet available
Emergency Laparotomy Audit (NELA)	Y	MGH - 16 TWH - 141	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	MGH - 4 TWH - 11	100%
National Hip Fracture Database (NHFD)	Y	464	88%
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	N		Directorate decision
Mandatory Surveillance of bloodstream infections and Clostridium Difficile infection	Y	149	100%
MBRRACE-UK; Maternal Mortality surveillance and mortality confidential enquiries	Y	0	100%

National Clinical Audits for inclusion in Quality Accounts 2020/21	*Participation* Y or N	*No. of cases submitted*	*% cases submitted*
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	Y	0	100%
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	Stillbirth: 11 Neonatal: 2 Extended Perinatal: 0	100%
MBRRACE-UK; Perinatal Mortality Surveillance	*Y*	Stillbirth: 11 Neonatal: 2 Extended Perinatal: 0	100%
Myocardial Ischaemia National Audit Project (MINAP)	Y	MGH - 132 TWH - 158	>91%
National Adult Diabetes Inpatient Audit (NaDIA)	N		Data not submitted - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Pulmonary Rehabilitation	Y	MGH - 3 TWH - 14	21.25% Limited data submission - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care	Y	MGH - 21 TWH - 47	Limited data submission - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – Adult Asthma Secondary Care	N		Data submission optional - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care (Paediatric Asthma)	Y	64	100%
National audit of Breast Cancer in Older people (NABCOP)	Y		Submission data not yet available
National audit of Cardiac Rehabilitation (NACR)	Y	MGH - 284 TWH - 437	100%
National Audit of Care at the End of Life 2020 (NACEL)	N		Data submission postponed - COVID-19

National Clinical Audits for inclusion in Quality Accounts 2020/21	*Participation* Y or N	*No. of cases submitted*	*% cases submitted*
National Audit of Dementia (NAD)	N		Data collection suspended - COVID-19
National audit of Percutaneous Coronary Interventions (PCI) (Coronary angioplasty)	Y	267	100%
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	Y	99	100%
National Bowel Cancer Audit (NBOCA)	Y	333	100%
National Cardiac Arrest Audit (NCAA)	Y	MGH - 33 TWH - 50	100%
National Comparative Audit of Blood Transfusion Programme - 2020 Audit of the management of perioperative paediatric anaemia	N		Data submission postponed - COVID-19
National Core Diabetes Audit (NDA)	Y	MGH - 627 TWH - 668	100%
National Diabetes Foot Care Audit	Y	MGH - 6 TWH - 8	100%
National Diabetes Inpatient Audit – Harms	Y	MGH - 12 TWH - 4	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N		Data not submitted - COVID-19
National Heart Failure Audit	Y	MGH - 192 TWH - 216	>88%
National Joint Registry (NJR)	Y	MGH - 250 TWH - 211	100%
National Lung Cancer Audit (NLCA)	Y	255	100%
National Maternity and Perinatal Audit (NMPA)	Y	5626	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Y	88	100%
National Ophthalmology Database Audit	N		Data not submitted - software issues

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
National Paediatric Diabetes Audit (NPDA)	Y	TWH - 100 MGH - 143	100%
National Pregnancy in Diabetes Audit	Y	34	100%
National Prostate Cancer Audit (NPCA)	Y	394	100%
NCEPOD: Dysphagia in people with Parkinson's Disease study	Y	7	88%
NCEPOD: Physical Health in Mental Health Hospitals	Y	0	100%
Neonatal Intensive and Special Care (NNAP)	Y	650	100%
Paediatric Inflammatory Bowel Disease	Y	31	100%
Perioperative Quality Improvement Project (PQIP)	N		Patient recruitment optional -COVID-19
RCEM Fractured Neck of Femur (care in emergency departments)	N		Data not submitted - COVID-19
RCEM Infection Control (Care In Emergency Departments)	N		Data not submitted - COVID-19
RCEM Pain in Children (Care in emergency departments)	N		Data not submitted - COVID-19
Sentinel Stroke National Audit Programme (SSNAP)	Y	601	April 2020 – Dec 2020, ongoing data submission
Serious Hazards of Transfusion 2020 (SHOT) UK. National haemovigilance scheme	Y	22	100%
Society for Acute Medicine Benchmarking Audit	N		Data collection postponed - COVID-19
Surgical Site Infection Surveillance	Y	4	Incomplete data submission, to be entered retrospectively
The Trauma Audit and Research Network (TARN)	Y	647	83-100%

National Clinical Audits for inclusion in Quality Accounts 2020/21	*Participation* Y or N	*No. of cases submitted*	*% cases submitted*
UK Registry of Endocrine and Thyroid Surgery (BAETS)	N		No access to the data entry platform

In 2020/21, 41 national clinical audits and confidential enquiries published reports that covered the relevant health services provided by Maidstone and Tunbridge Wells NHS Trust. 41 were reviewed by the Trust and a full list of these national clinical audits and the key actions developed in response to the reports published can be found in **Appendix A**.

In 2020/21, 71 local clinical audits were completed at Maidstone and Tunbridge Wells NHS Trust. A full list of these local clinical audits and the key actions developed in response to the findings of the clinical audits can be found in **Appendix B**.

NICE Guidelines

NICE
National Institute for Health and Care Excellence

Every year the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. The role of NICE is to improve outcomes for people using the NHS by producing evidence-based guidance and advice to monitor compliance through set quality standards and performance metrics.

The Trust reviews all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines to assess the Trust's compliance. These clinical audits focus on a number of key quality standards that are designed to drive measurable service improvement to enhance practice and the care of patients.

By the end of 2020/21 a total of **1857** NICE guidance documents have been disseminated to Trust specialty leads since NICE guidance began to be published in 2005. Of those, **1698 (91%)** have been evaluated. **706 (41%)** of the evaluated guidance are considered to be relevant to the Trust's activities. Each Directorate is regularly updated of the actions required to meet compliance.

The impact of the COVID-19 pandemic led to changes in priorities for clinicians and evaluation of guidelines not linked to COVID-19 were deferred. This has led to a backlog that will be addressed in 2021.

Guidance published from 1 April 2020 to 31 March 2021.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (CG/NG)	34	18	12
Interventional Procedures (IPG)	18	2	0
Technology Appraisals (TA)	60	8	2
Others other types of guidance	22	7	3
Totals	**134**	**35**	**17**

Please see Appendix B for full details of Trust compliance with NICE guidance that has been audited and completed during 2020/21.

Research

Maidstone and Tunbridge Wells NHS Trust recruited 3,580 participants to 76 research projects during 2020/21 that were approved by the Research Ethics Committee, against an annual plan of 1556 participants. This plan was agreed with the Clinical Research Network for Kent, Surrey and Sussex and based on the predicted number of patients to be recruited to trials open at the start of the financial year. 2020/21 saw the highest number of patients recruited to trials at MTW on record.

The 2020/21 research year started with the Research and Development department involved in delivering a number of COVID-19 clinical trials.

Delivering research during a pandemic

Many MTW research delivery staff were ring-fenced throughout the year to ensure important treatment trials continued where possible and where safe to do so as 'normal' NHS service provision had to scale down. This also ensured there were research staff ready to open and deliver the new, high profile COVID-19 studies that were commenced in response to the pandemic.

It usually takes around four to six weeks to set up a clinical trial within the organisation. We were tasked with setting up COVID-19 trials within just 9 days during the pandemic.

The urgency of the situation required staff to ready themselves for the unexpected. Used to delivering a set programme of research studies, the team were now tasked with opening one new COVID-19 study every 4 weeks, in record time, within existing resources.

Staff regularly worked over-time, during unsociable hours, and at weekends, to ensure studies were set up safely and on time. With no known treatments or cure for COVID-19, the clinical trials were patients' only hope. Hospital teams such as Pharmacy and Pathology also worked over and above to support the trials and were key to delivering the studies safely and accurately.

Our successful delivery of COVID-19 research was in part thanks to the establishment of very capable and engaged research teams who, even before the pandemic, had made a name for themselves as excellent researchers.

To support our existing research staff, we also welcomed a number of new staff to the team during the year, both from external organisations and from within the Trust, including Research Nurses and Clinical Trial Co-ordinators. The appointments followed a number of research staff moving on to the next stage in their careers to take promotions in other areas of healthcare.

Nursing and administrative support was also drafted in from neighbouring healthcare providers to help the Trust research team deliver our ever-growing number of COVID-19 trials. Research nurses, practitioners, data managers and administrative staff joined our research team between August and December in what was a truly collaborative effort between health provider organisations.

"The UK's research response to the COVID-19 pandemic was unparalleled. It triggered a system-wide, collaborative approach that enabled unprecedented speed and efficiency in clinical trial approvals, set-up and recruitment. As a result, the UK has been able to rapidly answer questions of global importance about the safety and efficacy of COVID-19 treatments and vaccines." (National Institute for Health Research, 2021)

COVID-19 trials

A total of 17 COVID-19 studies were opened by the end of the year, including all studies of national importance badged as Urgent (to) Public Health. Notable studies include:-

The RECOVERY Trial

MTW is one of 181 UK sites delivering this national research study that recruited almost 40,000 patients during the year. The RECOVERY trial is currently the world's largest trial of potential COVID-19 treatments. The study was successful in identifying Dexamethasone as being an effective treatment for some patients with COVID-19, showed that Hydroxychloroquine and convalescent plasma gave no benefit to patients and found that some anti-inflammatory drugs are beneficial to patients.

Recruitment to this trial at MTW is delivered by a small team of clinicians, led by Dr Matt Szeto, Consultant Physician and Rheumatologist. Over 150 patients have been recruited to date.

SIREN Study

210 members of MTW staff signed up to take part in the SIREN study during 2020. The SIREN study, led by Public Health England was set up in over 130 hospitals across the country to measure antibody levels in healthcare workers such as doctors and nurses, porters and cleaners. The purpose of this study was to understand whether prior infection with the virus that causes COVID-19 protects against future infection with the same virus. The research team performed swab and blood tests on staff and sent them to laboratories for analysis.

In February 2021, SIREN published findings that healthcare workers were 72% less likely to develop infection after one dose of the vaccine, rising to 86% after the second dose based on nearly 50,000 NHS staff test results.

Psychological impact of COVID-19

Led by Southern Health NHS Foundation Trust, MTW was one of 55 sites in the UK promoting the global study, which was open to the general population. Over 250 people took part from MTW. Early results show that one third of all respondents identified worsening levels of stress, anger and loneliness due to the pandemic, with women more likely to report than men. The study is currently continuing across the globe.

REMAP-CAP study

The REMAP study was already open at MTW before the pandemic and is designed to evaluate treatments for Community Acquired Pneumonia in patients admitted to intensive care units. It was adapted early last year to include patients admitted to intensive care with COVID-19. The study is open at 300 hospitals across 21 countries to provide truly global findings relating to COVID-19 treatments. The study is ongoing and looks at the effectiveness of treatments such as antibiotics, antivirals and steroids in helping patients recover. 185 patients were recruited to the study last year, contributing to nearly 7,000 patients recruited nationally. REMAP-CAP has been named by the Chief Medical Officers of the United Kingdom as a key clinical trial for COVID-19.

Novavax COVID-19 Vaccine trial

The research team was very happy to be accepted as a participating site on the international Novavax vaccine trial in September 2020. Over 100 people from the local population were consented to join the blinded trial at Maidstone hospital with 50% of participants receiving the Novavax trial vaccine and the other 50% receiving a placebo. This study allowed some of our local population to receive a COVID-19 vaccine months before the national vaccine roll out, so people were very keen to take part. Study findings released in January 2021 found the vaccine to be

89.3% effective during what was a period of high transmission and with a new UK variant strain of the virus emerging and circulating widely. The study was led at MTW by Dr Arabella Waller, Consultant Physician and Rheumatologist.

Impact of the pandemic on research delivery

76 studies were open and recruiting during the year (including COVID-19 studies), across a wide range of specialisms. During March and April 2020, 56 studies were paused in response to the pandemic. Studies were paused as patient services were halted or changed to reduce the infection risk at the hospital. Many study-specific processes had to stop as they did not match the new way of providing services during the first months of the pandemic. The Trust made every effort to ensure as many studies as possible remained open (if safe to do so) to ensure patients on treatment trials did not miss out on receiving their medication. Many studies in oncology and haematology in particular, remained open over the year. We ensured the oncology and haematology research nurses remained ring-fenced throughout the year to continue caring for their patients.

Hospital departments recruiting the largest number of patients to trials during 2020/21 remained the same as the previous year - Critical Care (281 patients), Oncology (114 patients) and Women's services who recruited over 1,500 expectant mothers to the POOL water-birth study.

Research collaboration

Working in research during a pandemic has been challenging but has also facilitated the benefits of working collaboratively with others. Over the year, the Trust worked closely with the Kent Surrey and Sussex Clinical Research Network to share important information on new COVID-19 research studies as they became available and to plan how these would be delivered across the region. Research staff also came together to set up the Kent and Medway Project Review Group in response to the pandemic. The Project Review Group, hosted by Medway NHS Foundation Trust with research representation from across Kent and Medway met on a weekly basis to support clinicians from all healthcare providers to collect data, design studies and collaborate across organisations to address clinical issues and questions relating to COVID-19. From this collaboration MTW's first long-COVID-19 study was developed by Consultant Respiratory Physician, Dr Loke.

Research staff feel very proud to have actively supported critical care and ward-based colleagues in offering trial drugs to COVID-19 patients to help save lives in what has been an unprecedented period of research provision.

Goals agreed with commissioners

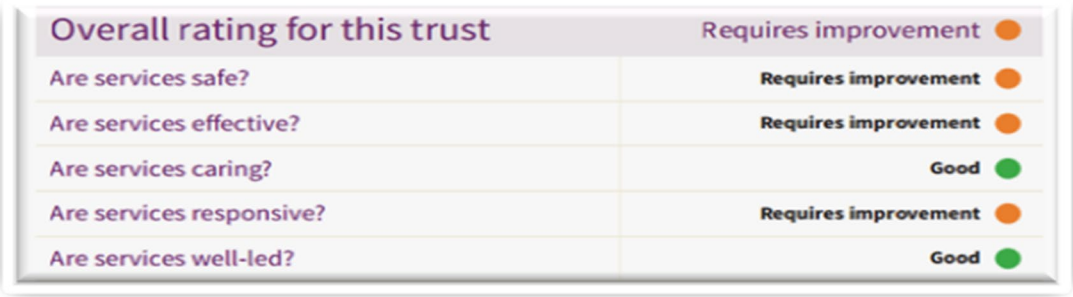
This section usually describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The intention of the CQUIN framework when it was initially introduced was to support the cultural shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals.

Due to COVID-19, the CQUIN programme was suspended for 2020/21. This meant that there was no agreed programme or targets for 2020/21. However, the Trust still continued its work in vital areas which formed part of last year's CQUIN programme such as Sepsis, Falls and staff receiving the flu jab.

Statements from the CQC

The Trust has not been inspected since the update provided in the Quality Accounts 2019/20.

The most recent inspection undertaken of the Trust took place during the period 18th October, 2017 to the 1st February, 2018 with the report published in March 2018. The overall rating for the Trust was 'Requires Improvement'.



Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

The CQC reported that they had seen significant improvements since our previous inspection three years ago and although we have been rated as 'Requires Improvement', they acknowledged that significant and sustained improvements had been made and we were moving towards a 'Good' rating.

We received 17 specific recommendations from the CQC. Each of these recommendations have been addressed, with ongoing checks in place to ensure that the actions have been embedded. The full report can be accessed via the CQC website - http://www.cqc.org.uk/provider/RWF

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's business as usual (BAU) quality improvement agenda. The Trust monitors compliance with CQC registration requirements itself; primarily through a programme of in-house assurance visits/inspections. These were paused during 2020/21 due to COVID-19 and will be reinstated in 2021/22. In addition to these, the Trust will be working with neighbouring Trusts to consider a programme of peer review to monitor compliance with CQC requirements.

Such inspections, which are managed by the Quality Governance and Corporate Nursing teams, include patient representatives and representatives from NHS Kent and Medway Clinical Commissioning Group, the main commissioner of the Trust's services. The outcomes of the inspections are used to identify areas for improvement, which are then acted upon. The Quality Improvement Committee provides the governance and oversight of this programme of work.

This committee, which is chaired by the Chief Nurse and reports to the Quality Committee, was pivotal in overseeing timely delivery of the recommendations from the last CQC inspection and is responsible for the ongoing prioritisation of key areas for focus.

A bi-monthly operational working group chaired by the Chief Nurse is also in place, which facilitates progress against key priorities and supports divisions with their continuous improvement plans.

Quarterly engagement events have taken place with the CQC during 2020/21. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been visited during these events. The Trust also ensured that they submitted feedback on the strategy consultation launched by the CQC in January 2021.

In addition, Maidstone and Tunbridge Wells NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

TIAA Audit

The core purpose of the audit undertaken by TIAA was to assess the Trust's position against the original 17 'Should Dos' resulting from the last CQC inspection of 2017. The audit reviewed how the Trust has addressed the recommendations and how we continue to monitor the position and deliver ongoing improvement against them. All action plans, trackers and evidence were reviewed alongside the work to achieve an 'Outstanding' CQC rating governance structure.

Whilst the final report is pending (expected May 2021), the post audit exit interview and draft report indicate a very positive outcome. The feedback acknowledged successful completion of the 17 'Should Dos' and the subsequent iterative approach required to achieve an outstanding rating by the CQC.

The TIAA draft report has commented on a "reasonable level of assurance" and suggest the following key strategic findings:

- Consider the need for a putting a process in place to ensure clear linkages to CQC fundamental standards are referenced in Trust policies, procedures and guidance. This would help to raise awareness and improve compliance with the embedding of standards.
- Consider implementing a document management system or process for CQC supporting evidence. Create a central repository to which supporting evidence could be regularly uploaded to facilitate effective monitoring by the CQC Project Team and improve processes.
- An effective Quality Framework with a sound governance structure is in place, which includes reporting to the Trust Board through the Integrated Performance Report and monitoring through the Board Assurance Framework (BAF).

Additional positive findings include:

- The Trust's relationship with the CQC is good having proactively engaged with them through virtual CQC engagement events. These have been well received and valued by both the CQC and Trust Divisions, who have been enthusiastic to demonstrate their progress through the Trust's journey to Outstanding.
- Testing confirmed that the Trust has implemented the "Should Dos" resulting from the last CQC inspection. The Trust has continued to make progress and have stretched objectives in their journey to Outstanding.

The draft report suggests 3 key actions; 1 rated as important and 2 as routine.

The CQC programme group are developing a proposed management response to these recommendations.

Improving data quality

Maidstone and Tunbridge Wells NHS Trust is committed to providing services of the highest quality. Specifically, MTW needs to ensure its information is:

- Consistently captured
- Recorded accurately
- Securely shared within the boundaries of the law

High quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

The Trust has progressed with implementation of the Data Quality Strategy during the year, continuing to focus on data quality as a priority across the organisation. A number of governance groups are now in place to ensure our vision set out within the strategy is delivered. Our vision is 'to ensure that we adhere to all relevant local and national data standards and applicable best practice guidance to support the delivery, commissioning and regulation of high quality and safe healthcare service at MTW'.

These groups focus on the following areas:

- Governance and leadership
- Policy
- Systems and processes
- People and skills
- Data use and reporting

Progress on the work plan linked to the new strategy will be reported quarterly to Trust Management Executive and onward to the Board as appropriate.

NHS Number and General Medical Practice Code Validity

Data quality is also monitored for each submission the Trust is required to make throughout the year to NHS Digital, Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was (as at Month 10):

- 99.8% (99.7% 19/20) for Admitted Patient Care
- 99.9% (99.9% 19/20) for Outpatient Care
- 99.0% (98.6% 19/20) for Accident and Emergency Care

which included the patient's valid General Medical Practice code was:

- 100% (99.9% 19/20) for Admitted Patient Care
- 99.9% (99.9% 19/20) for Outpatient Care
- 99.9% (99.9% 19/20) for Accident and Emergency Care

The Trust has developed a data quality dashboard to assist service managers and clinicians.

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Organisations must make an annual submission supported by appropriate evidence to demonstrate that they are working towards or meeting the required standards.

Due to COVID-19 the deadline for the DSPT 20/21 submission was pushed back by NHSX to 30 June 2021. The Trust continues with its preparations for submission and has requested TIAA to complete an audit of mandatory evidence posted against 13 assertions across the 10 standards as selected by NHS Digital for 2020/21. The review will test the evidence for completeness and validity.

In September 2020, the submission date for 2019/20, the Trust submitted a 'Standards Met' return.

In addition to completing the toolkit, the Trust reviews its Information Governance Management Framework on an annual basis. This document details the governance arrangements concerning the obtaining, recording, holding, using, sharing and destruction of all data and records held or used by the Trust in accordance with the law and best practice.

An action plan is developed each year to address any areas of weakness identified. Progress against the action plan is monitored by the Information Governance Committee, which is chaired by the Trust Senior Information Risk Officer.

The Trust Board is kept fully apprised of Information Governance issues affecting the organisation.

Clinical Coding

The table below provides the results of the 2020/21 clinical coding audit scores.

Code Type	Percentage Correct	Data Quality section of Data Security Standard 1 Level of Attainment	
		Standards met	Standards exceeded
Primary Diagnosis	98.5%	90% or above	**95% or above**
Secondary Diagnosis	99.02%	80% or above	**90% or above**
Primary Procedure	99.29%	90% or above	**95% or above**
Secondary Procedure	97.28%	80% or above	**90% or above**

The 2019/20 audit recommendations for clinical coding were all implemented and are detailed below.

R1	Provide additional training to all clinical coding staff to aide extraction from the clinical case notes of all relevant conditions and mandatory comorbidities (immediate and ongoing)
R2	Provide additional training to all clinical coding staff to ensure all relevant imaging procedures are correctly captured and coded (immediate and ongoing)
R3	Coding department to continue to liaise with relevant departments in order to continue to improve the filing of case notes
R4	Coding staff to search all relevant documentation and additional systems within the timeframe of the inpatient spell to ensure all relevant conditions are captured (immediate and ongoing)

During the COVID-19 pandemic the clinical coding source documents and access to these were greatly affected due to the coders having to work remotely. The Trust is working towards full implementation of an electronic patient record (EPR) and in the interim the coding department had to use the electronic source documentation that was available. There were some exceptions to this, which included the coding of deceased patients, implementation of an electronic patient record (EPR) and in the interim the coding department had to use the electronic source documentation that was available. There were some exceptions to this, which included the coding of deceased patients.

Part **three**


METS MODULAR DISTAL FEMUR
SURGICAL PLANNING GUIDE
ESCHMANN T 30-m+

Results and achievements against the 2020/21 quality priorities

The table below summarises the quality improvement priorities MTW set out to achieve during 2020/21. We have made progress in many areas resulting in improved outcomes for patients but delivery of these quality priorities has been affected by the COVID-19 pandemic.

	SUMMARY		
	PATIENT SAFETY	**PATIENT EXPERIENCE**	**CLINICAL EFFECTIVENESS**
Aim	To create reliable processes that will build a supportive environment that recognises and reduces avoidable harm.	To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.	To improve the management of our patient journeys through the utilisation of evidence-based practice.
2020/21 Quality Priorities	Embracing all aspects of the National Patient Strategy to ensure that a safety culture is recognised as everyone's role and responsibility Continue to develop a downward trend in avoidable healthcare associated infections Increased focus on reducing the number of hospital acquired deep tissue injuries (DTI) and Category 2 pressure ulcers Improve the outcomes and experience of our expectant parents and their babies Improve the recognition and escalation of the deteriorating patient with specific focus on sepsis and diabetes	Implementation of the Patient Engagement and Experience Strategy 'Making it Personal' The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process Sustain improvement in the timely completion of Duty of Candour notifications as part of a wider commitment to improve patients and their carers' experience of adverse incidents and complaints Embedding safeguarding practices in all aspects of clinical care	Improving the flow of patients into and out of our wards and departments The development of site-specific centres of excellence commencing with the centralisation of colorectal surgery, followed by the hyper-acute stroke unit (HASU), concentrating on new and improved ways of working, which will support best practice and the opportunities for new roles.

This section will describe the results and achievements in greater detail against each of the quality priorities. Later in this section other significant improvements in patient care and quality initiatives are outlined to provide further examples of the implementation of the quality agenda within the Trust.

Patient Safety

Aim/Goal - To create reliable processes that will build a supportive environment that recognises and reduces avoidable harm.

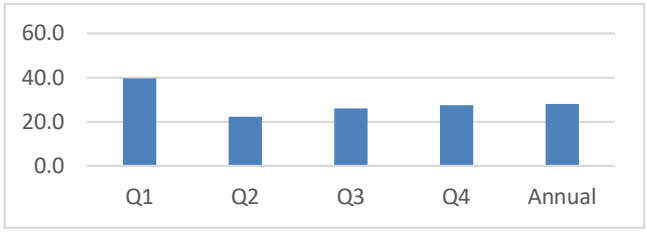
Objective	Criteria	Progress
1) Embracing all aspects of the National Patient Strategy to ensure that a safety culture is recognised as everyone's role and responsibility		
a) Increasing the number of incidents that are reported to identify themes to support positive change and improvement	Increase in number of incidents* reported in 2020/21, based on 2019/20 numbers	**This criterion was achieved.** Patient safety incidents reported in 2019/20: 10,261 Patient safety incidents reported in 2020/21: 10,361
	All relevant reporting about incidents will include: themes, actions in place to address these themes and tangible change as a result of learning from investigations	**This criterion was achieved.** Themes, actions, changes and learning are included in the monthly Serious Incident (SI) Update report for the Executive team meetings and bi-monthly for the Quality Committee. In relation to SIs both the recommendations and learning are captured in the Root Cause Analysis (RCA) reports and used as case studies in the Governance Gazette.
	Design qualitative process to evaluate staff experience of incident reporting	**This criterion was achieved.** In March 2021 the Patient Safety team re-launched the Staff Safety Culture Survey, which is an evaluative exercise to include incident reporting. The data has been analysed and preliminary recommendations identified based on those results.
b) Improve the quality and timeliness of investigations to support the learning lessons agenda	Increase in achievement of 60 day** key performance indicator (KPI) in 2020/21, based on 2019/20 compliance figures	**This criterion was not achieved** as the majority of serious incident investigations were undertaken by the Patient Safety Team to ensure clinicians could focus on patient care during COVID-19. This impacted on investigation timelines. An increase in achievement was reported in the first three quarters compared to 2019/20 but then decreased in Q4. The Patient Safety Team continue to work to improve the 60-day compliance and this is a quality priority for 2021/22.

Objective	Criteria	Progress
	Decrease in number of investigations with further queries returned from CCG, based on 2019/20 numbers	**This criterion was achieved.** There has been a significant decrease in the number of Non-Closures issued by the CCG. The Patient Safety Manager (PSM) meets monthly with the PSM at the CCG to review outstanding cases and ways to streamline the process. MTW PSM is now a member of the CCG SI panel, which facilitates timely processing and sign-off of investigations.
	Design qualitative process to evaluate patients and families' experience of our Serious Incident process	**This criterion was not achieved** and is a quality priority for 2021/22. Due to pressures from the COVID-19 pandemic, this has not yet been implemented. However, through the SI process, the corporate and clinical teams have worked with a number of families regarding their experience of the SI process to enable learning and improve future experiences for patients and their families.
c) Development of performance dashboards and reports that provides meaningful data to support departments and Divisions	Every ward to have a performance dashboard in place on Datix (the Trust's incident reporting system)	**This criterion was partially achieved.** Due to COVID-19 pressures this has not yet been fully implemented. The implementation is ongoing and is monitored through the monthly Datix Implementation Group meetings. The plan is to launch the dashboards in 2021/22. The dashboards have been designed and created. Access has been given to the key leads in the directorates which allows them to see a snapshot of current incident, SI and Duty of Candour performance.
	Decrease in numbers of incidents breaching 45 day closure timeline, based on 2019/20 numbers	**This criterion was not achieved** and is a quality priority for 2021/22.
d) Supporting all staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety	Plan in place to recognise World Health Organisation (WHO) - World Patient Safety Day (17th September annually)	**This criterion was achieved** and events took place to recognise the World Patient Safety day in September 2020. The theme for 2020 was "Health Worker Safety, Safe health workers, Safe patients". Members of the Patient Safety Team spoke with over 70 Trust staff about what staff and patient safety means to them and how to improve safety at MTW.
	Increase numbers of staff attending both Human Factors and Root Cause Analysis	**This criterion was partially achieved.** Human factors training was reinstated in July 2020, providing two full day sessions a month. Due to demand this was then increased (pre 2nd surge of COVID-19) to four full day sessions a month. Face to face RCA training did not

<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td rowspan="4"></td><td>(RCA)training</td><td>take place in 2020/21 but has been reinstated in May 2021.</td></tr>
<tr><td>Development of actions module (to monitor compliance with open actions from investigations) on Datix to drive performance</td><td>This criterion has been partially achieved.

The actions module has been developed and will be rolled out and embedded in 2021/22.</td></tr>
<tr><td>Ensure every staff member has access to the final Serious Incident (SI) investigation report</td><td>This criterion has been achieved.

Currently all staff involved in the investigation and the relevant Divisional Director for Nursing and Quality (DDNQ) and Clinical Leads are sent the final SI report. SI reports are now also being attached to the original Datix incident, which will make them accessible to all staff.</td></tr>
<tr><td>Design qualitative process to evaluate staff experience of being involved in our SI process</td><td>This criterion was not achieved and is a quality priority for 2021/22.</td></tr>
<tr><td colspan="3">2) Continue to develop a downward trend in avoidable healthcare associated infections, in particular</td></tr>
<tr><td>a) Gram negative bloodstream infections</td><td>21.5 cases per 100,000 bed days (whilst acknowledging national 5 year target of 50% reduction across the healthcare system by 2021)</td><td>This criterion was not achieved.

The rate of E.coli blood stream infections is per 100,000 bed days, results per quarter and annual are shown below.
<table><tr><td>Q1</td><td>39.6</td></tr><tr><td>Q2</td><td>22.3</td></tr><tr><td>Q3</td><td>26.0</td></tr><tr><td>Q4</td><td>27.6</td></tr></table> 
Annual = 28.0</td></tr>
<tr><td rowspan="2">b) Control of hospital acquired COVID-19</td><td>Systems in place for infection prevention and control of COVID-19 in line with the Hygiene Code</td><td>This criterion was achieved.

Infection prevention guidelines for COVID-19 follow PHE guidelines and are in line with the Hygiene Code.</td></tr>
<tr><td>Self-assessment undertaken of national framework</td><td>This criterion was achieved.

Self-assessment undertaken and presented to Trust Board in December 2020 within the infection prevention and control board assurance framework (BAF). The BAF has</td></tr>
</table>

Objective	Criteria	Progress
		been presented at Board monthly since Dec.
	Compliance of self-assessment to be monitored through the Infection Control Committee with periodic reports to Trust Board	**This criterion was achieved.** Completed and ongoing.
3) Increased focus on reducing the number of hospital acquired deep tissue injuries (DTI) and Category 2 pressure ulcers		
10% decrease in number of hospital acquired avoidable DTIs and Category 2 pressure ulcers by year end, based on 2019/20 numbers		**This criterion was not achieved.** Q4 saw the highest rate of hospital acquired (HA) pressure ulcers for the year. The acuity and dependency of the patients and the higher levels of unfilled shifts during the second wave of the pandemic are thought to be the main contributory factors. Q4 saw a reduction in HA Cat 2 pressure ulcers of 39%, but an increase in DTIs of 30% for the same quarter in the previous year. 2020 / 2021 saw an overall reduction in HA Cat 2 pressure ulcers of 3%, but an increase in HA DTIs of 38%. It is important to note that there has been ongoing national and international research into COVID-19 related skin changes. The evidence suggests small vessel changes with COVID-19 have caused skin damage that presents in identical discolouration and similar shaping as a DTI caused by pressure. Therefore, some skin damage declared as DTIs in COVID-19 positive patients may have been COVID-19 related skin changes.
4) Improve the outcomes and experience of our expectant parents and their babies through:		
a) Delivery of the ten key elements of the maternity transformation plan (one of which is the Continuity of Carer's directive)	Each element of the plan in place	**This criterion was not achieved.** Due to pandemic pressures, the focus is currently on the continuity of carer's directive, maintaining quality and safety and the digital strategy. Progress is tracked monthly at the Maternity Board.

Objective	Criteria	Progress
b) Engage with the Maternal & Neonatal Safety Collaborative (MatNeo) and implement the improvement plan on sepsis	Improvement plan for sepsis implemented and being monitored	**This criterion was achieved.** This is being implemented and is monitored through the monthly Maternity Board. Review of the Sepsis policy forms part of the improvement plan and this is underway.
5) Improve the recognition and escalation of the deteriorating patient with specific focus on:		
a) Sepsis	Undertake quarterly audit of 50 sets of notes to assess screening for and treatment of sepsis	**This criterion was partially achieved.** Data collection for this audit was severely impacted due to critical care staff redeployed to clinical work during both COVID-19 waves. Q3 audit results - sepsis screening of eligible patients with raised NEWS 2 scores = 77.3% and IV antibiotic treatment of red flag patients within 1 hour remains at 100%. No data collected during Q4 but a separate audit undertaken by medical team on Acute Medical Unit produced similar results to Q3.
	Report findings on a quarterly basis to the Sepsis Committee	**This criterion was partially achieved.** Sepsis Committee met on the 14th October 2020. Q1 audit data was reported, discussed and captured in the minutes. Sepsis Committee met on the 17th February, results of AMU audit discussed and captured in the minutes.
	Committee to propose required actions as a result of audit findings	**This criterion was achieved.** Main issues identified, which include continuing sepsis education and raising awareness of the sepsis proforma. Sepsis is a mandatory training requirement for clinical staff. Plan to update the sepsis e-learning module. Sepsis competencies for all registered healthcare professionals ready for roll-out. 43 sepsis trolleys have been purchased and will be distributed to clinical areas in May 2021. Each trolley will have six sections containing everything required to implement sepsis screening and an action plan. Having everything to hand will support the prompt treatment/management of sepsis, improve patient safety and enhance the quality of care delivered. Need to review resources for sepsis audit data collection.

Objective	Criteria	Progress
b) Diabetes	Audit of Blood Glucose Monitoring and Hypoglycaemia guideline to assess use of blood glucose monitoring form and algorithm	**This criterion was not achieved.** It was not possible to undertake this audit during the COVID-19 pandemic due to staffing pressures within the diabetes team. A Diabetes Inpatient Specialist Nurse (DISN) has been recruited to however the start date is yet to be confirmed. Secured confirmation within the new financial year to go out to advert for the second agreed DISN role. Connectivity meter roll out has been successful in the Trust and connection to the EPR is pending. With these successful steps forward we will be in a position to start this priority audit over the next few months.
	Implementation of blood glucose monitoring connectivity meters and associated staff training	**This criterion has been achieved.** All connectivity meters are now distributed and in place across the Trust. Trust targets for clinical staff training have been achieved.
	Assessment of training levels for clinical staff in relation to diabetes and e-learning for Safer Use of Insulin	**This criterion was partially achieved.** The e-learning for 'Safer use of insulin' module was launched on the MTW Learning site in 2020. 2356 Trust staff identified as needing to complete the module, so far 75% of these staff have undertaken the module. The remaining 25% will be targeted this year. The Diabetes Educator post has been recruited to and this role will monitor and ensure compliance with the e-learning module on insulin. The post holder will also carry out a wider review of diabetes training needs cross-site to inform strategic planning of diabetes education.
	Quarterly audit of prescription chart focusing on insulin prescribing and administration	**This criterion was partially achieved.** Pharmacy team commenced this audit in Q1 with 1 day per month screening of prescription charts against audit criteria. Data received and shared with Diabetes team. Analysis of data and sharing of learning limited due to current pandemic situation.

Patient Experience

Aim/goal - To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.

Objective	Criteria	Progress
1) Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'		
a) Re-establish the Patient Experience Lead role to lead on the strategy		**This criterion has been achieved.** The interim Patient Experience Lead is now full time since the 01/12/20. This role has been recruited to substantively in May 2021.
b) Monitor implementation and delivery of the strategy quarterly at the Patient Experience Committee (PEC)		**This criterion has been achieved.** A progress update on delivery against the Patient and Carer Strategy, including a specific focus on a review of learning in regards to communications with patients during COVID-19 and the steps implemented to improve communication were presented to the PEC in Dec 2020. In addition, further work was completed to present an update to the Committee in March 2021 to share how MTW are ensuring the optimum experience of patients and their families in the COVID-19 environment. Key initiatives, which have been implemented and are ongoing include: volunteer hubs at each main entrance to assist with signposting and prompt delivery of patient's belongings, patient welfare calls to discharge patients established and ongoing, photo badges which show staff faces behind face masks have been successfully trialled in paediatrics, 'Always' checklist refined and relaunched as our pledge to all patients and carers and service users. Ward quality rounds are underway. As a direct result of the quality rounds, the

Objective	Criteria	Progress
		"One Team Runner" role was established; focusing on releasing time to care for patients.
2) The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process		
a) Continue to undertake Trust bereavement survey and maintain consistently good results		**This criterion has been achieved.** The Bereaved Carers Survey 2019/20 has maintained consistently good results and has demonstrated an increase in patients accessing spiritual care at the end of life. The survey was temporarily halted during the first wave of the pandemic due to restricted visiting and changes in processing of the death certificates. However the survey was resumed during September and will be reported on in May 2021.
b) Improvement in the National End of Life Care (NACEL) survey results, based on most recent results		**This criterion has been partially achieved.** The NACEL audit was halted for 2020, due to the COVID-19 pandemic. The NACEL audit is planned to go ahead for 2021, and details of the audit have now been provided to the Trust. Data collection will now also include a staff survey and data collection will commence June 2021. The Palliative care team are currently undertaking an audit of the COVID-19 deaths that occurred during the first wave to review processes. This audit has now been adapted to incorporate data from the second wave for comparison and incorporates many of the realms of the NACEL audit.
c) Improvement in completion of individualised care plans for End of Life, based on last audit results		**This criterion has been partially achieved.** The audit has now been completed and identified that although mandated, the use of the ICP document remains low. However, its use has increased since the last audit and it is now used in 36% of cases in this sample, compared to 14% in 2019. Some form of End of Life care plan (be that ICP or a written narrative in the medical notes) was present in over half (58%) of all patients in this audit; however, this is a decrease from last year's figure, which identified that two-thirds of patients had a plan. When looking at all deaths it will not be possible to ever achieve 100% compliance, as death remains a possibility even when active treatment is being undertaken in unwell hospitalised patients; and in this context an End of Life plan is unlikely to be completed. An action plan has been developed in response and is being

Objective	Criteria	Progress
		monitored through the EoLC Steering Committee.
d) To improve advance care planning in EoLC, through the increased use of the treatment escalation plan (TEP), (audited as part of ICP audit and national EoLC audit)		**This criterion has been partially achieved.** The use of the TEP was also audited as part of the ICP audit. The TEP document was poorly used and only 2 patients from the medical records audited had a completed TEP. The results were shared with the Medical Director at the COVID-19 Ethics meeting in October 2020 for consideration of further action required. The current COVID-19 audit being undertaken also collects data on the use of TEP.
3) Sustain improvement in the timely completion of Duty of Candour notifications as part of a wider commitment to improve patients and their carers' experience of adverse incidents and complaints		
a) Refine reporting to capture all three elements of Duty of Candour – verbal notification, written notification and sharing the findings of the investigation		**This criterion has been achieved** (albeit in April 2021 and not in 2020/21 as planned). As of 1st April 2021, the reporting elements have been amended to capture all three elements and the incident reporting system has been reconfigured to capture this, whilst also linking to the Directorate dashboards.
b) Improved compliance, based on 2019/20 figures		**This criterion has been achieved.** However there is further room for improvement in 2021/22 which is why this will continue to be a quality priority.
c) Develop Duty of Candour dashboard on Datix		**This criterion has been achieved.** Dashboards are now in place for every division. This will be further developed in 2021/22 for each ward.
4) Embedding safeguarding practices in all aspects of clinical care		
a) Further develop tools to enable practitioners to ensure that mental capacity assessments (MCA) are documented appropriately enable practitioners to ensure	Tool to be developed and co-designed with practitioners	**This criterion has been achieved.** The tool has been developed and co-designed with practitioners and is now in place on the wards.
	MCA level 2 and 3 training package to be redesigned (including methodology of delivery)	**This criterion has been achieved.** The training package has been redesigned and is currently being delivered as e-learning due to the pandemic.

Objective	Criteria	Progress
that mental capacity assessments (MCA) are documented appropriately		
b) Demonstrate the involvement of the patient and their representatives in decision making in relation to safeguarding	Audit to be undertaken assessing involvement of the patient and their representatives	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be shared with relevant wards and any necessary actions put in place	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be presented at the Safeguarding Committee	**This criterion has been achieved.** A progress update was presented to the Safeguarding Committee in January 2021.
c) Ensure that all Deprivation of Liberty Safeguard applications are supported by a documented assessment of capacity	Audit to be undertaken assessing involvement of the patient and their representatives	**This criterion has been partially achieved**. Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be shared with relevant wards and any necessary actions put in place	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be presented at the Safeguarding Committee	**This criterion has been achieved.** A progress update was presented to the Safeguarding Committee in January 2021.

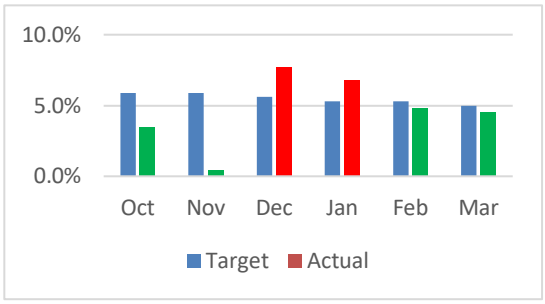
Clinical Effectiveness

Aim/Goal - To improve the management of our patient journeys through the utilisation of evidence-based practice.

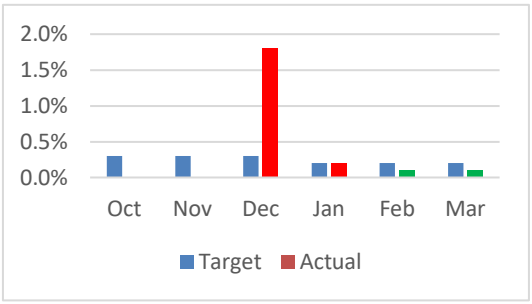
<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td colspan="3">1) Improving the flow of patients into and out of our wards and departments by: -</td></tr>
<tr><td>a) Increasing the effectiveness of ambulance handovers</td><td>See below</td><td>This criterion has been achieved.

The Emergency Department staff worked hard over the year to swiftly admit patients from ambulances to the departments despite the increased pressures of the COVID-19 pandemic. Data from October to March is displayed below.

Ambulances waiting over 30 mins to handover patient

<table>
<tr><th></th><th>Target</th><th>Actual</th></tr>
<tr><td>Oct</td><td>5.9%</td><td>3.5%</td></tr>
<tr><td>Nov</td><td>5.9%</td><td>0.4%</td></tr>
<tr><td>Dec</td><td>5.6%</td><td>7.7%</td></tr>
<tr><td>Jan</td><td>5.3%</td><td>6.8%</td></tr>
<tr><td>Feb</td><td>5.3%</td><td>4.8%</td></tr>
<tr><td>Mar</td><td>5.0%</td><td>4.5%</td></tr>
</table>


Ambulances waiting over 60 mins to handover patient

<table>
<tr><th></th><th>Target</th><th>Actual</th></tr>
<tr><td>Oct</td><td>0.3%</td><td>0.0%</td></tr>
<tr><td>Nov</td><td>0.3%</td><td>0.0%</td></tr>
<tr><td>Dec</td><td>0.3%</td><td>1.8%</td></tr>
<tr><td>Jan</td><td>0.2%</td><td>0.2%</td></tr>
<tr><td>Feb</td><td>0.2%</td><td>0.1%</td></tr>
<tr><td>Mar</td><td>0.2%</td><td>0.1%</td></tr>
</table>

</td></tr>
<tr><td>b) Improving the timeliness of discharge of patients from Intensive Care (ICU)</td><td>Improve performance with regard to ward-based discharge (within 4 hours), based on 2019/20 numbers</td><td>This criterion was partially achieved.

The COVID-19 pandemic led to many changes and challenges within critical care. ICU capacity was expanded on both sites during the 2 waves of the pandemic. An increase in performance for timely discharge from ICU occurred for periods but was not fully sustained throughout the year.</td></tr>
</table>

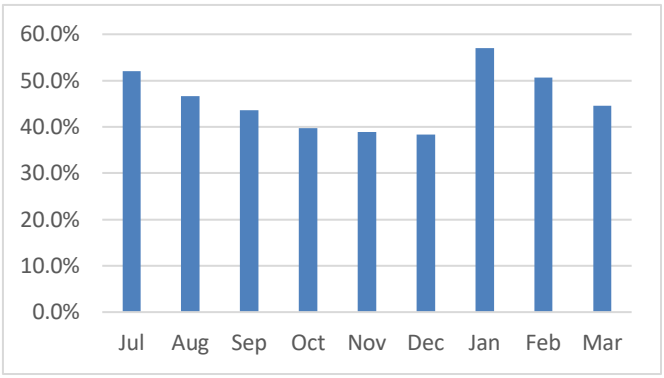
<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td></td><td>Decrease number of night-time discharges from the Intensive Care Unit (10pm-7am), based on 2019/20 numbers</td><td>This criterion was partially achieved.

The increase in ICU beds in response to the COVID-19 pandemic led to some reduction in discharges at night-time from ICU for some periods. Comparison with 2019/20 figures is difficult due to the impact of the pandemic.</td></tr>
<tr><td>c) Ensuring the necessary support is in place to allow patients to leave hospital when it is planned for them to do so</td><td>Decrease in the numbers of patients with a length of stay of 7 days or more and 21 days or more respectively, based on 2019/20 numbers</td><td>This criterion has been achieved.

There have been significant reductions for both 7-day and 21-day length of stay figures each month in 2020-21 compared to 2019-20 data. Each month throughout the year the figures are lower than for each respective month in the previous year for both 7 day and 21 day LOS. Please see table below showing the full data for both years.
<table>
<tr><th></th><th colspan="3">7 day LOS</th><th colspan="3">21 day LOS</th></tr>
<tr><th></th><th>Maid</th><th>TWH</th><th>Trust</th><th>Maid</th><th>TWH</th><th>Trust</th></tr>
<tr><td>Apr-19</td><td>131.1</td><td>179.8</td><td>310.9</td><td>51.0</td><td>64.5</td><td>115.5</td></tr>
<tr><td>May-19</td><td>129.3</td><td>183.7</td><td>313.0</td><td>49.6</td><td>69.4</td><td>118.9</td></tr>
<tr><td>Jun-19</td><td>123.4</td><td>178.2</td><td>301.6</td><td>40.8</td><td>66.4</td><td>107.2</td></tr>
<tr><td>Jul-19</td><td>125.5</td><td>174.0</td><td>299.5</td><td>47.5</td><td>66.5</td><td>114.0</td></tr>
<tr><td>Aug-19</td><td>130.0</td><td>169.3</td><td>299.3</td><td>41.7</td><td>66.8</td><td>108.5</td></tr>
<tr><td>Sep-19</td><td>137.9</td><td>172.5</td><td>310.4</td><td>53.7</td><td>64.4</td><td>118.0</td></tr>
<tr><td>Oct-19</td><td>133.5</td><td>159.1</td><td>292.7</td><td>49.6</td><td>56.4</td><td>106.0</td></tr>
<tr><td>Nov-19</td><td>142.0</td><td>159.3</td><td>301.3</td><td>54.7</td><td>52.3</td><td>107.0</td></tr>
<tr><td>Dec-19</td><td>145.5</td><td>173.1</td><td>318.7</td><td>55.9</td><td>54.3</td><td>110.2</td></tr>
<tr><td>Jan-20</td><td>161.1</td><td>180.6</td><td>341.7</td><td>69.5</td><td>66.4</td><td>135.9</td></tr>
<tr><td>Feb-20</td><td>161.8</td><td>166.6</td><td>328.4</td><td>61.8</td><td>54.5</td><td>116.2</td></tr>
<tr><td>Mar-20</td><td>130.2</td><td>137.9</td><td>268.1</td><td>53.6</td><td>43.5</td><td>97.2</td></tr>
<tr><td>Apr-20</td><td>68.6</td><td>68.1</td><td>136.8</td><td>15.3</td><td>16.1</td><td>31.4</td></tr>
<tr><td>May-20</td><td>69.1</td><td>81.1</td><td>150.1</td><td>22.5</td><td>20.8</td><td>43.3</td></tr>
<tr><td>Jun-20</td><td>67.7</td><td>98.4</td><td>166.0</td><td>21.7</td><td>23.1</td><td>44.8</td></tr>
<tr><td>Jul-20</td><td>78.5</td><td>91.8</td><td>170.3</td><td>22.7</td><td>18.3</td><td>41.1</td></tr>
<tr><td>Aug-20</td><td>94.6</td><td>116.5</td><td>211.0</td><td>27.4</td><td>26.2</td><td>53.6</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Sep-20</td><td>113.9</td><td>113.5</td><td>227.4</td><td>37.3</td><td>25.9</td><td>63.2</td></tr>
<tr><td>Oct-20</td><td>126.6</td><td>120.2</td><td>246.8</td><td>45.8</td><td>23.6</td><td>69.5</td></tr>
<tr><td>Nov-20</td><td>141.1</td><td>120.6</td><td>261.7</td><td>45.7</td><td>29.3</td><td>75.0</td></tr>
<tr><td>Dec-20</td><td>150.4</td><td>150.5</td><td>300.9</td><td>52.2</td><td>35.4</td><td>87.6</td></tr>
<tr><td>Jan-21</td><td>161.6</td><td>163.8</td><td>325.4</td><td>54.4</td><td>46.9</td><td>101.3</td></tr>
<tr><td>Feb-21</td><td>126.4</td><td>136.4</td><td>262.8</td><td>38.6</td><td>43.7</td><td>82.3</td></tr>
<tr><td>Mar-21</td><td>108.6</td><td>113.0</td><td>221.6</td><td>34.6</td><td>26.1</td><td>60.7</td></tr>
</table>
</td></tr>
<tr><td>d) Increasing the number of virtual clinics</td><td>Transfer 50% of outpatient activity to virtual clinics, based on 2019/20 figures</td><td>
This criterion has been partially achieved.

Data for Q2, Q3 & Q4 for percentage of outpatient activity which was delivered virtually, not face-to-face, is shown below:

<table>
<tr><th>Month</th><th>Number</th></tr>
<tr><td>Jul</td><td>52.3%</td></tr>
<tr><td>Aug</td><td>46.7%</td></tr>
<tr><td>Sep</td><td>43.6%</td></tr>
<tr><td>Oct</td><td>39.7%</td></tr>
<tr><td>Nov</td><td>38.9%</td></tr>
<tr><td>Dec</td><td>38.3%</td></tr>
<tr><td>Jan</td><td>57.0%</td></tr>
<tr><td>Feb</td><td>50.6%</td></tr>
<tr><td>Mar</td><td>44.5%</td></tr>
</table>


January was the highest month at 57.0% and the Trust was meeting this Quality Priority in Q1 during the first wave of the pandemic.

Video conferencing technology is now being used by various departments across the Trust to host virtual appointments with patients. Currently, there are 114 users across 11 specialities using the facility. Initial feedback has revealed that 67% of patients say the video appointments are equivalent or better than a face to face appointment. The software is being used by teams in Diabetes and Endocrinology; Neurology; Paediatrics; Cardiology; Sexual Health; Ophthalmology and Oncology and will soon be rolled out to Trauma and Orthopaedics, Physiotherapy Outpatients and Respiratory Services. Benefits of the service include reduced travel times and associated expenses for patients as well as reduced footfall at our sites as patients can attend their appointment from the comfort of their own home or any other appropriate location. In addition, it is also helping to improve patient care between teams.

For example, the Emergency Department can show an Ophthalmologist a patient's eye injury. Using a camera attached to a slit lamp, the attending clinician can shine the light into the patient's eye and send the video images directly to the
</td></tr>
</table>

Objective	Criteria	Progress
		Ophthalmologist allowing them to view it from where they are and make a diagnosis meaning the patient is treated quickly and their length of stay is reduced. Work began last summer to start rolling out video conferencing technology in identified specialities as part of a pilot project but the outbreak of COVID-19 pushed the value of the service to the forefront and as a result it was implemented in other departments ahead of schedule. The pandemic has certainly demonstrated how we need to work differently and as we return to normal levels of activity; the Trust's forthcoming digital transformation strategy aims to continue to utilise this form of technology by default for outpatient care. As a result we anticipate up to 60% of future outpatient appointments will be done via the phone or video conferencing. This will enable us to comply with social distancing recommendations, to maintain safety for patients, and help us ensure we have sufficient staff for those patients who need to come into hospital for a face to face consultation.
2) The development of site-specific centres of excellence commencing with the centralisation of colorectal surgery, followed by the hyper-acute stroke unit (HASU), concentrating on new and improved ways of working, which will support best practice and the opportunities for new roles.		
a) Development of colorectal surgery centre		**This criterion has been partially achieved.** Phase one surgical reconfiguration is embedded from an emergency and elective perspective (pending pandemic reductions). Further changes have been made to move the Consultant body to a 24 hour on call rostering pattern and an associate Registrar rostering pattern that will move with their paired Consultants' job plan. This has taken effect as of the 29/03/21. Discussions continue in regards to the formation of a Digestive Diseases Unit (DDU) and the required movement of Gastroenterology to the Pembury site, which continues to be delayed due to the second wave of the COVID-19 Pandemic. The Upper GI service is continuing to increase its portfolio of services. Discussions are continuing with our relevant CCG partners in regards to the commissioning of Bariatric Surgery at Tunbridge Wells. Furthermore, the department is looking to insource support for the restart of PH Manometry and Bravo Capsules with a view to providing this service for the Kent area. Finally, AR Manometry and our Pelvic Floor clinic offering will be restarting by the end of April 2021, following an equipment upgrade.

Objective	Criteria	Progress
b) Development of a Hyper-Acute Stroke Unit (HASU)		**This criterion has not been achieved due to reasons stated below.** The implementation plan for three hyper-acute stroke units (HASUs); one of which will be at Maidstone Hospital has not progressed due to: a) Lack of feedback from the Secretary of State for Health on the appeal made by Medway Council for a review of the decision-making process on the three HASU sites. b) Delays due to the OBC approval process. c) COVID-19 pandemic impact leading to delays. In response to the COVID-19 challenges MTW put in place two stroke rehabilitation initiatives - home rehabilitation with Hilton Nursing Partners and stroke rehabilitation beds at Sevenoaks Hospital. It is imperative stroke rehabilitation is working effectively for the successful functioning of the HASU/ASUs. In response to the delays and a lack of confirmation of the capital development timeline MTW have: a) Consolidated stroke inpatient services on the Maidstone site. b) Developed 46 acute beds to cope with the increase in activity as a result of the Medway stroke unit closure. c) Increased staffing levels to ASU national guideline levels. d) Developed the specialist stroke rehabilitation pathways. e) Improved the flow through the ASU. f) Implemented an assessment bay to improve patient care and facilitate patient flow through the Emergency Department (ED) g) Implemented a telephone and video triage process with SECAMB to ensure the right patients are transported to the right care setting. The outcome of implementing all of the above actions is that despite the COVID-19 pandemic and resulting challenges, the Trust achieved a 'B' SSNAP rating, the majority of stroke staff posts are recruited to and staff training and development continues. The first four months of the remote triage with SECAMB resulted in 140 patients being diverted away from Maidstone ED. Due to the delays with the stroke unit build, a review of the stroke flow has been undertaken and low-level works are being recommended to continue to improve the service. This will be

Objective	Criteria	Progress
		progressed through May 2021.

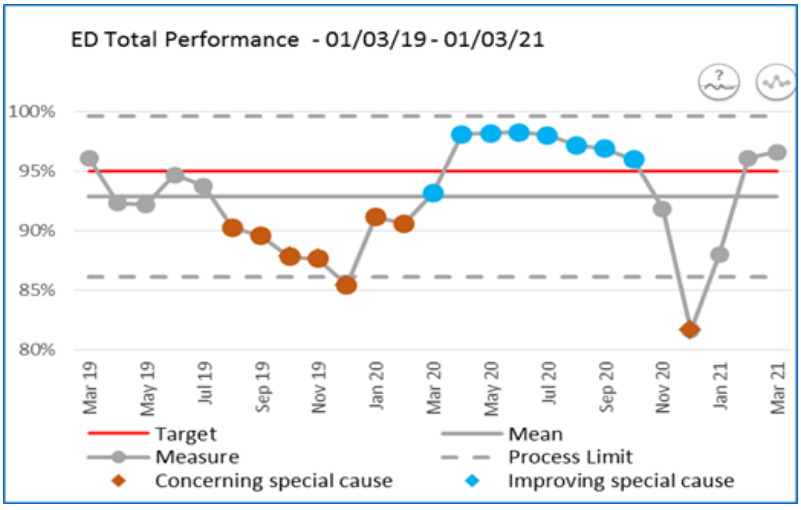
Ambulance handover targets

	Maidstone Target	By Quarters	Tunbridge Wells Target	By Quarters
% of handovers exceeding 30 mins	5.00%	End Q1 6%	5.00%	End Q1 10 %
		End Q2 5%		End Q2 7%
		End Q3 5%		End Q3 5%
		End Q4 5%		End Q4 5%
% of handovers exceeding 60 mins	0.10%	All quarters the same	0.20%	End Q1 0.4%
				End Q2 0.4%
				End Q3 0.3%
				End Q4 0.2%

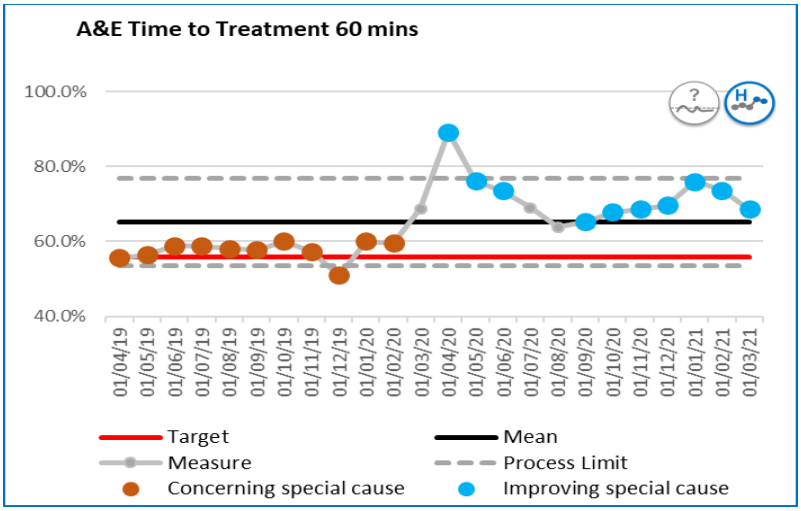
Further Review of Quality Performance

In addition to the information and tables provided in the above section reviewing progress against the 2020/21 quality priorities, other measures of quality performance are displayed below.

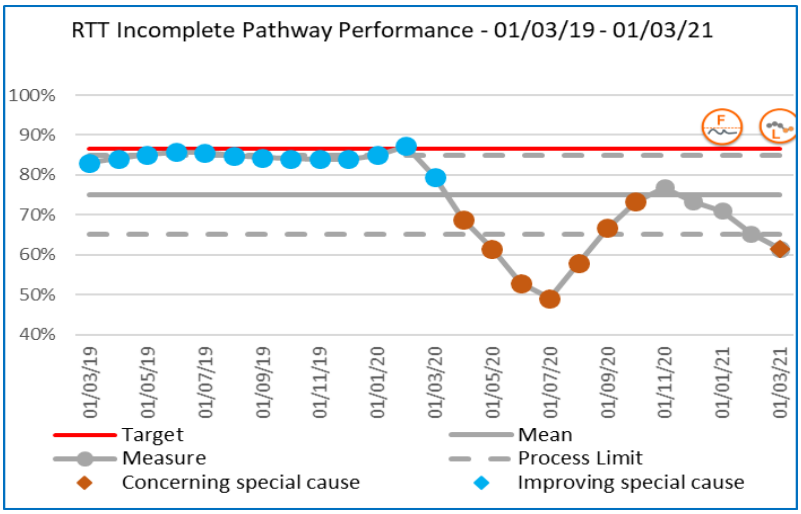
Emergency Department (ED) 4-hour access – the Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its Emergency Departments in 2020/21. The Trust was above the Trust's planned recovery trajectory for the year at 94.7% against the target of 88.0%. There was a significant drop in Type 1 ED Attenders of 21.9%, driven by the COVID-19 pandemic.



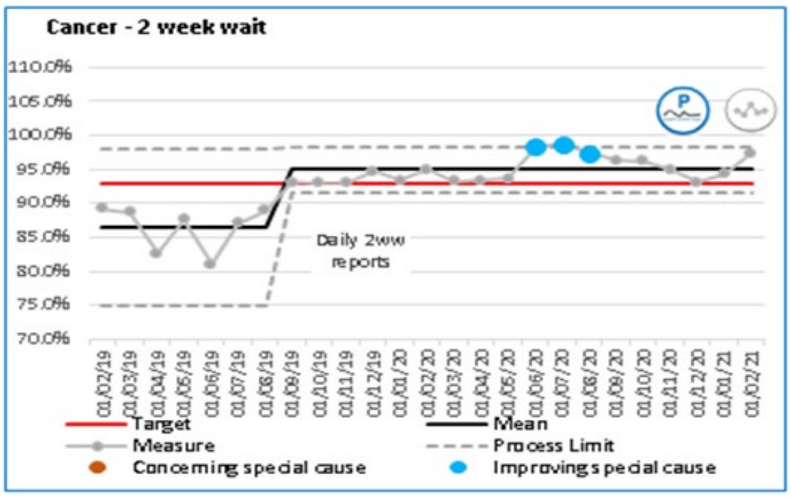
Emergency Department Time to Treatment <60 minutes – the Trust achieved this standard of 55.9% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 71.8%. This is a significant improvement on last year's figure of 58.5%.



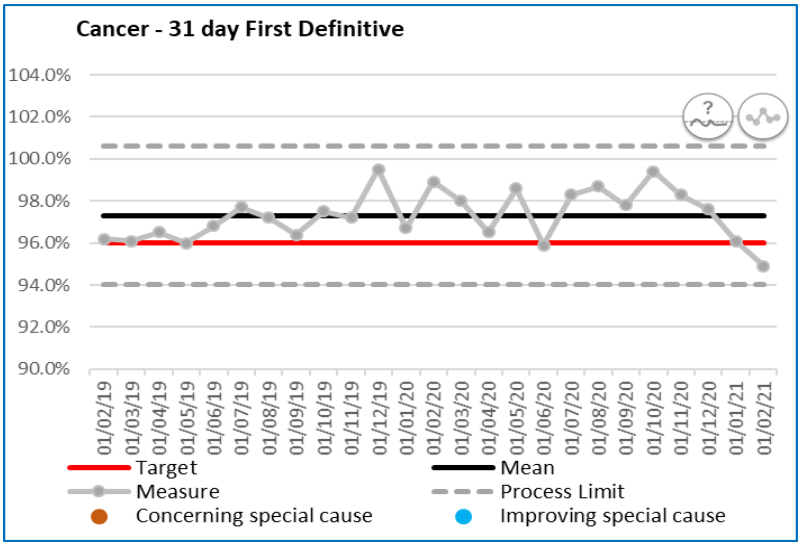
18 weeks standard – the Trust did not achieve the national standard of 92% of patients on an Incomplete Pathway being treated within 18 weeks, predominantly driven by the COVID-19 pandemic. A process has been established to review patients on waiting lists to ensure they do not come to harm whilst waiting for procedures / treatment.



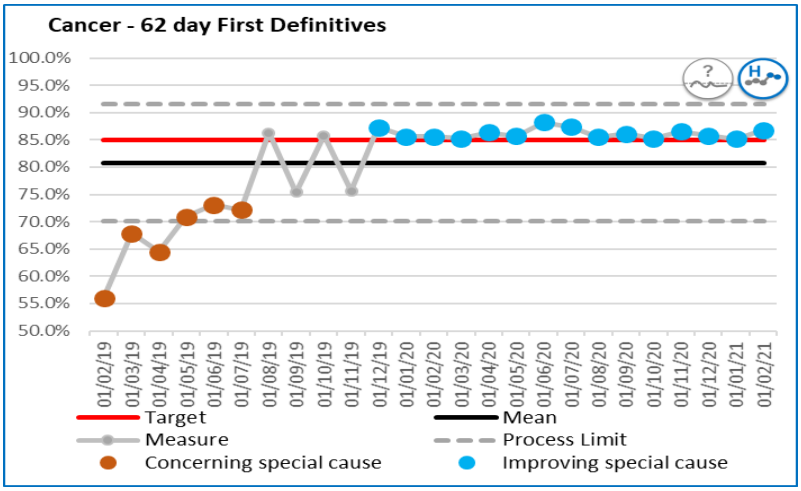
Cancer Waiting Time Targets: 2 weeks from referral – the Trust has consistently achieved this standard of ensuring that 93% of patients with suspected cancer are seen within two weeks throughout 2020/21 at 95.8%. This is a significant achievement both against the previous year and throughout the COVID-19 pandemic.



Cancer Waiting Time Targets: 31 day first definitive treatment – the Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.

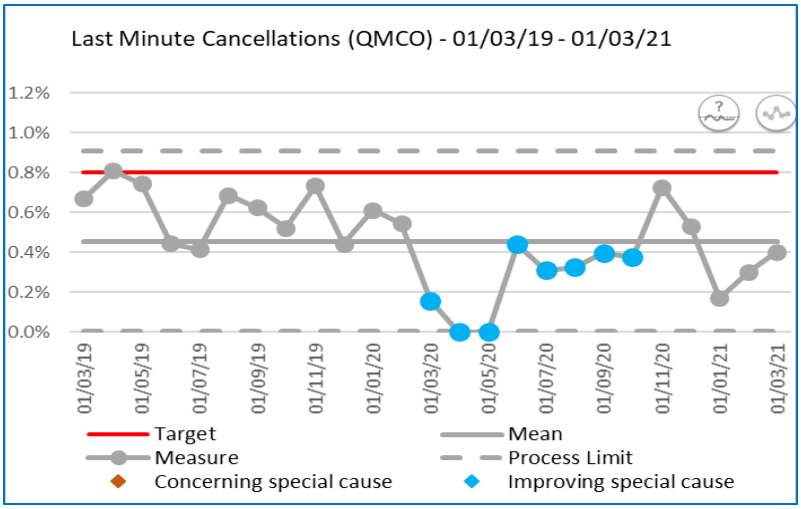


Cancer Waiting Time Targets: 62 day first definitive treatment – the Trust achieved this standard of 85% of patients who needed to start their first definitive treatment within 62 days throughout 2020/21 at 86.3%. This is a significant achievement both against the previous year and throughout the COVID-19 pandemic.



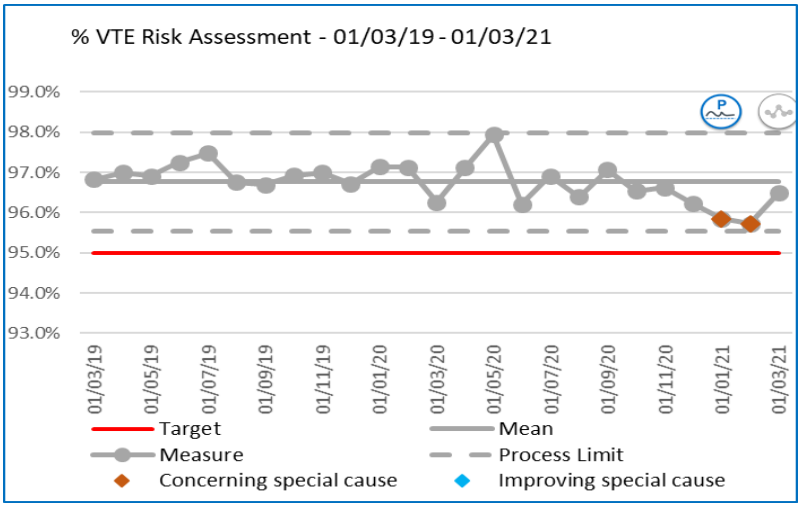
All three of the cancer targets were met in 2020/21, a significant achievement compared to 2019/20. This is a picture the Trust is committed to continuing to deliver during 2021/22.

Cancelled operations – the Trust achieved this standard with 0.3% of operations cancelled at the last minute against the national maximum limit of 0.8%. In order to achieve this, a Task and Finish group was established, which focused on monitoring cancellations in order to rectify trends that occurred.



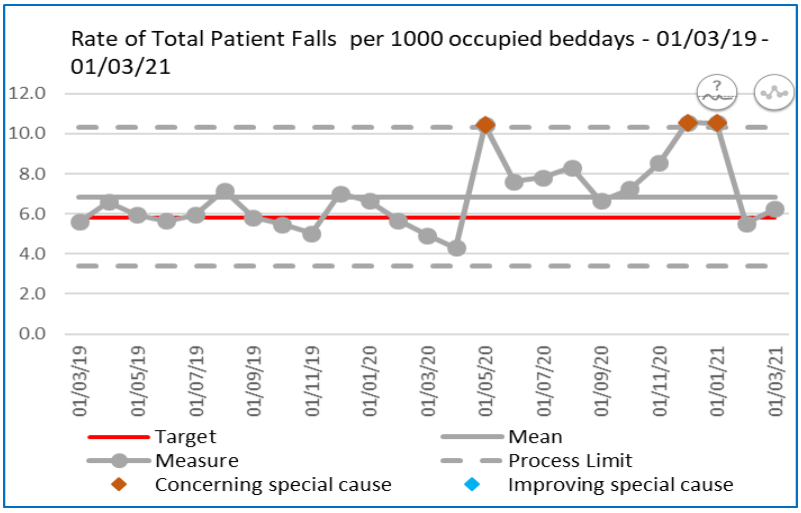
Prevention of Venous Thromboembolism (VTE)

The Trust ensured that the national target of 95% of patients had a VTE Risk Assessment completed on admission to hospital in 2020/21 with an overall score of 96.6%.



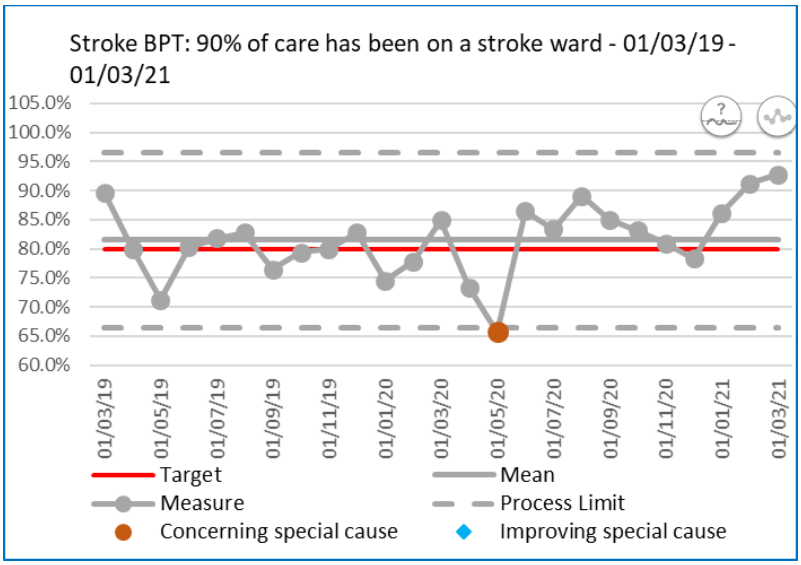
Reducing the number of patient falls

The Trust's rate of falls per 1,000 Occupied Bed days is above the Trust maximum limit of 6.0 at 7.8 at year end (6.9 for the previous year). Fall rates increased considerably during wave 2 of the COVID-19 pandemic, but have subsequently improved.



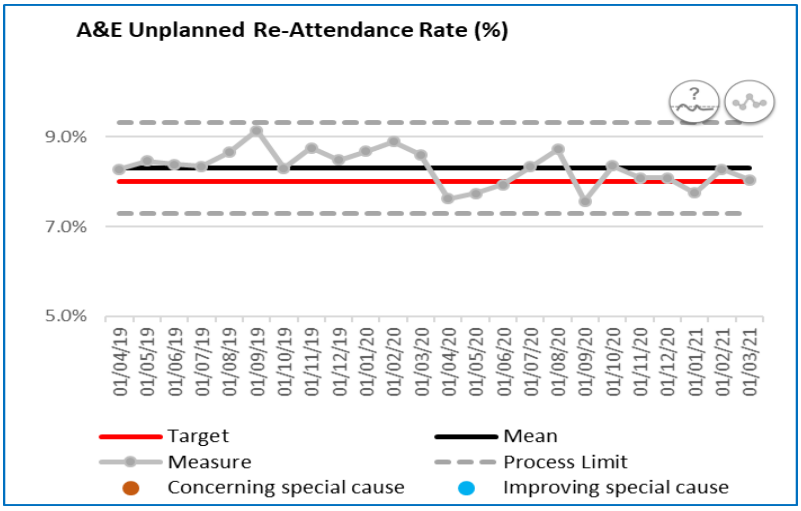
Improving care for patients who have had a stroke

The Trust achieved the standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2020/21 at 92.8%, compared to 77.8% in 2019/20.



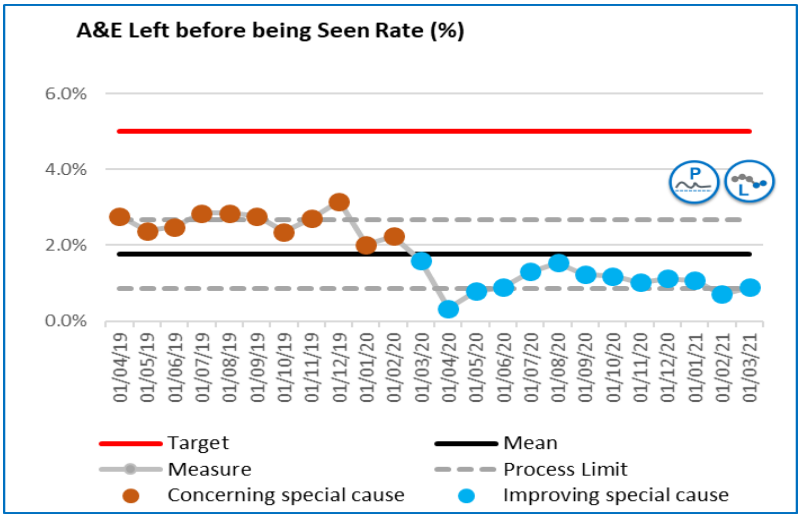
Emergency Department Unplanned Re-attendance Rate

The Trust achieved this standard of less than 8% unplanned re-attendance rate at 8%.



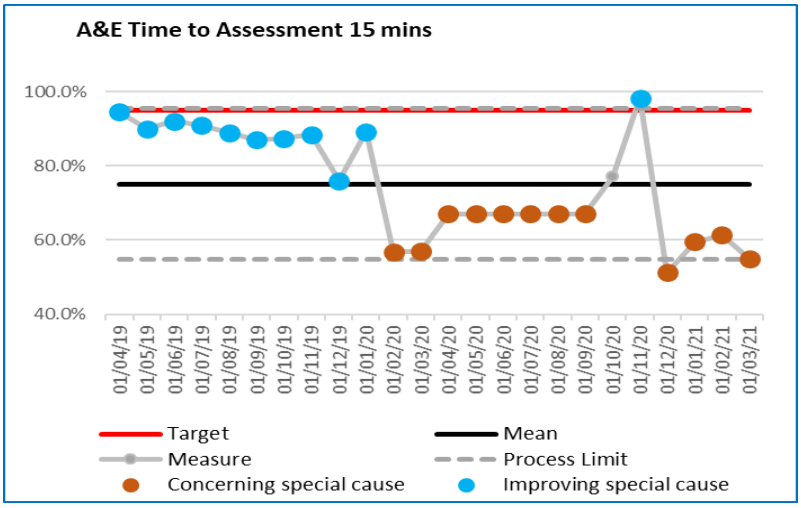
Emergency Department Left without being seen rate

The Trust achieved this standard of less than 5% of patients leaving the Emergency Departments without being seen at 1%. This is an improvement compared to 2.5% in 2019/20



Emergency Department Time to Initial Assessment <15 minutes

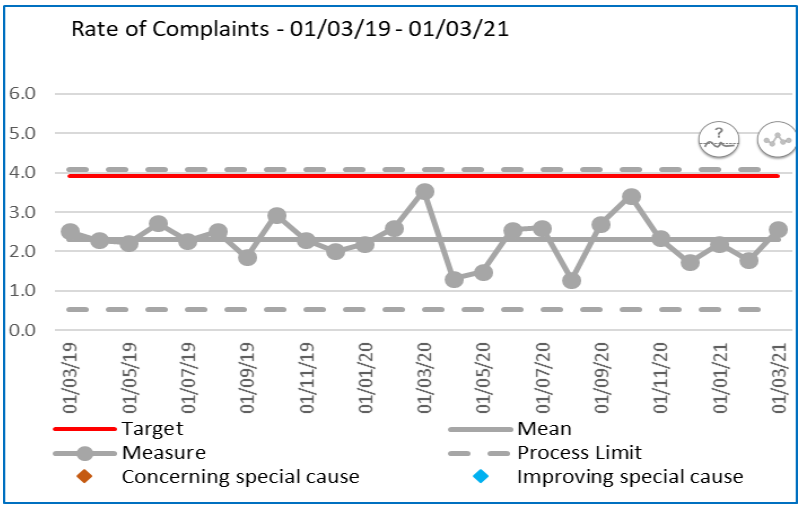
The Trust did not achieve this standard of 95% of patients arriving in the Emergency Departments being assessed within 15 minutes of arrival at 67.1%.



Complaints

The number of formal complaints received by Maidstone and Tunbridge Wells NHS Trust in 2020/21 significantly decreased. This was a direct result of the COVID-19 pandemic, which saw a reduction in clinical activity for periods during the year, coupled with an assumed increase in support for the NHS by the public.

The Trust's rate of new complaints per 1,000 occupied bed days is within the expected range of between 1.318 and 3.92 at 2.20 for the year (2.40 for the previous year).



On 31 March 2020, NHS Improvement/England issued guidance to all NHS healthcare providers, recommending that the complaints system be 'paused' for an initial three-month period. Emphasis was placed on the need to continue to maintain any Patient Advice and Liaison Service (PALS, or equivalent) to ensure that any incoming complaints/concerns could be

triaged on receipt. Triaging would ensure all immediate appropriate action could be taken should the complaint/concern identify a serious incident, safeguarding or competency issue.

All complaints open at that time were reviewed by the Complaints and PALS Manager to identify which could be completed with no or minimal input from the patient facing clinical teams. Those complaints, which could not be progressed without moderate/significant input from the front-facing clinical teams were 'paused' in line with the recommendations. All affected complainants were contacted to advise them of the situation.

At the same time, all face to face services offered by PALS and complaints were suspended. This was to support the national lockdown, government instruction to 'stay home' and to ensure the safety of staff. The PALS offices were closed to personal callers (attending the actual office in person), but remained accessible to the public via telephone and email. Any complainant awaiting a local resolution meeting was contacted and advised that this would be postponed indefinitely at that time and they were offered the opportunity to receive a further written response instead. In mid-May, the complaints leads were issued with laptops and the team began to organise virtual local resolution meetings using WebEx.

The 'pause' ended on 30 June 2020. A full complaints service resumed, although local resolution meetings continue to be held virtually. The PALS offices have remained closed to personal callers, in order to maintain COVID-19 secure environments. Going forward, this will be reviewed in line with the national roadmap and local arrangements.

Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints England Regulations 2009)

The Trust has a statutory duty to investigate and respond to complaints in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the regulations). This statutory obligation is further supported by the Trust's values – PRIDE – which highlight the importance of being patient-focused and striving for continuous improvement. Whilst complaints are often considered to have a negative connotation, we recognise that they are also a valued method of feedback and can highlight shortfalls in current practice or policy. This feedback is essential in helping us to improve the quality of our services and the way in which we engage with our patients and their visitors**.** This includes being open and honest and saying sorry when it is required.

Quote from a complainant:

'I wanted to acknowledge how thorough and personal the response was – it addressed elements of our complaint in a pragmatic and understanding way and I am pleased that the overall complaint was upheld……The written response has gone a long way in addressing our concerns and it is encouraging to hear of the specific actions taken as a result.'

During 2020/21 we received 389 new complaints, compared to 562 in 2019/20. We aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of receipt, depending on the severity of the complaint. We achieved performance of 71.3% for the year, against a target of 75%. As might be expected, performance has varied during the year in line with activity levels linked to the management of the COVID-19 pandemic. However, the Trust achieved or exceeded 75% for seven months of the year, peaking at 96.8% in August.

An annual report on Complaints and PALS (Patient Advice and Liaison Service) activity including learning and outcomes is produced and presented to the Patient Experience and Quality Committees. Quarterly reports are provided to the Patient Experience Committee on activity and actions taken in response to complaints and an interim update report is provided to the Quality Committee in January on the same. Case studies and key messages from complaints are regularly included in the Trust's monthly Governance Gazette. The Gazette is an electronic newsletter used as a tool for sharing learning and other information from the Quality Governance team.

COMMUNICATION CORNER

We recently responded to a complaint from a patient with a hearing impairment, who had a poor experience when attending an outpatient clinic. The patient received no support in terms of her hearing loss, despite her informing the clinic receptionist on arrival that she was profoundly deaf and lip reads. The only seat in the waiting area was positioned somewhere the patient could not see the staff. After an hour, the patient enquired and was told that her name had not been called, but a short while later, the patient was collected by a nurse who told her that she "hadn't been listening" and her name had been called an hour ago.

On investigation, one of the points that was identified was that there was no flag on Allscripts to alert staff to this patient's hearing impairment and this was not identified by staff on her arrival at the clinic.

This case is a good example of the importance of us meeting the **Accessible Information Standard**. This is a statutory requirement placed upon us to ensure that service users receive information in a format that is accessible for them.

How you can help

- **ASK** if people have any information or communication needs and find out how to meet those needs.
- **RECORD** those needs and consent in a way that is highly visible on the electronic and / or paper record.
- **FLAG** on the person's electronic record and put a communications need sticker on their paper record
- **SHARE** information about the person's needs with other teams, services, agencies and providers during referral, discharge or handover.
- **ACT** to make sure people get their information in the way they have requested and have their communication needs met.

Patient Surveys

The Trust employs a range of methods to gather feedback from patients including three different forms of patient surveys:

- National patient experience surveys
- Local patient surveys
- The Friends and Family Test (FFT).

These each provide a different insight into the experience of our patients and enable us to develop services to meet the needs of our patients and their loved ones.

National Patient Experience Surveys

The Trust participates in the national annual patient experience survey programme and undertakes all national surveys stipulated by the Care Quality Commission (CQC) each year.

During 2020/21 the Trust participated in three national patient surveys: Urgent and Emergency Care (UEC) Survey, Inpatient Survey and Children and Young People's Survey. The surveys were undertaken by Quality Health for our Trust. At the time of writing the results for the Urgent and Emergency Care (UEC) Survey had been released to the Trust but these are embargoed

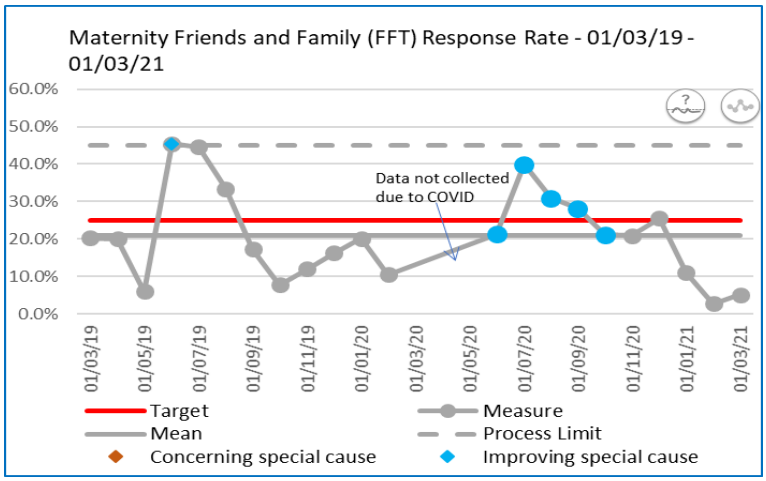
until they are released nationally later in the year. The Trust awaits the results for the Inpatient Survey and the Children and Young People's Survey.
Due to the COVID-19 pandemic the Maternity survey was cancelled and the Trust chose not to participate in the National Cancer Patient Experience Survey, which became voluntary to undertake. The Trust will be taking part in the Maternity Survey in 2021.

Friends and Family Test (FFT)

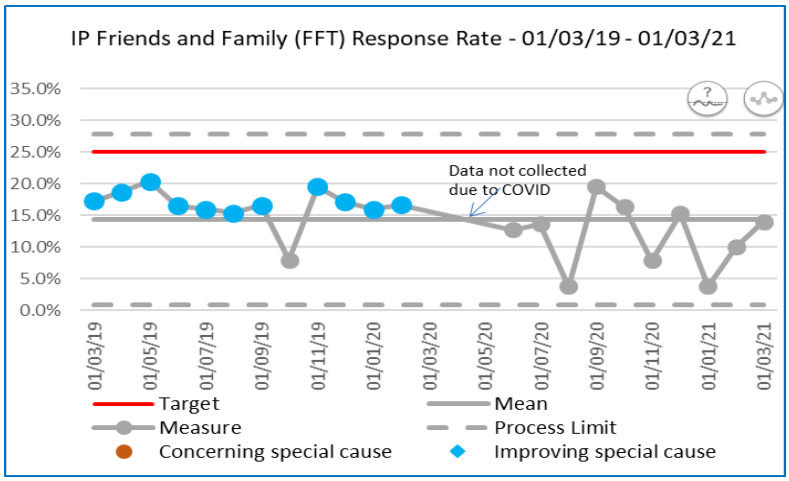
Friends and family feedback submission was stopped temporarily during the first wave of the COVID-19 pandemic. The data submission discontinued in accordance with NHSE/I guidelines. The organisation received instruction to recommence submission of December's data for the January reporting period; this was during the second peak of the pandemic. Due to these circumstances, submission was not as expected in the same reporting period for the previous years.

Submission of feedback increased significantly in the month of March 2021 when the peak of the pandemic had subsided. We are working towards a higher rate of submission to capture larger feedback in order to evidence and action future change. We have moved towards electronic submission, which provides immediate capture and analysis.

The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to patients after giving birth with a result of 20.7%. Of all the responses received for patients accessing Maternity Services 97.6% were positive. Data was not collected for April and May 2020 due to the COVID-19 pandemic.



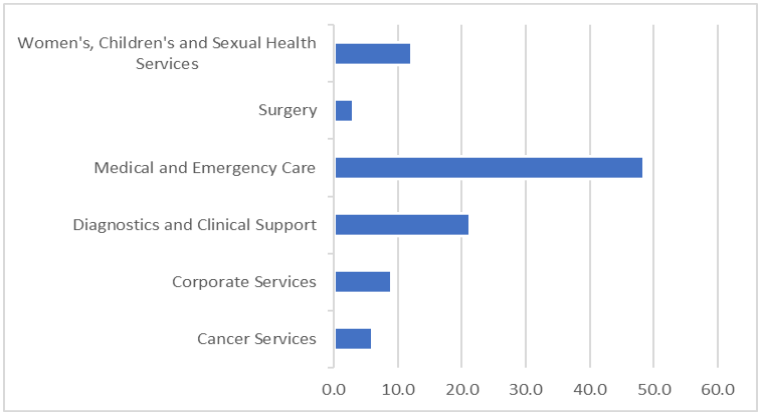
The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients with a result of 14%. Of the responses received 96.1% were positive. Data was not collected for April and May 2020 due to the COVID-19 pandemic.



Local Patient Surveys

All local surveys that are registered with the Patient Outcomes team are entered into a database and their progress is followed up to monitor completion. 33 local patient surveys were registered with the Patient Outcomes Team during 2020/21. Final reports with action plans were submitted to the Patient Outcomes team for 9 (27%) surveys. There were a high number of surveys that were put on hold due to the COVID-19 pandemic and staff being redeployed.

Directorate	No	%
Women's, Children's and Sexual Health Services	4	12.1
Surgery	1	3.0
Medical and Emergency Care	16	48.5
Diagnostics and Clinical Support	7	21.2
Corporate Services	3	9.1
Cancer Services	2	6.1
	33	



An action plan database has been populated to monitor implementation of actions arising from the local patient surveys. This will capture evidence of developments to improve patient experience.

Staff Survey / WRES

Staff Survey 2020, WRES 2020, WDES 2020

This section outlines our most recent staff survey results from 2020 with a focus on the experiences of staff regarding harassment, bullying, abuse and discrimination; equal opportunities in terms of career progression and reasonable adjustments for staff with disabilities.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
White staff: 20.0% (2019 findings 25.8%) – national average for acute Trusts is 24.4%

BAME staff: 27.4% (2019 findings 26.9%) – national average for acute Trusts is 29.1%

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

White staff: 87.2% (2019 findings 86.4%) – national average for acute Trusts is 87.7%

BAME staff: 75.1% (2019 findings 74.2%) – national average for acute Trusts is 72.5%

Percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months

White staff: 5.8% (2019 findings 6.4%) – national average for acute Trusts is 6.1%

BAME staff: 16.5% (2019 findings 13.3%) – national average for acute Trusts is 16.8%

Very little has changed since 2019 but we have seen a 3.2% increase in the number of BAME staff who have experienced discrimination from staff. This is also reflected in the average national increase of 2.6%.

Percentage of staff experiencing harassment, bullying or abuse from their manager in the last 12 months

	2019	2020
MTW: staff with a LTC or illness	23.8%	20.6%
MTW: staff without a LTC or illness	10.3%	10.7%
Average: staff with a LTC or illness	18.5%	19.3%
Average: staff without a LTC or illness	10.8%	10.8%

*LTC – long term condition

Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

	2019	2020
MTW: staff with a LTC or illness	28.7%	26.3%
MTW: staff without a LTC or illness	18.6%	18.4%
Average: staff with a LTC or illness	27.7%	26.9%
Average: staff without a LTC or illness	17.5%	17.8%

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

	2019	2020
MTW : staff with a LTC or illness	74.4%	77.6%
MTW : staff without a LTC or illness	86.0%	86.2%
Average : staff with a LTC or illness	79.3%	79.6%
Average : staff without a LTC or illness	86.1%	86.3%

Percentage of staff agreeing that they have had reasonable adjustments made to enable them to carry out their work

	2019	2020
MTW : staff with a LTC or illness	68.3%	76.3%
Average : staff with a LTC or illness	73.4%	75.5%

There has been little change from the 2019 results with the exception of a 7% increase in the number of staff receiving reasonable adjustments to help them undertake their role. All results are in line with the national average of acute Trusts in England.

Staff Networks

The Cultural and Ethnic Minorities Network have provided additional support to our BAME staff over the last year by hosting twice monthly meetings. These meetings enabled our BAME staff to discuss the issues affecting them by COVID-19 and the killing of George Floyd. Over time the meetings have evolved into learning sessions with speakers from MTW and outside the Trust, including our local MP Helen Grant. The sessions have been open to all MTW staff.

The LGBT+ Network have struggled to move their usual activities and celebrations during the year to the virtual environment and are very much looking forward to returning to a face to face environment in the coming months.

The Disability Network was re-launched at the end of 2020 and is in the early stages of forming the committee. They are dedicated to supporting the learning and development of staff and managers to aid their support of staff who have disabilities or have long term health conditions.

Focus for 2021/22

- **Safe Space Champions Network** – developing a network of staff who are trained and supported to provide a listening ear to staff with worries and concerns. Developing staff confidence to tackle issues or signpost to alternative support.
- **Mediation provision** – developing a robust mediation process, which provides facilitated conversations and mediation to help resolve workplace issues and concerns.

- **EDI Recruitment Champions** – developing a network of staff who are trained in how to provide challenge within the recruitment process to ensure fairness and equity.
- **BAME Mentoring Programme** – developing opportunities to train staff in mentoring skills to provide support to BAME staff in bands 5 – 7 to help develop their career within MTW.
- **Reverse Mentoring Programme –** launch first cohort of the programme with a focus on the lived experiences of BAME staff paired with members from the Trust Board, including all Executives and Non-Executive Directors.
- **White Ally Programme –** developing a programme of learning to support white staff to become active allies for our BAME colleagues.
- **Talent Boards** – creating talent boards with effective stretch assignments, with a focus on BAME staff in bands 5 – 8A.
- **Reasonable Adjustments Passport** – design and launch a reasonable adjustments passport that supports discussions with managers for staff with long term health conditions to ensure that adjustments are made and reviewed regularly.
- **Disability Leave Policy** – introduce a policy that reflects the differences between disability related sickness and disability leave.

Freedom to Speak Up (FTSU)

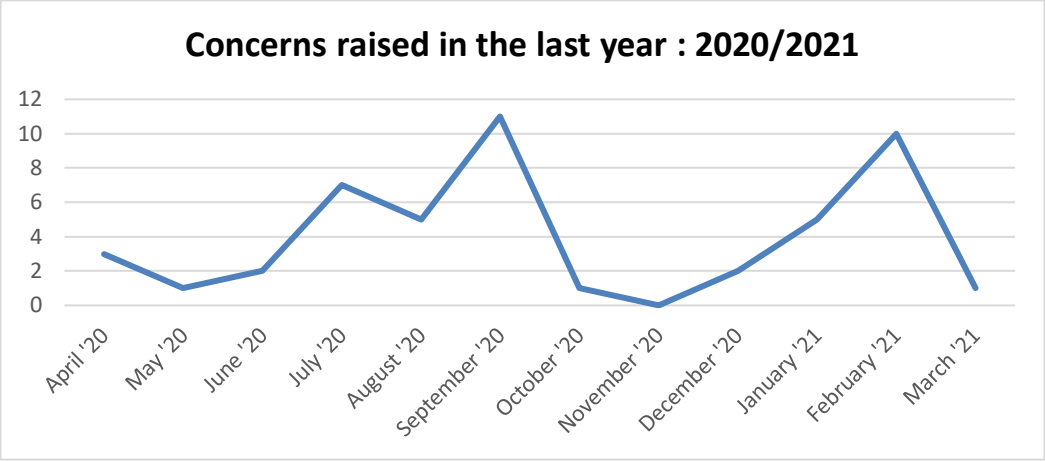
The Freedom to Speak Up (FTSU) agenda is to:

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

By ensuring that:

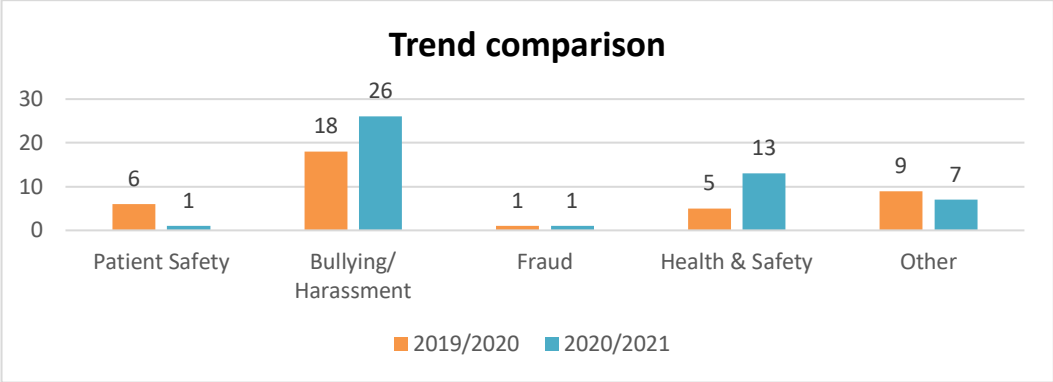
- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

During 2020/21 49 cases were raised through FTSU, an increase of 10 cases compared to 2019/20. As the lockdown started to ease in June 2020 and more staff were returning to work on site there was a significant increase in cases. September had the highest recorded number of cases raised. As the number of COVID-19 cases began to increase for the second wave across the UK and in the Trust with new lockdown rules being introduced, the number of concerns raised through FTSU decreased initially but began to gain traction in January/February 2021.



Trends comparison

In comparison to 2019/20, the highest number of concerns raised through FTSU were concerns around bullying/harassment and health and safety, an increase of eight concerns for each. In regards to patient safety, there was a huge decline, with only one concern raised in 2020/21, compared to six concerns in 2019/20.



Progress in implementing the FTSU strategy

In addition to the number of concerns raised and in spite of the vaccine roll out during the previous quarter, the following actions have been successfully achieved by the FTSU guardians to further promote the agenda:

- FTSU Guardians continue to attend various network meetings and provide support to staff who raise concerns through the networks
- Materials /screensavers for publicising the FTSU agenda are now available and have been put up in staff areas on both sites
- An interview was held with Peter Maskell, Medical Director, in January to promote the FTSU agenda
- BAME lived experience session was held with the BAME allies in January and a follow up meeting was held to discuss action plans, which are currently been implemented
- A Freedom to Speak Up presentation and facilitated conversation took place on 25th February during the Cultural and Ethnic Minority Network meeting; this enabled BAME staff to share some of their experiences and the support they receive
- The FTSU guardians, in partnership with the Learning and Development team, have worked closely in embedding the FTSU agenda in Trust inductions
- The process of recruiting Safe Space Champions to work closely with EDI and FTSU team is ongoing. In March, a pilot training to review the content of the presentation was

conducted with representatives from various networks. The Learning and Development team were also in attendance.

Growing the Speaking Up Agenda

The National Guardian office, in partnership with Health Education England, has launched two 'Speaking up' themed e-learning packages for all workers and line managers. This training will be very useful for promoting the FTSU agenda. The first module, ***Speak Up***, is for all workers while the second module***, Listen Up***, is for managers. Both modules focus on listening and understanding the barriers to speaking up. A final module, ***Follow Up***, for senior leaders, will be launched later in the year to support the development of FTSU as part of the strategic vision for organisations and systems.

Work is being undertaken with the Learning and Development team to include these modules in the MTW e-learning system with the recommendation that this should be a mandatory course for all MTW staff with subsequent refresher training every three years.

Rota Gaps

In August 2020 there were no gaps identified at Foundation Year 1 (FY1) level or at Foundation Year 2 (FY2) level. In addition, we were allocated three additional F2s for August 2020 in order to support the increased intake into GP training programmes in line with the People Plan. Due to the continuing proactive approach by Medical Staffing in the early advertising for prospective gaps we did however recruit three supernumerary FY2s locally. This helped reduce the reliance on agency doctors for gaps through sickness absence, etc. The few gaps at a senior level did not cause a detrimental impact. Overall the fill rate was very good across all specialties, including an additional training post in Clinical Radiology.

In addition, we have a number of key initiatives supported by our Medical Education Department:

- Clinical Fellowship Programmes: There are a number of established Fellowship Programmes in the Trust, particularly in the Emergency Medicine Department and the Anaesthetic Department.
- Senior Clinical Fellows: The Emergency Medicine Department has an ongoing four year Senior Clinical Fellow Certificate of Eligibility for Specialist Registration (CESR) programme. The programme entails undertaking essential secondments in Anaesthetics, ITU, Paediatrics and Acute Medicine to complete the Curriculum requirements.
- The Widening Access to Specialty Training (WAST): This is a national Health Education England scheme for overseas doctors to gain experience in the UK in order to better prepare them for application to their chosen specialty training programme. Trust post numbers were increased; however in the event only one WAST doctor joined the Emergency Medicine Department on a year's placement. This doctor has remained in the Trust in the Acute Medicine Department.
- One Chief Medical Registrar was appointed in October 2020, at Tunbridge Wells Hospital, under the Royal College of Physicians programme. The Chief Registrar undertakes this 50% clinical and 50% management role whilst in their training programme.

- Medical Training Initiative (MIT): Anaesthetics, Paediatrics and Obstetrics & Gynaecology have recruited overseas doctors through this training initiative.
- Physicians Associate and Advanced Practitioner roles continue to be recruited to and provide multi-professional support to our services and rotas.

This approach is ongoing and will continue for the medical intake in August 2021; updates are provided to the Trust's Workforce Committee.

The Trust followed Health Education England directives during the peak periods of the COVID-19 pandemic. In line with this guidance Trainee rotations that were due to take place in April 2020 did not occur, with Trainees remaining in their original placements. However, for operational reasons a number of Trainees were redeployed and F2 doctors in GP Practice and F1s in Community Psychiatry were brought back to the Acute Trust to support Emergency Medicine and Medicine. During the second wave, the directive was that training should continue and planned rotations took place. During the peak of the second wave it was necessary to seek Postgraduate Dean approval to bring some Trainees back to the Trust from their GP community placements; however this was only for a 2-4 week maximum period.

Learning from Serious Incidents and Never Events

Serious Incidents

To ensure that there is a system of learning from serious incidents and never events we have a robust reporting, investigation and learning process in place. All serious incidents (SIs) are reported on StEIS (Strategic Executive Information System – the system which supports the monitoring of investigations between NHS providers and commissioners) and this has to be done within 48 hours of the SI being identified. The Patient Safety team identify themes and trends to help reduce risks going forward and learning is shared with the Directorates, both by sharing the final investigation report and a monthly learning report. Due to the COVID-19 pandemic, the face to face Trust-wide learning events were postponed. The Patient Safety team plan to launch "virtual" Learning Events in 2021/22 where staff and stakeholders will be invited to attend.

All SIs are assigned a lead investigator outside of the service where the incident happened and also a Directorate link from the service involved in the incident. A root cause analysis (RCA) is completed using recognised investigative tools (e.g. five whys, fishbone, human factors). Action plans are developed to share learning across the Trust to prevent recurrence of the same incident. In March 2020 the Trust updated the incident reporting management system (Datix) to a fully web-based system, which now enables actions to be monitored on the system.

The Trust declared 129 SIs in 2020/21; compared to 131 in 2019/20, which decreased to 113 following 18 downgrades granted by the Clinical Commissioning Group. The number of downgrades for 2020/21 is awaiting validation so the figure of 129 may reduce.

Never Events

"Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective factors are available at a national level and should have been implemented by all healthcare providers."

NHS Improvement, 2018

Two 'Never Events' were declared at the Trust in 2020/21. Full RCA investigations were undertaken for the two events and presented to the Executive-led SI Panel. The findings were shared with NHS Improvement to ensure wider learning. The incidents were subject to scrutiny through the serious incident investigation process with the aim of ensuring that lessons are learnt to prevent recurrence.

Actions and learning from SIs are key to improving safe, effective and high-quality patient care. In 2020/21 learning and actions included:

- Introduction of competencies that allow extended roles for experienced nurses.
- Human factors training in place to help change the culture to enable junior staff to challenge senior staff effectively.
- Introduction of Pressure Ulcer Champions and Link Nurses.
- Review, implementation and dissemination of revised Terms of Reference for the Slips, Trips and Falls Group.
- Robust Standard Operating Procedure for security officers working in the Emergency Department to be written, agreed and disseminated across the teams.
- New interim local protocol implemented, identifying that any chest x-rays requested for confirmation of NG tube placement should be reviewed by reporting radiographers, consultant radiologists and consultant anaesthetists to confirm safe placement prior to commencing feed.
- Immediate review of e-learning package against national patient safety alert for enteral feeding and implementation of a working group to establish and implement competencies to run alongside the e-learning package.
- Clarification of roles and responsibilities and education on the new Tele-tracking system.

Actions completed by the Patient Safety Team in 2020/21:

- A training package and schedule was put in place for joint root cause analysis (RCA) with Kent and Medway NHS and Social Care Partnership Trust (due to the pandemic the training was put on hold in March 2020).
- Created and launched the new Performance Dashboard module on Datix.
- Delivered revised Duty of Candour training.
- Delivered Datix training Trust-wide.
- Established the Patient Safety Strategy Working Group to implement the revised Patient Safety strategy (established but postponed due to the pandemic).
- Wrote a briefing paper in preparation for the introduction of the Patient Safety Incident Response Framework (PSIRF) (implementation now on hold until Spring 2022).
- Nominated two Patient Safety Specialists to represent the Trust in the delivery of the NHS Patient Safety Strategy and PSIRF.
- Recruited two Serious Incident Investigators to the team to lead on investigations and identify learning and actions to improve patient safety.
- Launched the culture survey in March 2021 to ascertain feedback from staff around the incident reporting process
- Reviewed and strengthen processes for following up outstanding Duty of Candour notifications.
- Reviewed and strengthen how Duty of Candour is recorded on Datix.
- Implemented and embedded Duty of Candour dashboards for Divisions to easily identify outstanding incidents.

Next steps for the Patient Safety Team:

- To continue to report on monthly Key Performance Indicators.
- Complete quarterly compliance audits for Duty of Candour.
- To continue to deliver regular Duty of Candour training sessions Trust-wide.
- To increase support for staff having Duty of Candour conversations with patients and/or families in order to improve patients'/families' experiences.
- Implement the action plan developed in relation to the culture survey
- Recruit to substantive Governance Systems (Datix) expert role. This role will be the subject matter expert and will work with staff to make the system as user friendly as possible, therefor having a positive impact on incident reporting.
- Reinvigorate the working group set up in response to the National Patient Safety Strategy and accompanying action plan.
- Prepare for the rollout of PSIRF (currently planned for Spring 2022).
- Expand the pool of both incident and SI lead investigators in the Trust.
- Support clinicians through training sessions to investigate incidents robustly and in a timely way, with the patient/family at the centre of the investigation.
- Explore closer working with the Medical Examiner Service to ensure bereaved families have a positive experience of both Patient Safety and Medical Examiner services.

Seven Day Services

The national Seven Day Services Programme (7DS) is designed to ensure that patients, who are admitted as an emergency, receive high quality consistent care; whatever day they enter hospital. Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh, which involved a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted and are:

- Standard 1: Patient Experience
- **Standard 2: Time to Consultant Review**
- Standard 3: Multi-Disciplinary Team Review
- Standard 4: Shift Handover
- **Standard 5: Diagnostics**
- **Standard 6: Consultant Directed Interventions**
- Standard 7: Mental Health
- **Standard 8: Ongoing review in high dependency areas**
- Standard 9: Transfer to primary, community and social care
- Standard 10: Quality Improvement.

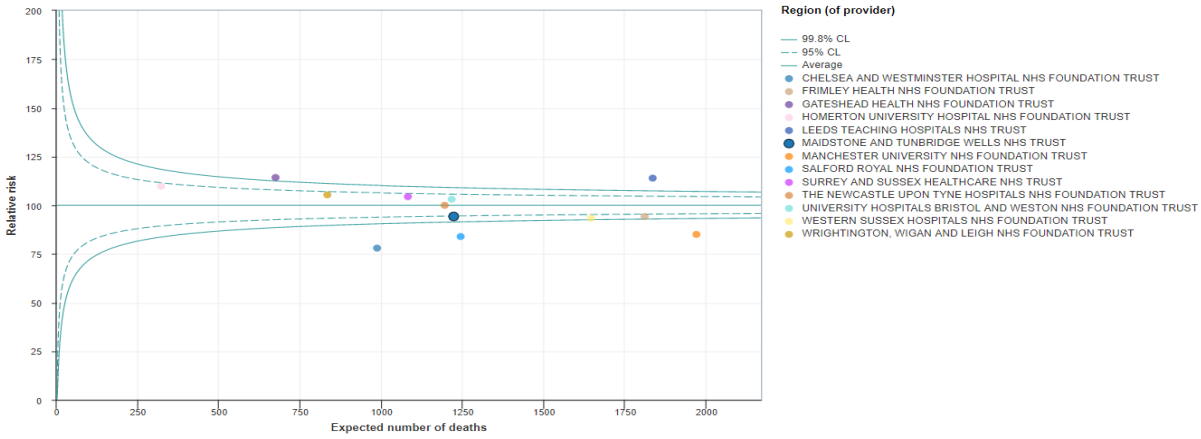
Those highlighted in **bold are the priority standards.*

Reviews against these standards were paused during 2020/21 due to the COVID-19 pandemic and will be re-established during 2021/22.

Learning from Deaths (Mortality Reviews)

During 2020/21 the Trust has continued to see mortality rates reduce overall in line with the reduction we previously evidenced in 2019/20. A slight increase has been seen in the most recent reporting period, which will be monitored closely at the monthly Mortality Surveillance Group and will be considered in the context of the second wave of COVID-19 experienced in November 2020 – January 2021. However, we are still performing below the expected rate of 100 (expected number of deaths). As we were achieving well against our peers in the region we made the decision to challenge ourselves further and are now benchmarking against NHS Acute Trusts who are recognised as being 'Good' or 'Outstanding' by the Care Quality Commission. This continues to demonstrate that we remain in a favourable position amongst our peers and compliance is at a sustained acceptable level.

HSMR Benchmarking – Good and Outstanding Trusts



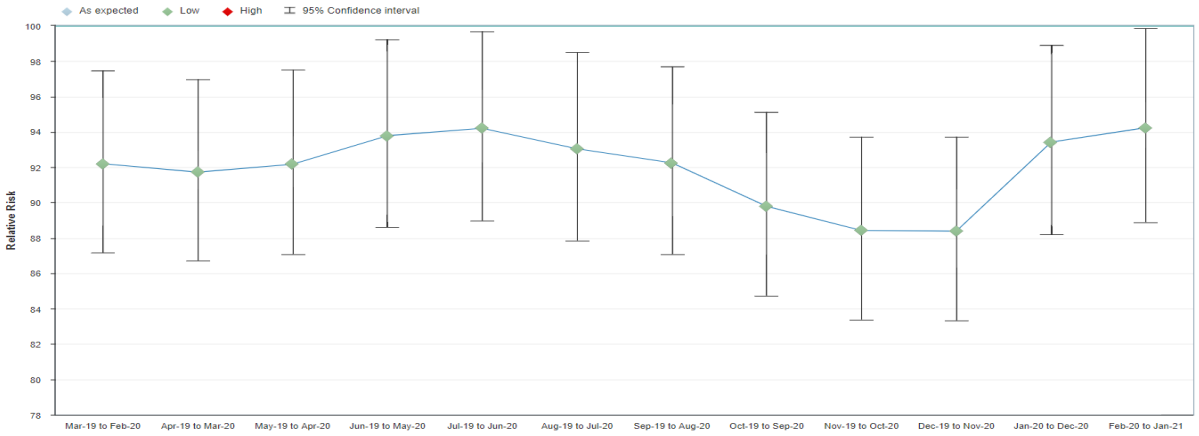
The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group reports directly to both the Quality Committee and the Trust Board. The chair of this Group is the Chief of Service for the Medicine and Emergency Care Division.

The MSG closely monitors both local and national data in an effort to identify themes and trends that may impact on the care our patients receive. The MSG uses both the Hospital Standardised Mortality Rate (HSMR) and Standardised Hospital Mortality Indicator (SHMI), which support us to benchmark amongst our peers but more importantly to look for any unusual trends or themes against particular diagnosis codes.

Both the HSMR and SHMI when tracked over time are also indicative of how successful a hospital has been in managing their deaths and improving upon the care provided.

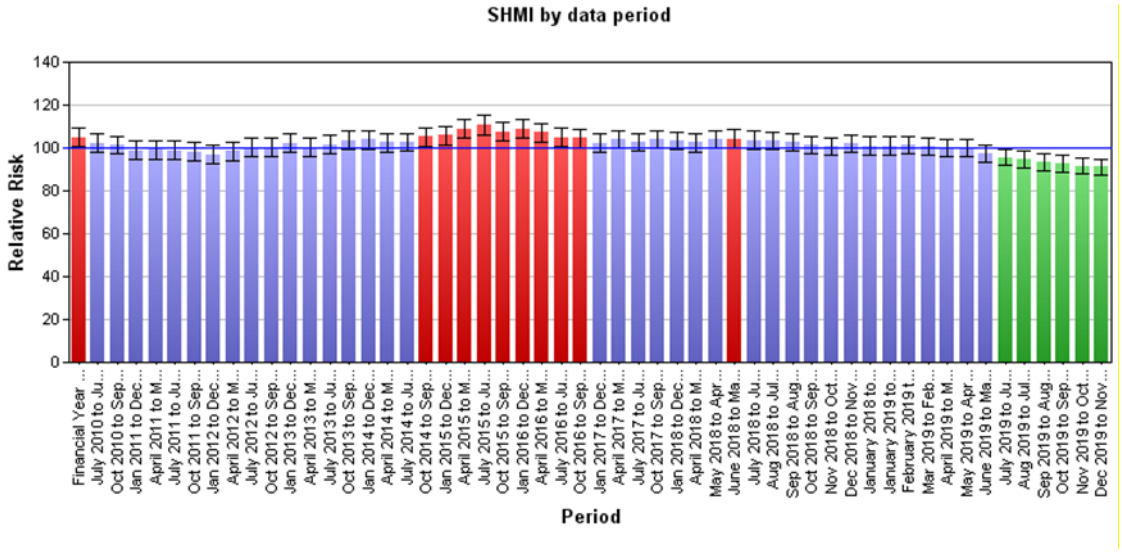
In March 2020 our HSMR was recorded as just below 92 (a ratio of the actual number of deaths to the expected number of deaths); in January 2021 we reported HSMR at 94.2. The expected rate is 100 or below.

HSMR Data from February 2020 – January 2021 (rolling 12-month view)



Further evidence of improvement in mortality at the Trust is seen in the SHMI, this is a measure of mortality and performance, which includes all deaths in hospital regardless of diagnosis. In addition, it includes all those individuals who die within 30 days of discharge from hospital.

The most recent SHMI data published by the Health and Social Care Information Centre (HSCIC) for the period December 2019 to November 2020 showed the Trust's SHMI as 0.9106, which was banded at level 2 'as expected'. As a Trust, our SHMI continues to improve, with 6 months consecutively as a positive outlier.



Each death that occurs in hospital is a sad and distressing event for the loved ones and staff involved in that person's care. For those deaths that are considered to be unexpected it is even more so. In this Trust we recognise our responsibility to review the care that was provided to our patients and when concerns are identified with the care provided, these deaths are then allocated for a more in-depth review (structured judgement review, SJR).

During 2020/21 the Trust recorded 1,905 patients who had died: 1,871 inpatient deaths and 34 in the Emergency Department (ED). The current mortality review process had already been identified as being labour intensive with learning having to be manually extracted. Funding had been approved to purchase the Mortality Datix IQ Cloud module; however, work to progress this was paused due to COVID-19. The module will be implemented in 2021/22. Once this is in place the process will be automated and will enhance our ability to analyse our themes and trends to support the 'Lessons Learned' agenda.

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

TIAA undertook an internal audit of the mortality review process in Maidstone and Tunbridge Wells and published their findings in February 2021. Their overall assessment of the process found "reasonable assurance". An action plan has been developed in response to the findings and this is being reported to and monitored by the MSG.

Reporting Period April 2020 – March 2021

Trust	Q1	Q2	Q3	Q4	Total
No of Deaths	387	313	576	629	1905
No of Completed Reviews	281	194	484	619	1578
% completed reviews	**72.6%**	**61.9%**	**84%**	**98.4%**	**82.8%**

In relation to the 1,905 patient deaths that occurred during 2020/21, 34 structured judgment reviews have been completed to date, equating to 1.78% of all deaths having had an in-depth review undertaken of the care that they received. Reviews are undertaken for several reasons, which include concerns with care provided; in addition the review process will also make this judgement. Of the 34 reviews undertaken the judgements in regard to care provided were:

Very poor care	1
Poor care	3
Adequate care	8
Good care	12
Excellent care	10
Total received	34

Learning identified from Mortality Reviews during 2020/21 includes:

- The need for clear and comprehensive documentation in the patient's healthcare record.
- The need for prompt assessment of our patients' pressure areas on admission and the delivery of timely treatment if indicated.
- The need for prompt Venous Thromboembolism (VTE) assessment and timely preventative measures if these are indicated.
- The need for comprehensive and clear documentation around VTE assessment.
- The need for thorough assessment of our patients prior to discharge from the Emergency Department.
- The need for prompt recognition of patients who are at end of life so that they can be cared for appropriately and so that timely and clear communication can take place with patients and their families.

Medical Examiner Service

There is a requirement for all Acute Trusts in England to establish a Medical Examiner Office.

The purpose of the Medical Examiner System is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- To ensure the appropriate direction of deaths to the Coroner

- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data.

Maidstone and Tunbridge Wells implemented this service in September 2020 and it is now well embedded in the Trust. Since September, the service has been working to scrutinise all deaths that happen in the hospital. This involves reviewing the patient's healthcare record and speaking with a medical member of the team who looked after the patient. The Medical Examiner will also speak to the family to provide them with an opportunity to talk to a doctor who wasn't involved in the care of their loved one and raise any concerns they may have.

The scrutiny may prompt a number of different actions such as a referral to the Coroner, signposting the family to our Patient Advice and Liaison Service or a further, more in-depth review such as an SJR. Where it is detected that sub-optimal care may have been provided, the service requests that the Serious Incident process is considered and Duty of Candour is instigated where indicated. This is an opportunity to then review Trust processes and procedures to make the necessary changes as a result of lessons learned.

The Medical Examiner Service provides monthly updates to the Mortality Surveillance Group so that any learning the service has identified in their scrutiny and from talking to bereaved families can be shared and addressed.

The Trust is now working with key external stakeholders such as the local community Trust, the local hospice, GPs and the CCG to plan for and implement the rollout of the Medical Examiner Service to the community in 2021/22.

National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.

Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:

- The Trust submitted a 'standards met' Data Security and Protection Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as carrying out the "completeness and validity checks".
- In addition, three key indicators are selected and audited each year as part of the Trust's assurance processes.

The NHS Outcomes Framework has five domains:

1. Preventing people from dying prematurely
2. Enhancing the quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to	2020/21 local and national data	2019/20 local and national data	National average
1 & 2	(a) the value and banding of the Summary Hospital-level Mortality Indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	91.63 (Band 2 – "As Expected") 36% Nov 2019 – October 2020	102.03 (Band 2 – "As Expected") 43% Dec 2018 – Nov 2019	Best 73.22 Band 3 Worst 112.74 Band 1 Lowest 8% Highest 59% Mean 36% Nov 2019 – October 2020
3	PROMS			
	i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (*See below for explanation of reporting data)*	No data No data 0.50 0.340	No data No data 0.44 0.337 (Apr 16 - Mar 17)	No data No data 0.437 0.323
3	the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital, which forms part of the Trust during the reporting period.	**Elective** 5.7% *1 **Non-Elective** 6.2% *1 **Elective** 10.9% *1 **Non-Elective** 18.5% *1	**Elective** 5% *1 **Non-Elective** 5.2% *1 **Elective** 8.2% *1 **Non-Elective** 17.1% *1	**Elective** 4.1% **Non-Elective** 9.4% **Elective** 3.8% **Non-Elective** 14.0%
4	The percentage of staff employed by, or under contract to, the Trust	81.4%*2	74%*2	

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to	2020/21 local and national data	2019/20 local and national data	National average
	during the reporting period who would recommend the Trust as a provider of care to their family or friends.			69.93% 2017
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96.6%*3	96.7%*3	95.33% Lowest 71.59% Highest 100%
5	The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	27.4 *4	21.4 *4 2019/20	13.85 2017/18 tbc
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	12,470 14.62 per 1,000 bed days 129 (0.44%)	12,491 302 (0.46%)	1.23%

*1 2019/20 data is Apr-19 – Feb-20 as March not currently available. Data taken from local tables and readmissions within 30 days (not 28 days).
*2 Based on Quarter 3.
*3 Q4 not yet published so taken from local data.
*4 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.

Patient Reported Outcome Measures (PROMs)

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. Data is collected in the form of a patient questionnaire. This helps to measure and improve the quality of care.

There are two surgical procedures for which PROMs data is captured: hip and knee replacements. Up to three measures are used to assess the outcomes of these procedures. Results are uploaded on the NHS Digital website from which the graphs below are provided.

Data published in February 2021 (based on April 2019 to March 2020) shows an improvement in health gain following an operation for both surgical procedures.

Adjusted average health gain

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure

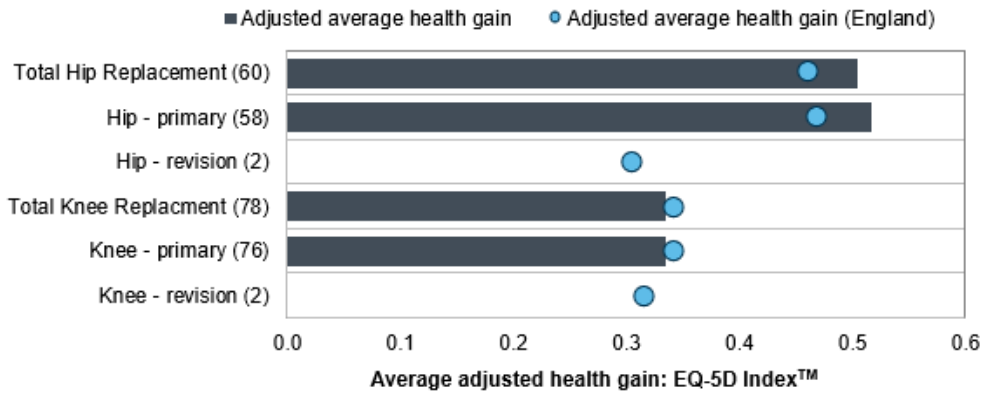


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

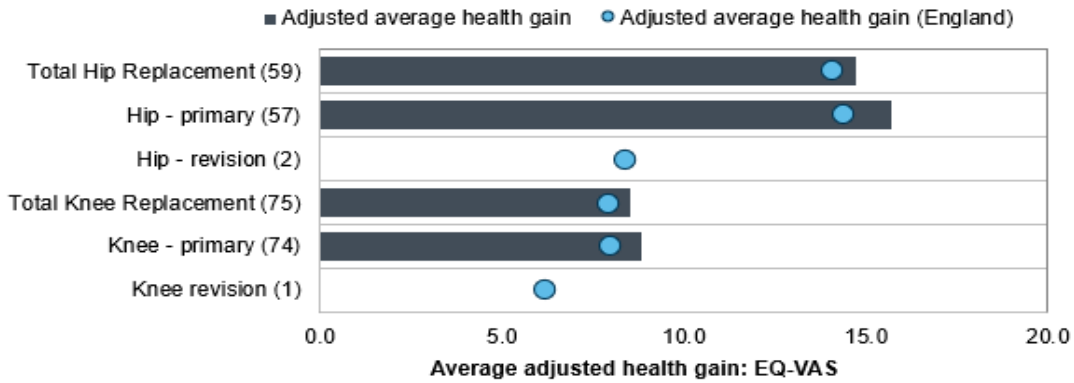
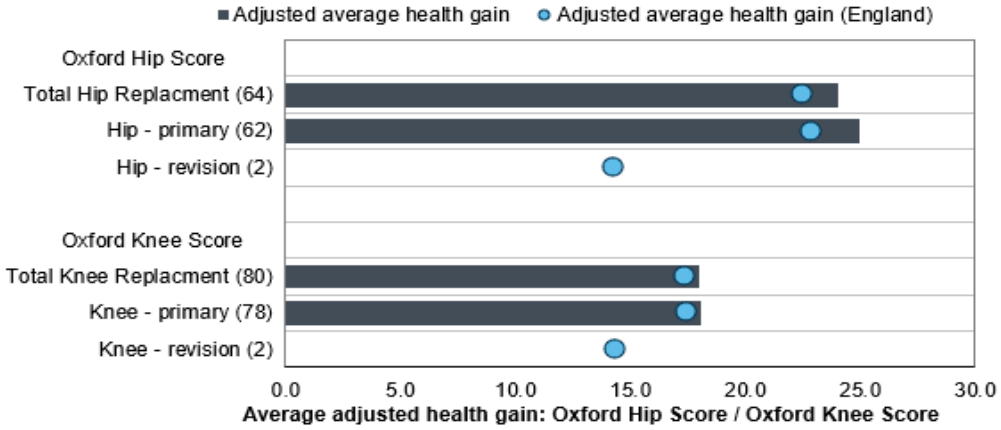
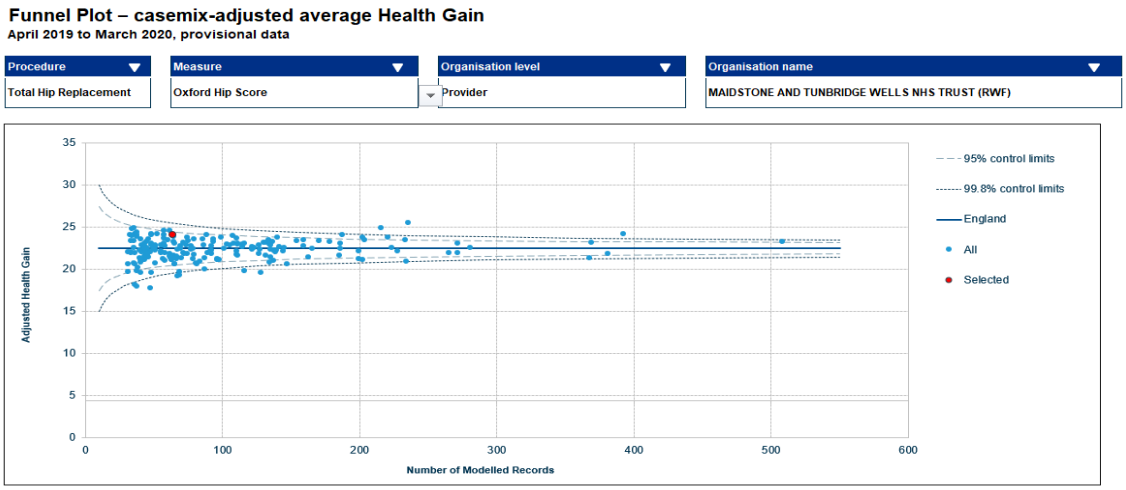


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

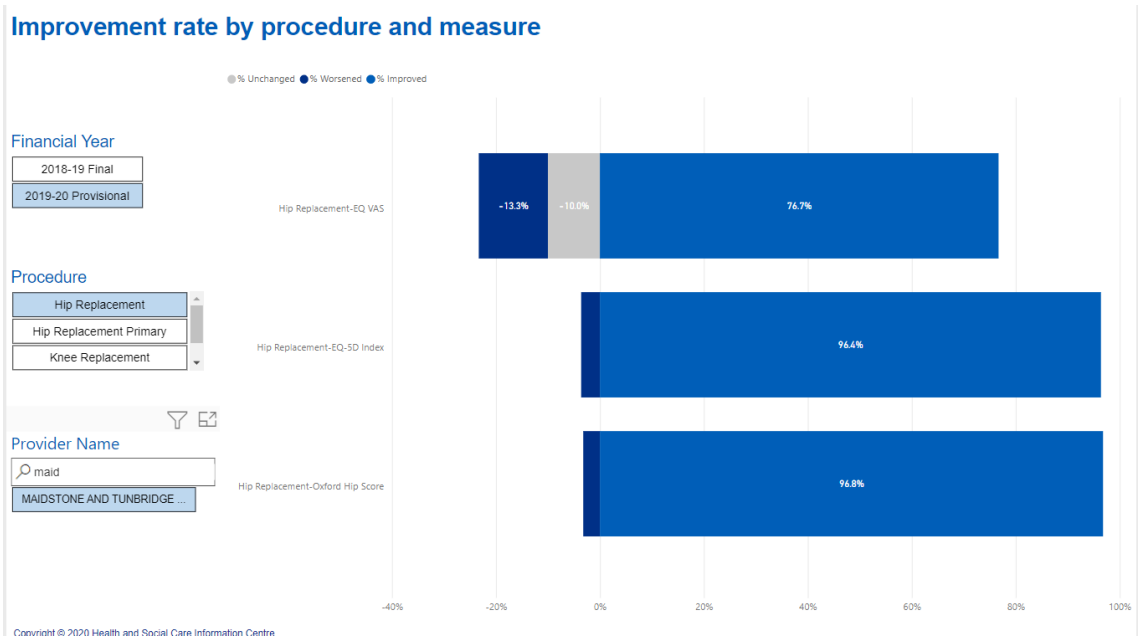


As can be seen the Trust scored above the national average for all three measures for Total Hip and Knee replacements, with most patients reporting an improvement following surgery.

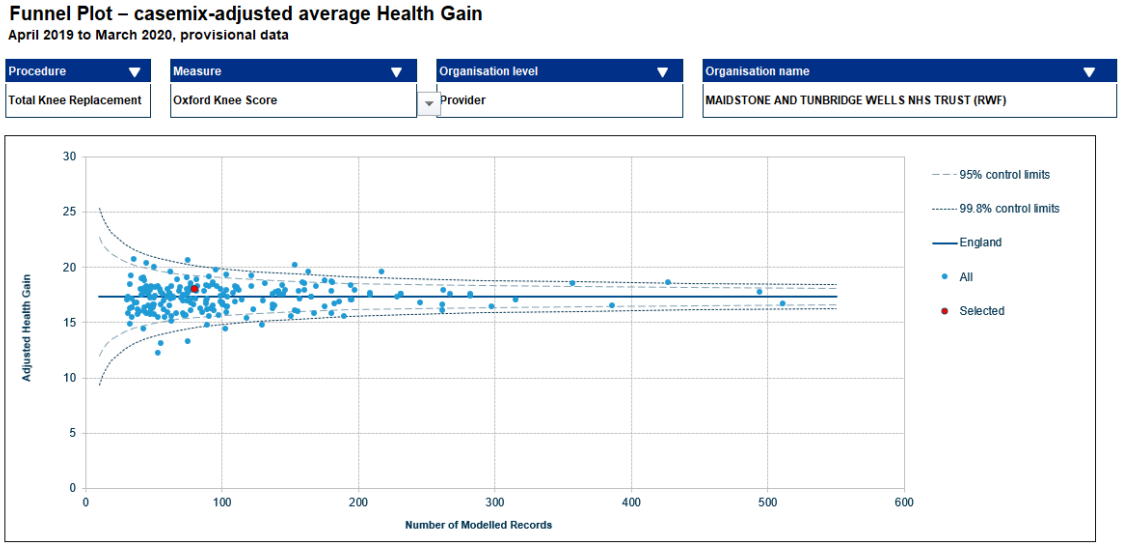
Total Hip Replacement – 64 returns of which 63 reported an improvement in health following the procedure (using the Oxford Hip Score PROMS Measure).



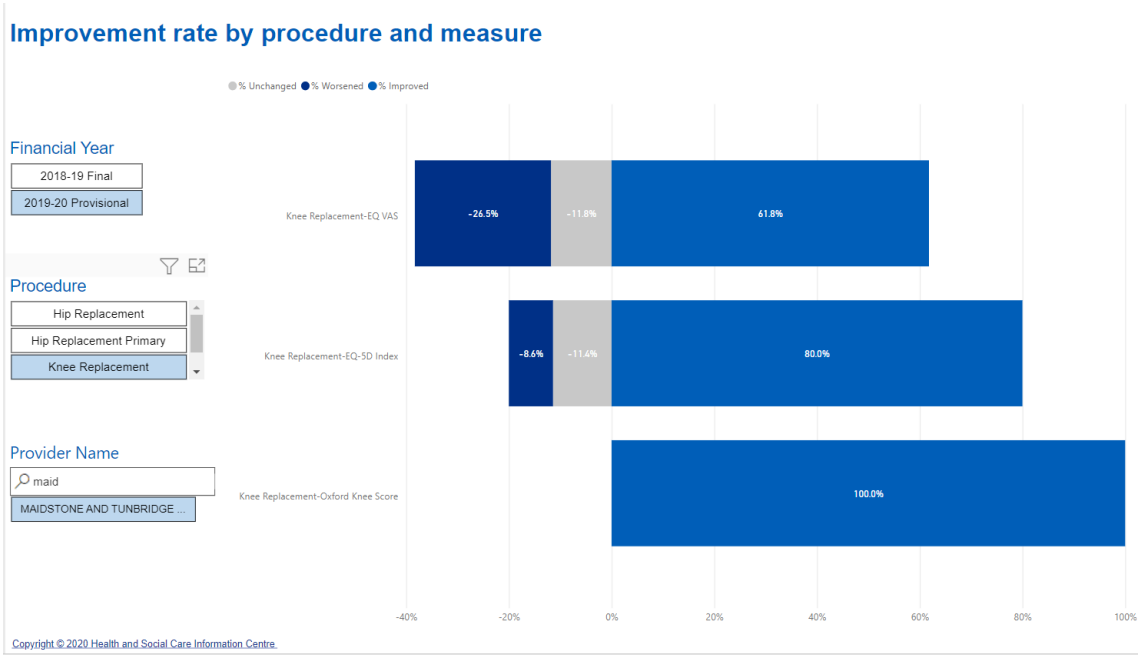
The Improvement Rate for all measures relating to Hip Replacements is shown below.



Total Knee Replacement – 80 returns of which 79 reported an improvement in health following the procedure (using the Oxford Knee Score PROMS measure).



The Improvement Rate for all measures relating to Knee Replacements is shown below.



Additional areas of significant improvement during 2020/21

1. Response to COVID-19 Pandemic

MTW Vaccination Centre

The Academic Centre at Maidstone was converted into a vaccination centre in December 2020 to provide Covid-19 vaccinations to MTW staff. A portal system was set up for booking slots and a range of staff from across the organisation worked together to deliver an efficient and effective vaccination roll-out. Non-clinical staff were redeployed to provide the administration support needed, pharmacy staff ensured a ready supply of the vaccines and clinical staff undertook the vaccine administration. The Trust worked with colleagues from South East Coast Ambulance Service (SECAmb) and local hospices to include their staff in the vaccination programme. The Centre also managed to vaccinate some of our high risk patients with cancer. In total 30,300 vaccinations were administered.

Respiratory Enhance Care Unit (RECU)

A 12-bed respiratory unit was set up within 24 hours at Maidstone hospital to meet the needs of clinically unwell patients with COVID-19 that required enhanced respiratory care but not intensive care. General Managers, Doctors and Matrons worked with teams from Estates and Facilities, Emergency Planning, IT and Programme Management Office (PMO) to create the unit in space freed up by ITU. This was possible because ITU vacated this location, moving into an alternate space to create more ITU capacity. The unit was staffed by seven specialist respiratory nurses providing care to patients requiring this non-invasive type of ventilation. The specialist respiratory nurses were supported by seven Clinical Support Workers (CSWs) and one Nursing Associate, working alongside respiratory doctors and physiotherapists.

COVID-19 Virtual Ward

Joint working between the Respiratory Team, Clinical Systems and the Transformation Team led to the establishment of a COVID-19 Virtual Ward, with the first patient being admitted just three weeks from the first discussion. The virtual ward allowed patients who no longer require in-hospital care for coronavirus, to monitor their condition from the comfort of their own home, safe in the knowledge that they were still under the care of MTW. The patients had regular telephone calls from the virtual ward team to check on their condition.

Drive through pharmacy for patients with cancer

A drive through pharmacy was set up so patients with cancer could receive vital medication without the need to enter Maidstone Hospital during the COVID-19 pandemic.

The cabin, known as a Medicines Pick Up Pod, was set up in car park B next to the Kent Oncology Centre so patients, or a relative or carer, could drive up or arrive on foot to collect their prescribed medicines. These were issued by one of the two members of staff from the Trust's Oncology Pharmacy Team. The drive-through pharmacy helped to 'shield' patients with cancer from COVID-19 as they are at high risk of contracting the virus due to having a weakened immune system.

Connecting patients with their families virtually

iPads helped inpatients stay connected with their loved ones whilst on our wards. More than ever inpatients needed to be able to stay in contact with their family and friends. Being able to stay in touch with their loved ones is not only good for our patient's wellbeing but also their recovery.

To help them stay connected with their nearest and dearest during the pandemic the Trust provided 55 iPads to wards at both hospital sites so patients could see and speak to those closest to them via video messaging services, such as FaceTime or Skype. A total of 42 iPads were introduced initially in April 2020 after visiting restrictions were put in place to help protect both patients and staff from the virus but as the weeks passed more iPads were allocated, including 10 to the Intensive Treatment Units (ITU) at both hospital sites.

Heart-warming stories shared by staff about how patients have used the iPads include a patient on ITU being able to wish their son a happy birthday from their hospital bed and another patient

being able to see his wife, children and dog for the first time in five weeks. Due to the visiting restrictions, having the iPads on ITU meant staff could also help relatives who sadly need to say their final goodbyes to their loved one before they pass away. In line with infection prevention control policies, the iPads are wiped down before and after each use.

As well as providing patients with technology solutions so they can communicate with their loved ones, policies have also been put in place by the Trust so relatives, carers and friends can still get essential items to inpatients during the pandemic.

One Team Runners

A project was set up to recruit staff members, working at all levels across the Trust, to volunteer to help and support clinical areas during the pandemic. The project was called 'One Team Runners' and was an outstanding success. The volunteers were paid on the staff bank to work extra hours over and above their normal MTW role. Tasks undertaken by the runners differed from ward to ward and included the following:

- Ensuring staff get a cup of tea and something to eat
- Passing items required into bays / rooms for clinical staff i.e. linen, washing items, sundries, meals and drinks
- Answering the phone and taking messages
- Running errands such as collecting medication from pharmacy or delivering notes
- Collecting patient property and making sure it gets to the patient
- Co-ordinating and assisting with communicating with families i.e. Facetime – ensuring equipment is charged and connecting to Wi-Fi
- Supporting patient surveys and feedback
- Receiving handover from clinical staff in order to be able to make a pro-active call to the patient's family and update them on any non-clinical aspect of care
- Receiving messages from family to pass onto the clinical support volunteer / nurse / patient / CSW
- Restocking the wards
- Monitoring hand hygiene.

This is me - the face behind the mask

Staff working on the Woodlands Unit at Tunbridge Wells Hospital developed a novel way of letting the children they treat see their faces without the need to remove their mask - they each wear a badge showing their faces normally. This helps to create a more patient focused environment and is also proving to be a conversation starter for the children with many of them commenting on what the nurse really looks like underneath their mask.

Woodland themed visors for paediatric staff

More than 450 woodland themed visors were developed and donated to paediatric staff working on Woodlands Unit and Hedgehog Ward at Tunbridge Wells Hospital and the Riverbank Unit at Maidstone Hospital. The reusable, polycarbonate, child-friendly visors can be worn by the Paediatric Team whilst carrying out procedures on children, which involve them having to cough or having throat swabs or bloods taken.

PPE Safety Officers

The importance of using, donning and doffing Personal Protective Equipment (PPE) correctly led to the creation of a PPE Safety Officer role within MTW. The PPE Safety Officers were introduced across both sites providing a 7 day service from 08.00 to 16.00 / 21.00hrs. The PPE Safety Officer's purpose is to ensure staff are safe and feel safe wearing PPE. They routinely visit all wards and departments offering advice on the correct use of PPE and answer any questions the staff have. This role is one of many developed in response to the COVID-19 pandemic including a team providing FIT-testing of FFP masks, staff undertaking COVID-19 swabbing and a team rolling out the lateral flow testing kits to staff.

2. Awards

Finalist for the Acute or Specialist Trust of the Year Award

17 March 2021 marked the virtual awards ceremony of the HSJ Awards and MTW was one of four finalists to be shortlisted for the Acute or Specialist Trust of the Year Award. It was a great achievement to make it through to the final stages of this prestigious competition as it recognised the achievements of staff across the organisation and their focus on delivering outstanding patient care. As a result of everyone's efforts, MTW is now one of the best performing Trusts in the country for emergency care and cancer services. The Trust has introduced a wide range of patient and staff-centred initiatives – all focused around its 'Exceptional People, Outstanding Care' programme. Not only improving the care and services it provides but also making MTW a great place to work. MTW has also invested in new facilities and staff development and welfare, brought in new talent locally and from overseas thanks to successful recruitment campaigns, and introduced innovative ways of working to ensure patients get skilled, compassionate care quickly.

National award for Infant Feeding Team

A film made by the Trust's Infant Feeding Team has won JOHNSON'S® Excellence in Maternity Care and Innovation Award in the Royal College of Midwives (RCM) Annual Awards. The video Colostrum Collection in Pregnancy: 'When to start and how to do it', shows those who are pregnant how to express their first breast milk (colostrum) by hand in the late stages of pregnancy, collect it using a syringe and then label and store it in a freezer at home ready to take to the hospital when they go into labour.

This practice is recommended if it is anticipated that the baby may experience difficulties with feeding or maintaining their blood sugar levels after birth, as the previously collected colostrum can then be used. This is especially important for babies at risk of being born prematurely, if the parent has diabetes, or it is a twin pregnancy. It is also recommended in other circumstances, such as if the person is taking certain medications, has a raised BMI, has a breast abnormality or has had breast surgery, or found breastfeeding challenging in the past.

Known as 'liquid gold' due to its golden yellow colour, colostrum is the perfect food for new born babies because it is full of antibodies which help protect them from infections and also contains the perfect balance of carbohydrates, fats and proteins.

HSJ Value Awards

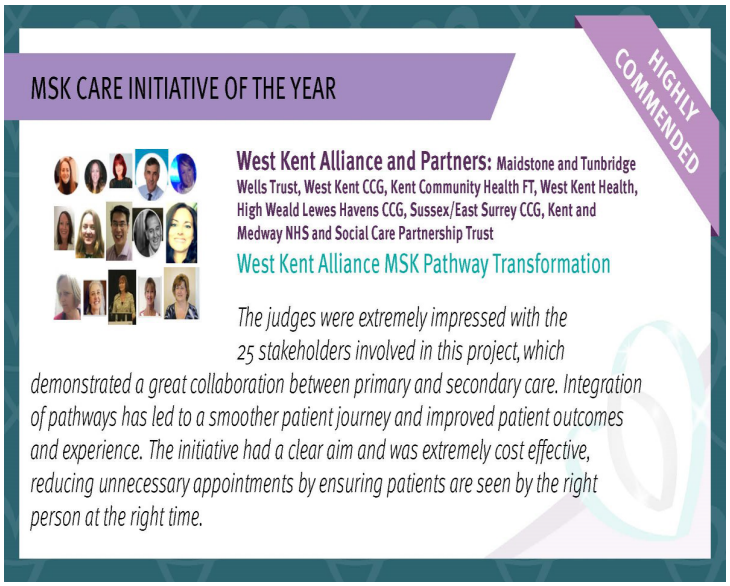
The Finance Team received a highly commended award after it put itself forward for Finance Team of the Year in the Operational and Corporate Category. The five shortlisted NHS teams were asked to showcase the most efficient and innovative projects they are working on that are helping their wider organisations deliver better services and improved outcomes.

The MTW team was recognised for supporting the Trust's Outstanding Care, Exceptional People commitment; supporting the Trust from Financial Special Measures to recurrent surplus within 3 years, as well as the links it has developed with industry, research and national bodies.

The West Kent Alliance (WKA) Musculoskeletal (MSK) Pathway Transformation Team, which MTW's Transformation Team is part of, received a highly commended award for the Musculoskeletal (MSK) Care Initiative of the Year in the Clinical and Medical Services category.

The WKA is made up of six NHS partners, including MTW NHS Trust, which all work together with the support of a Joint Programme Management Office (JPMO) to transform and deliver system wide treatment pathways for patients.

It is through this joint approach that the alliance has managed to improve waiting times for MSK patients by ensuring they get patients to the right place first time for MSK services in West Kent acute and community services. This was done by creating a single point of access and clinical decision making unit all of which has resulted in good patient and staff feedback. The changes also resulted in a £1million saving.



Finalists in the Dementia Care Awards
MTW made it through to the finals of the Best Dementia Friendly Hospital category in the National Dementia Care Awards 2020 hosted by the Journal of Dementia Care.

3. New developments

New Patient Experience Midwife

A six-month pilot was undertaken to test the concept of a Patient Experience Midwife role that enabled us to hear from parents about their first-hand experience of our maternity services. The midwife listened to many new parents describing their experiences of maternity care at Tunbridge Wells Hospital. Gathering peoples' experiences, will help us understand what we can do to make everybody's experience the best it can possibly be and ultimately hopefully reduce complaints.

Video messaging service on the Neonatal Unit

Parents of premature and sick babies being cared for on the Neonatal Unit at Tunbridge Wells Hospital can see their baby via video when they're unable to be with their child. The secure video messaging application vCreate, which has been rolled out on the Neonatal Unit permanently following a successful three month pilot, is now more important than ever for bringing babies and parents together. The technology, which allows clinical teams to send video updates to parents when they're not able to be at the hospital, was made possible thanks to the Morrisons' Foundation. The Foundation, part of the national supermarket chain, donated £9,600 to Maidstone and Tunbridge Wells NHS Trust Charitable Fund, which will fund the service for two years.

vCreate aims to minimise separation anxiety and bring comfort to worried parents who haven't been able to take their baby home with them as planned. Parents can login to the vCreate App at any time to see how their child is progressing and can leave notes and feedback for the nursing team. Once their baby has been discharged from hospital, parents are able to download the videos and keep them forever.

John Allen and partner Allison Woods (pictured) used the app when they couldn't physically be with their son Rafferty whilst he was being cared for on the Neonatal Unit at Tunbridge Wells Hospital.

Rafferty, who was born at 26 weeks weighing just 900 grams, spent a total of 102 days in three different hospitals – 65 of which were spent on the Neonatal Unit at Tunbridge Wells Hospital – following his birth on 19 December 2019. He was eventually discharged from the unit on 30 March 2020 – six days after his original due date. Dad of two John, from Kings Hill, said the video messaging service gave the family a boost because it meant they were able to see Rafferty was doing ok in between hospital visits.

Launch of Mental Capacity Act Hub

As part of the ongoing work to improve compliance with the Mental Capacity Act and safeguard our patients the Trust launched a Mental Capacity Act (MCA) E-Hub in 2021. The hub is an electronic resource for staff with access to detailed information, videos and the MCA Directory from the Social Care Institute for Excellence (SCIE).

Maidstone Acute Frailty Unit

Building work to extend the Acute Frailty Unit (AFU) at Maidstone Hospital has now been completed. Former office space at the front of Whatman ward, where the unit is located, has been converted to accommodate four assessment chairs which now sit alongside the existing five trolleys in an adjoining bay. AFUs, which have been running for two years at both the Maidstone

and Tunbridge Wells sites, provide specialist care to patients over the age of 70 from 8am to 8pm, Monday to Friday and from 10am to 6pm, on weekends and Bank Holidays. Patients are currently referred to the unit either via the Emergency Departments or the Acute Assessment Units on each site. By expanding the unit at Maidstone, the plan is for GPs to be able to refer patients directly to the unit and for South East Coast Ambulance Service (SECAmb) to be able bring patients straight to the unit on a more regular basis in the near future with the aim of reducing admissions, decreasing the patient's length of stay and improving patient outcomes. Not only will this help with patient flow but also provide our patients with a better experience during their time on the unit. Increasing the size of the unit also means there is more room for the consultant, three registrar doctors, two nurses and a personal assistant who are based there to work in.

Expansion of Maidstone Rapid Assessment Point

An assessment area for patients brought by ambulance to Maidstone Hospital's Emergency Department (ED) was doubled in size to help ensure patients receive rapid access to the right care and treatment by the right people in the right place. Opened on Monday, 8 June 2020 as part of the Trust's plans to improve patient care, the number of bays in the Rapid Assessment Point (RAP) has increased from three to seven after the service was moved to the front entrance which is used by South East Coast Ambulance Service (SECAmb).

In order to create the clinical area, several offices were relocated to the new Acute Assessment Unit (AAU) which opened at the beginning of March and is sited next to, and accessed via ED. The total cost of the RAP expansion project, which was overseen by the Trust's Estates Department, was £400,000. Included in the cost are plans to convert the former RAP area into further clinical space.

RAP is a national best practice tool designed to support best patient care. Patients who arrive by ambulance are taken to RAP where they are assessed by a senior clinical decision maker, such as an emergency medicine registrar or consultant. That person can then either refer the patient to a speciality such as the medical or surgical teams or order tests or images to help diagnose a patient so those investigations are ready when they are assessed by the next emergency clinician, speeding up their visit to the department. Increasing RAP's capacity allows rapid handover of the patient's care from SECAmb to our staff, which then allows SECAmb crews to get back on the road and respond to the next emergency call in the community.

New Surgical Assessment Unit

A new Surgical Assessment Unit (SAU) at Tunbridge Wells Hospital was opened on 21 December 2020.The SAU, which was previously based inside the hospital, is now located in a new modular building adjacent to the Emergency Department (ED). The move forms part of the Trust's plans to enhance its Same Day Emergency Care (SDEC) pathway so that more patients can benefit. The acute unit, which is operational 24-hours a day seven days a week, houses a waiting area, a clinic room, and a procedure room complete with an ultrasound machine. It is staffed by a Senior Surgical Doctor, who is based on the unit at all times, Nurses and Clinical Support Workers (CSWs). A receptionist will staff the desk Monday to Friday between the hours of 8-6pm.

Part **four**

Appendices

Appendix A

41 national audit reports were published where the topic under review was relevant to the Trust in 2020/21. These national reports are listed below with the key actions developed in response to the recommendations stated in the reports to improve the quality of healthcare provided.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	Report summaries published in February 2021. The report is with Theatres and Critical Care for review and action plan development.
BAUS Urology Audits: Nephrectomy Audit 2017-19	Y	Report published 30th September 2020: The trust is not an outlier in any of the reported areas. No actions required.
BAUS Urology Audits: Radical Prostatectomy Audit	Y	Report published 30th September 2020: Fully compliant, no actions required.
Cardiac Rhythm Management (CRM) 2017/18 & 2018/19	Y	Report published 10th December 2020: A business case has been approved for a Band 4 coordinator to provide administrative support for NICOR audit data submissions
Coronary Angioplasty / PCI 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
Emergency Laparotomy Audit (NELA)	Y	Report published 12th November 2020: The report is with Theatres and Critical Care for review and action plan development.
Epilepsy12 National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Report published 10th September 2020: Mental health provision for children with epilepsy at the Trust to be reviewed. The outcome may result in a business case for in house CAMHS input for epilepsy and other paediatric subspecialty patients.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit of Inpatient Falls (NAIF).	Y	Report published 12th March 2020: 1. Laminated hard copies of falls guidance for older people to be provided to all wards and units 2. Trust-wide communication on the availability of the scoop stretchers and their locations
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture database (NHFD)	Y	Report published 14th January 2021: The report is with Trauma and Orthopaedics for review and action plan development.
Heart Failure 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
MBRRACE-UK Maternal, New-born and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2018	Y	Report published in 10th December 2020: The report is with Women's Services for review and action plan development.
MBRRACE-UK Perinatal Confidential Enquiry Stillbirths and neonatal deaths in twin pregnancies	Y	Report published 14th January 2021: The report is with Women's Services for review and action plan development.
MBRRACE-UK; Saving Lives, Improving Mothers' Care; Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18	Y	Report published 14th January 2021: The report is with Women's Services for review and action plan development.
MINAP 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
NACAP Adult Asthma National Clinical Audit Report 2019-2020	Y	Report published 14th January 2021: The report is with Respiratory for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
NACAP Pulmonary rehabilitation 2019	Y	Report published 10th December 2020: Fully compliant with recommendations, no actions required.
National Adult Asthma and COPD clinical audit 2018/19	Y	Report Published 9th July 2020: The Trust is undertaking service reviews and formulating business plans to increase staff resource, including the appointment of an Asthma and Non-Invasive Ventilation Consultant Lead.
National Adult Diabetes Inpatient Audit – Harms (NaDIA-Harms) 2019	Y	Report Published 13th November 2020: The report is with Medical Specialties for review and action plan development.
National Adult Diabetes Inpatient Audit (NaDIA) 2019	Y	Report Published 13th November 2020: The report is with Medical Specialties for review and action plan development.
National Audit of Bowel Cancer (NBOCAP)	Y	Report published 10th December 2020: The report is with Cancer Services for review and action plan development.
National audit of Breast Cancer in Older People (NABCOP)	Y	Report published 9th July 2020: The Trust is fully compliant with all criteria, no actions required.
National Audit of Care at the End of Life	Y	Report published 9th July 2020: 1. Business plan for a 7-day service to be submitted 2. Develop a medications information leaflet 3. Introduce advance care planning tool for end of life care i.e. AMBER Care Bundle.
National Audit of Lung Cancer (NLCA)	Y	Report published 13th August 2020: The report is with Cancer Services for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
National Comparative Audit of the Management of Maternal Anaemia	Y	Report published 6th August 2020: Develop "Management of Anaemia in Pregnancy" guidelines which will incorporate British Society for Haematology guidance.
National Confidential Enquiries into Patient Outcome and Deaths – Time Matters	Y	Report published 11th February 2021: Critical Care Department to review and update Percutaneous Coronary Intervention referral policy with Cardiology Department.
National Diabetes Audit (NDA) Core audit 2017-18	Y	Report Published 10th December 2020 The report is with Medical Specialties for review and action plan development.
National Early Inflammatory Arthritis Audit – Second Annual Report	Y	Report published 14th January 2021 The report is with Rheumatology for review and action plan development.
National Joint Registry (NJR)	Y	Report published 15th September 2020: Fully compliant with recommendations, no actions required.
National Maternity and Perinatal Audit (NMPA)	Y	Sprint Multiple Births Report published 13th August 2020: The report is with Women's Services for review and action plan development.
National Oesophago-gastric cancer (NAOCG) 2020	Y	Report published 10th December 2020: The report is with Cancer Services for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
National Paediatric Diabetes Audit 2018-19 (NPDA) (1193)	Y	Report published 12th March 2020: 1. Increase support for technology led monitoring such as Libre Flash Glucose monitoring by identifying the patients who would most benefit from the system due to impact of diabetes on quality of life 2. Create an amber alert point for high HbA1c patients at 64 mmol/mol and build a new amber alert pathway to include clinic appointments every 2 months and individualised plans in High HbA1c policy.
National Paediatric Diabetes Audit – parent and patient reported experiences (PREMS) 2019	Y	Report published 12th November 2020: The report is with Children's Services for review and action plan development.
National Perinatal Mortality Review Tool	Y	Report published 10th December 2020: The report is with Women's Services for review and action plan development.
National Prostate Cancer Audit 2020	Y	Report published 14th January 2021: 1. Where appropriate offer combined systemic therapy, either with docetaxel or novel anti-androgenic therapy to people with newly diagnosed metastatic disease 2. Submit a business case for a late radiotherapy toxicity clinic 3. Submit a business case for a local High dose-rate Brachytherapy Service.
National UK Inflammatory Bowel Disease Biologics Registry	N	Decision made by IBD Registry to postpone the IBD annual report for 2019/20 due to COVID-19.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Neonatal Intensive and Special Care (NNAP)	Y	Report published 12th November 2020: 1. Continue to encourage parents to be present on ward rounds as partners in care or use video calls for parents unable to visit. 2. Work towards UNICEF Baby Friendly Initiative Stage 2 award and accreditation. 3. Submit business case for increased outpatient time for physio to complete Bayley scoring system.
National UK Paediatric Inflammatory Bowel Disease Biologics Registry	N	Decision made by IBD Registry to postpone the IBD annual report for 2019/20 due to COVID-19.
RCEM Assessing Cognitive Impairment in Older People (care in the ED) 2019	Y	Report published 9th February 2021: The report is with Emergency Medicine for review and action plan development.
RCEM Care of Children in Emergency Departments 2019	Y	Report published 25th January 2021: The report is with Emergency Medicine for review and action plan development.
RCEM Mental Health Care in Emergency Departments 2019	Y	Report published March 2021: The report is with Emergency Medicine for review and action plan development.
Sentinel Stroke National Audit Programme – Annual Report 2019-20	Y	Report published 14th January 2021: The report is with Stroke Team for review and action plan development.
Serious Hazards of transfer (SHOT) UK. National Haemovigilane Scheme	Y	Report published 17th July 2020: The report is with Pathology for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
The Trauma Audit and Research Network (TARN)	Y	Report published April 2020: 1. Emergency Department consultant to be informed of trauma patient with Injury Severity Score (ISS) >15 on arrival in the emergency department to enable assessment within 5 minutes of arrival. 2. Trauma Fellow to review patients and identify any delays to CT to improve trauma pathway for patients with head injuries.

Appendix B

71 local clinical audits were completed during 2020/21. These local clinical audits are listed below with the key actions developed in response to the recommendations in the reports to improve the quality of healthcare provided.

Clinical Audit Title	Key Actions
Documentation Audit – General Surgery 2020	Include "Good record keeping" in General Surgery Junior Doctor Induction Programmes. Patient ID stickers and self-inking name pads introduced to save time.
Pressure Ulcer Prevalence Clinical Audit August 2020	Meetings with Tissue Viability Champions to assist with staff education to be rescheduled post COVID-19.
Re-audit of the accuracy of intraoperative frozen pelvic sections	This audit has shown a continued high accuracy rate of the frozen section service, but a persistent need to more evenly distribute the caseload between team members. To be discussed at Gynaecology Pathology Governance meeting.
Colorectal Cancer Audit for lymph node harvest, incidence of vascular invasion and serosal involvement: re-audit	Good compliance with standards, no actions recommended at this time.
Re-audit of compliance with the policy and procedure for the assessment of patients presenting with diarrhoea	1. Audit report to be included on Infection Prevention and Control Committee (IPCC) agenda (August 2020). 2. Audit report to be disseminated to ward managers and link workers.

Clinical Audit Title	Key Actions
Re-audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria	1. Audit report to be presented to the Infection Prevention and Control Committee (IPCC), Ward Managers and Matrons. 2. Findings of the audit to be shared at the Link Workers meeting 3. Share the findings of the audit with the Gram Negative Reduction UTI Working Group.
Monitoring compliance and effectiveness of antimicrobial prescribing for patients on Ward 20 at Tunbridge Wells Hospital	1. Provide training for prescribing members of the healthcare team emphasising the key points of antimicrobial stewardship and what they should be doing in their clinical practice. 2. Create handouts and posters for the ward and staff with reminders of the standards.
An audit to assess the rate of high-grade dysplastic adenomas for individual pathologists who report for the West Kent & Medway Faecal Occult Blood Tests BCSP (Bowel Cancer Screening Programme) during 2017	1. Audit results to be presented at the Medway and West Kent BCSP clinical meeting. 2. The audit will be presented at the GI pathology governance meeting.
Critical Care Pain Observation Tool (CPOT) Compliance Audit	Continue to disseminate the use of CPOT and reiterate the importance of pain assessment/ management for patients overall experience and outcomes by: 1. Ensuring that all patients have a CPOT baseline assessment completed. 2. All non-verbal patients will have at least one CPOT assessment per shift (non-baseline).
Compliance with spontaneous breathing trials in mechanically ventilated patients – Guideline for the Provision of Intensive Care Services standards	1. Increase ICU staff awareness of the need for daily respiratory function evaluations and that this is clearly documented within the patients' healthcare record at ICU staff meeting. 2. Display poster with audit results, findings and recommendations on the ICU.
Avoidance of gaps in the radiotherapy treatment schedule for all category 1 patients	Category 1 patients that have a gap in treatment schedule due to unrelated illness should have Biologically Effective Dose Calculations if hyper fraction is not possible (for discussion at Consultant's meeting post COVID-19).
Re-audit: are new, stopped or changed medications clearly documented on discharge summaries?	1. Clinical Audit report findings to be shared with clinical teams as a reminder about good record-keeping of medications in patient healthcare records. 2. Identify clinical pharmacy staff members who have not yet read the updated SOP C8 Discharge Medication Preparation and give them protected time to read it. 3. All new members of the clinical pharmacy team to read SOP C8 Discharge Medication Preparation as part of their induction programme.

Clinical Audit Title	Key Actions
Re-audit of Operation Note Completeness and Legibility: The Writing's on the Wall	Development of quick reference template sheet for all Trauma and Orthopaedic theatre staff for operation notes. Also provide instructions on using typed operation notes, with a check list.
A re-audit of compliance to the policy for the use of purple plunger oral /enteral syringes for the administration of liquid medicines and enteral feeds	1. Trust procurement to be contacted to ensure adequate levels of oral/ enteral syringes are available on the wards. 2. Pharmacy to check stocks of oral / enteral syringes on wards every 6 months. 3. Open oxycodone bottles on wards to be checked every 6 months, when undertaking controlled drug (CD) checks to ensure an ENFit bung is in situ.
Audit of fine needle aspiration cytology diagnosis in solid lesions of the pancreas at Maidstone and Tunbridge Wells NHS Trust over a 3-year period (2016-28)	Continue current reporting practices which include double reporting of malignant and suspicious EUS-FNA samples and correlation with concurrent pancreatic biopsies.
Endoscopy re-audit on the manual cleaning of flexible endoscopes prior to decontamination through an Automated Endoscope Re-processor	1. Maintain annual competency assessment of all endoscopy staff who will be involved in endoscope decontamination. 2. Maintain annual refresher training for all endoscopy staff. 3. All endoscopy departments should conduct internal audits on decontamination to ensure that standards are being maintained.
Audit of management outcome of stage 1 ovarian cancer in Maidstone Hospital NICE CG122	Fully compliant with standards. Consider carrying out an audit of frozen section evaluation of complex ovarian cyst/ masses in patients.
Re-audit: accuracy of bronchial brushing/ washing cytology diagnosis via correlation with histology at Maidstone Hospital	Findings of audit to be disseminated to lead respiratory physicians by email and presentation in lung TSSG meeting (concurrent bronchial washings/ brushings and bronchial biopsies should be reserved for cases where biopsy is difficult or contraindicated).
Audit of the management of moderate or severe hyperkalaemia	1. Present findings of audit at the Medical Grand Round in January 2020 at both hospitals. 2. Design and display hyperkalaemia flowchart that can be printed and left on wards to be filled out.
Adequacy of endobronchial ultrasound-guided trans-bronchial needle aspiration for diagnosis and molecular analysis	Fully compliant with standards, no actions required.

Clinical Audit Title	Key Actions
An audit to assess the value of deeper histological levels in Bowel Cancer Screening Programme (BCSP) negative polyps	Six further histological levels should be examined on BCSP negative polyps: • Inform all BCSP reporting pathologists. • Presentation of audit to West Kent & Medway Bowel Cancer clinical meeting. • Presentation at cellular pathology clinical governance. • Add recommendation to BCSP reporting SOP (Standard Operating Procedure).
Management of Appendicitis during COVID-19	Develop a criterion for patients booked for diagnostic laparoscopies to reduce the number of negative diagnostic laparoscopies and patient stay.
Re-Audit to check accuracy of Tumour Site Identification during Colonoscopy 2019	Purchase scope guides to improve the accuracy of tumour localisation (position) which will help when developing the patient's surgical management plan.
A re-audit assessing the quality of Surgical handovers	To improve multidisciplinary team approach to patient care:- 1. During the handover all mobile telephones and bleeps to be silenced to avoid any potential delay or disruption during the handover. 2. A weekly register of those expected to attend handovers will be distributed at the beginning of each week.
A re-audit of analysis of efficiency of emergency incision and drainage of abscesses under General Surgery	An abscess pathway has been implemented to direct patients to allocated emergency theatre sessions which are available three times per week.
NICE CG176 & 161; Management of Head Injuries Audit	A Computed Tomography (CT) cervical spine protocol has been developed to increase the number of patients having a CT cervical spine scan when they have a CT Head scan for trauma.
NICE NG 89 Re-audit Thromboprophylaxis and AES in Surgical patients	Continue to include a talk on VTE prophylaxis and documentation of risks and benefits during junior doctors' Inductions. Poster displayed on surgical wards to remind junior doctors and nursing staff of thromboprophylaxis guidelines.
NICE CG188; Audit of gallstone pancreatitis management	Develop a clear and agreed protocol between the surgery and radiology departments regarding the indication of magnetic resonance cholangiopancreatography (MRCP) in gall bladder disease.
Timing of laparoscopic cholecystectomy following percutaneous cholecystostomy	All patients who are managed with percutaneous cholecystostomy to be offered a follow up appointment within 4 weeks following discharge from hospital unless the patient is deemed unfit for any further management.

Clinical Audit Title	Key Actions
NICE CG188; Hot gall bladder pathway in emergency General Surgery - are we following the guidelines?	An algorithm of the management of patients admitted with a diagnosis of acute cholecystitis/biliary pancreatitis to be available to all doctors in the surgical team. A specific booking form for hot gall bladder pathway to be added to Allscripts to enable online booking and reduce surgical cancellations.
Re-audit: Assessing ENT department medical record keeping compliance using CRABEL scoring	Educate new doctors joining the ENT department during their induction on the importance of a high standard of record keeping; documentation of investigations, diagnosis and management plan. The utilisation of name stamps and patient stickers introduced.
Laser Precision: Checking Accuracy of YAG Laser Consent	1. Patients will be sent a patient information leaflet along with their appointment letter for the laser clinic. 2. To produce procedure specific complication stickers to be used on the consent form.
Re-audit: Number of Hemiarthroplasties that have Pre-Operative Templates	1. Training for those undertaking templating to ensure adequate ability to template. 2. Formal guidance to be developed and included in the patient pathway for templating patients undergoing hemiarthroplasties.
Re-audit of the management of supracondylar fractures of the humerus in children at TWH against BOAST 11 National guidelines	1. Teaching for Junior Doctors during induction on the importance of these fractures and the appropriate assessment and management. 2. Improve wire removal time by encouraging removal in clinic in the first instance.
Montgomery and Informed Consent in Trauma and Orthopaedics; audit of practice at MTW Trust	1. Leaflets to be produced for all procedures and given to patients prior to consent. 2. Jargon free clinic letters to be provided to all patients.
Re-audit: Documentation of medical records in fracture clinic	Reintroduction of the “Fracture clinic pro-forma” at the Trust to improve documentation and ensure that the documented plan is available for the doctor to review at the follow up visit.
Audit on the assessment and investigation of suspected Cauda Equina Syndrome (CES)	A protocol to be developed to prioritise patients with suspected CES in order to reduce the time from presentation to MRI scan and report.
Paediatric forearm fracture management in the children's Emergency Department: Audit and new guideline for manipulation with intra-nasal diamorphine and Entonox	Junior Doctors and Registrars educated at induction sessions on the management of paediatric forearm fractures in the Emergency Department.

Clinical Audit Title	Key Actions
NICE NG12; Assessing the appropriateness of GP referrals to breast clinics	Provide up to date information to West Kent GPs regarding the NICE criteria for 2 week wait referrals to breast clinic and the alternative non-urgent route for patients aged under 30 with an unexplained breast lump with or without pain to reduce inappropriate referrals.
NICE NG118 Acute Management of Renal and Ureteric Stones at MTW	Develop an ambulatory pathway for the management and treatment of renal and ureteric stones. Teaching to Emergency Department doctors and Urology junior doctors to raise awareness of the treatment pathway.
Breast Implant Loss Audit	1. Use of two surgical teams for bilateral cases to reduce operating time 2. Use of skin glue after subcuticular suturing to create an extra layer of protection to pathogens. 3. Business case to introduce medical photography service
NICE CG97 Comparison of the effectiveness of different techniques of prostate enucleation during HoLEP operation	Fully compliant with standards, no actions required.
Early Management of Sepsis re-audit	1. The funding for Sepsis trolleys on wards has been approved. Trolleys to be set up to improve management of sepsis. 2. Sepsis proforma added to the Sunrise Electronic Patient Record (EPR) with mandatory fields for patient reassessments.
Thromboprophylaxis Re-Audit	VTE risk assessment to be added to the Sunrise EPR to ensure compliance and electronic medication prescription service to reduce errors in prescribing.
NICE CG16 - Management of Deliberate self-harm in children who present to the Emergency Department re-audit	1. Electronic Emergency Department proforma to be used for all Deliberate Self Harm. 2. Education of all Emergency Department staff regarding paediatric self-harm and taking an effective psychiatric history
Pacing and DC cardioversion re-audit	Fully compliant with standards, no actions required.
NICE CG 32 Use of the MUST Screening for Malnutrition at Maidstone and Tunbridge Wells NHS Trust - 2019	1. E-Learning set up on Trust Learning Management System and continuation of MUST training on the wards. 2. Dieticians to ensure all wards have a laminated copy of BAPEN (British Association for Parenteral and Enteral Nutrition) MUST guide.
Therapy management of post distal radius fractures re-audit	Online tutorials set up on Trust Learning Management System to ensure efficient recording of data to maximise treatment plan

Clinical Audit Title	Key Actions
NICE CG124 criteria 1.7 Are fractured neck of femur patients receiving daily physiotherapy totalling a minimum of 2 hours in the first 7 days post-surgery?	1. Neck of Femur patients highlighted in written handover and on Nerve Centre to ensure that they are easily identified and prioritised for daily physiotherapy sessions to reduce their length of stay. 2. Amendment of physiotherapy prioritisation matrix
Medical Clerking Proforma Initial Audit	1. Audit findings presented at Clinical Governance and teaching sessions to emphasize the importance of accurate and complete documentation. 2. Current proforma updated for upload to Sunrise Electronic Patient Records.
Quality of Consent in Cardiac Procedures re-audit round 2	1. Circulation of recommendations for consent in the Catheter Laboratory sent to laboratory staff by way of an aide-memoire. 2. Pre-printed labels to be used for patient identification and cross-site procedure specific information to improve legibility of consent forms.
An audit to determine whether exercises are being provided to stroke patients with muscle weakness	1. Review of standardised exercise sheets to ensure that evidence-based advice is provided to patients. 2. Update of discharge checklist to include tick box to provide exercise sheets. 3. Provision of standardised exercise sheet to community services to improve flow and communication between the Acute and Community teams.
Acute Stroke Swallow Assessment	Change of the format of the swallow assessment tool to ensure correct nutrition and lower the risk of aspiration pneumonia
Concordance of Clinical and Imaging Coding with expected and actual Cancer Rates in the Symptomatic Breast Clinic	1. Email audit results to all staff who use clinical and imaging coding for the Symptomatic Breast Clinic 2. Write new SOP using audit findings titled “Clinical Examination of Breast Patients”
An Audit to Evaluate the Diagnostic Adequacy and Safety of Percutaneous Image Guided Liver Biopsy	Fully compliant with standards, no actions required.
Diagnostic Yield of Spinal Disc Biopsies for Malignancy or Infection at MTW Trust	Endeavour to have doctors hold off antibiotics until the disc biopsies are complete by distributing the report to key teams within Trust and advisory email to GPs.
Creating a new local CT Urogram protocol by retrospectively auditing the renal collecting system’s opacification.	Creation of a new CTU protocol to improve the efficacy of scans.
Temporal Artery Biopsy Audit	Clinicians to be made aware of the potential for tissue shrinkage after biopsy sample is taken and fixed in formalin.

Clinical Audit Title	Key Actions
NICE NG157; Guidance for elective shoulder replacements	1. The information leaflet for patients for elective Total Shoulder Replacement to be reviewed and updated. 2. Departmental discussion and consensus regarding the routine in-wound use of Tranexamic Acid and subsequent documentation of its use.
Re-audit of NICE CG98: the management of Neonatal Jaundice	Increase the use of transcutaneous bilirubinometer in Children's Services: 1. Add training in the use of transcutaneous bilirubinometer to induction sessions 2. Purchase additional transcutaneous bilirubinometers.
Safeguarding reports: are we doing it well? Completion of the audit cycle	1. Create a new template for safeguarding reports based on RCPCH's reports template. 2. Weight and height measuring equipment to be available at all required locations. 3. Update proforma to include parental discussion box on Sunrise Electronic Patient Records.
Hepatitis B&C - ways to promote and offer testing (NICE PH43 Criteria 7 only)	1. Improve team knowledge and documentation of Hepatitis B&C including "At Risk Groups" by reviewing case studies in Clinical Governance session. 2. Staff to revisit e-learning for health on Hepatitis B&C.
Re-audit of the Management of Urinary Tract Infections (UTIs) in the sexual health clinic	1. Training for staff on the core symptoms and urine analysis results to diagnose a UTI. 2. Develop UTI clinical diagnosis sheet for Clinical Management Summary on UTIs.
The use of condoms as the sole method of contraception.	1. Teaching session for staff within next three months regarding improving documentation. 2. Raise awareness of the facility to quickly and easily send links to leaflets via text whilst in the consultation (SMS templates).
Audit to assess documentation of recommended data and health parameters when providing Depo-Provera.	1. Develop the B.O.S.S. assessment (B = bones; O = observations; S = smoking status; S = smear test) and implement it. 2. Training session for all staff about the B.O.S.S assessment.
NICE NG 126, QS 69; Re-audit of Diagnosis & Management of Pregnancy of Unknown Location (PUL)	1. Improve communication regarding PUL within the team by updating the clerking proforma. 2. Ensure team is aware of updated NICE guidance and Trust guideline and when to escalate to Consultants by including in induction training session.
NICE NG133, QS35 Re-audit of Hypertension in Pregnancy	Use of mandatory risk assessment question on E3 (electronic patient records) to prompt Midwives and Obstetricians to risk assess patients for pre-eclampsia.
Re-audit of Clinical Outcomes of Obstetric ITU Admissions in 2018 & 2019 at TWH	Fully compliant with standards, no actions required.

Clinical Audit Title	Key Actions
Re-audit of compliance to the swab counting policy in the Obstetric Unit	Review and update the policy to reflect the move to recording SNI counts on the electronic E3 system. Update the departmental guideline. To be included in E3 training.
Audit of management of Obstetric Cholestasis	1. Disseminate the audit recommendations to all the maternity staff and publish it in Women's Echo newsletter. 2. Distribute guideline to all clinicians via email and ask for email confirmation that they have read and understood the guideline.

Part **five**


Exceptional people,
outstanding care
We put patients first!
62 DAY CANCER
STANDARD MET
FOR A YEAR
MTW

Stakeholder feedback

1. West Kent Clinical Commissioning Group
2. Health Overview and Scrutiny Committee – Kent County Council
3. Healthwatch Kent
4. Statement of Directors' responsibilities

West Kent Clinical Commissioning Group comments on the 2020/21 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

NHS
Kent and Medway
Clinical Commissioning Group

Ref: **Maidstone and Tonbridge Wells NHS Foundation Trust Quality Account**

Nursing & Quality Directorate
Paula Wilkins
Executive Chief Nurse
NHS Kent & Medway Headquarters
81 Station Road
Ashford
Kent
TN231PP

Claire O'Brien
Chief Nurse
Trust Headquarters
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ

Sent via email

27th May 2021

Kent and Medway CCGs MTW Quality Account Comments 20/21

Dear Claire,

We welcome the Quality Account for Maidstone and Tunbridge Wells NHS Trust (MTW). The CCG has a responsibility to review the Quality Accounts of the organisation each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document and the CCG confirms that the Quality Account has been developed in line with the national requirements with all of the required areas included.

Your report clearly sets out your key areas of quality focus for the coming year, by identifying priorities for 2021 for each of the three key quality domains; patient safety, patient experience and clinical effectiveness.

It is evident that Quality Improvement continues to drive your work and although the pandemic has had a major impact on your services, it has resulted in innovative ways of working and positive changes to patient pathways.

Staff at MTW are referred to in the account as a 'family of exceptional people' and their dedication has resulted in some key achievements during the pandemic by; increasing critical care capacity, delivering the 62 cancer access standard and consistent good performance for Emergency Department performance indicators. The culture of the staff is reflected in the response to the staff survey, carried out in the middle of the pandemic, which showed increased staff engagement rates. It is important to note the significant amount of work the Trust has put into supporting staff well-being during this time, alongside innovative ways of engaging with patients and their visitors. This includes the use of video messaging services for patient visitor interactions and the use of video messaging app on the neonatal unit. In addition, the awards the Trust and its staff have been nominated for and received confirms that patients are at the heart of everything you all do.

We would like to thank all of the staff at the trust for their hard work during this unprecedented time.

There is a thorough overview of the work that you have all undertaken this year with a focus on quality. Although the Trust's clinical audit plan was affected, it is noted that audits continued and were prioritised on those relating to clinical care. The Trust contributed to national and international studies relating to the pandemic to support service evaluations. There is a clear commentary on audits which were carried out and how they affected patient experience and outcomes. The research which has continued through the pandemic is noted in particular the responsiveness to which the team enabled delivery of COVID-19 research.

The continued relationship between the Trust and the CCG has allowed collaborative working which will develop into working together within our Integrated Care System (ICS). As the main provider of acute NHS services for the population in West Kent, the CCG Quality Team is proud to support the trust in their vision to provide: 'Outstanding hospital services delivered by exceptional people' with the Trust's objectives; To be recognised as a caring organisation, To provide sustainable services and To be improvement-driven across all areas.
Throughout the report you have provided clear and measurable objectives for the coming year, and have maintained the focus within the three clear domains, which gave the report a clear flow, that would be easy to follow for members of the public who may have an interest in reading this report.
In conclusion, the report is well structured and highlights that the quality of patient care remains a clear focus for the organisation and at the forefront of service provision. The CCG thanks the organisation for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working in the future.

Yours sincerely,

Paula Wilkins
Executive Chief Nurse for NHS Kent and Medway Clinical Commissioning Group

Health Overview and Scrutiny Committee – Kent County Council comments on the 2020/21 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Sent via email
semberson@nhs.net
Sarah Emberson
Patient Outcomes and Innovations Manager
Maidstone & Tunbridge Wells NHS Trust
Hermitage Lane
Maidstone
Kent
ME16 9QQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 11 June 2021

Dear Sarah,

Maidstone & Tunbridge Wells NHS Trust Quality Accounts 2020-21

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on the Maidstone & Tunbridge Wells NHS Trust's Quality Account. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trust which will be looking to KCC's HOSC for a response, and the short window for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of services delivered by your organisation and as part of it's ongoing overview function, the

Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk

Healthwatch Kent response to the Maidstone and Tunbridge Wells NHS Trust Quality Account

Healthwatch Kent response to the Maidstone and Tunbridge Wells NHS Trust Quality Account

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource into making a difference to services rather than reading Quality Accounts.

However, we'd like to support the Trust by setting out the areas we have worked together on in the past year:

- We have a strong and constructive relationship directly with the Trust. We meet regularly with the Chief Nurse, Deputy Chief Nurse and the Patient Experience Lead. We share the feedback we hear from the public directly with them.

- On some occasions we have escalated individual cases to them for immediate action and we're pleased to report that these are picked up and resolved swiftly.
- We are regular attendees as the Patient Experience Committee where we have a standing agenda item to update and discuss our joint work.
- We helped the Trust to organise a session with stroke patients and their families and carers as part of the Trust's plans to develop a new hyper acute stroke unit (HASU). The feedback from people that day has already been used to inform the new unit.
- More recently, we wanted to hear from Medway residents who were being treated on the stroke ward at Maidstone. The Trust willingly helped us to reach stroke patients because we were unable to visit ourselves during the pandemic. The feedback from that exercise will be shared shortly.
- Most encouragingly this year, the Trust have talked to us about their desire to hear from more patients across a range of communities. We offered to develop a Facebook group to enable them to hear directly from people who had been inpatients with Covid. The group, which is a pilot, has been established and is enabling the Trust to hear from and communicate with people about their experience.
- As always, we have continued to review the Trust's communication and engagement materials offering advice and suggestions about how they could be improved. In addition, we provide advice about how best to meet the Trust's statutory requirements to engage and involve people around any changes to services.
- Following our reports looking at the Accessible Information Standard, the Trust have made improvements including Makaton and BSL training being delivered to AIS champions and Recite me software has now been signed off for their new website.

You can read all the reports relating to our work with MTW on our website.
www.healthwatchkent.co.uk

We look forward to continuing our constructive working relationship with the Trust in the year ahead.

Healthwatch Kent June 2021

Statement of Directors' responsibilities

To be included once approved by Trust Board

Miles Scott
Chief Executive

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

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

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 12/05/21

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

Information, assurance and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Mortality Surveillance Group Report

May 2021

MTW
exceptional people, outstanding care

Contents

Note: Detailed analysis and a deep dive into specific areas are available on request - mtw-tr.informationdepartment@nhs.net

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

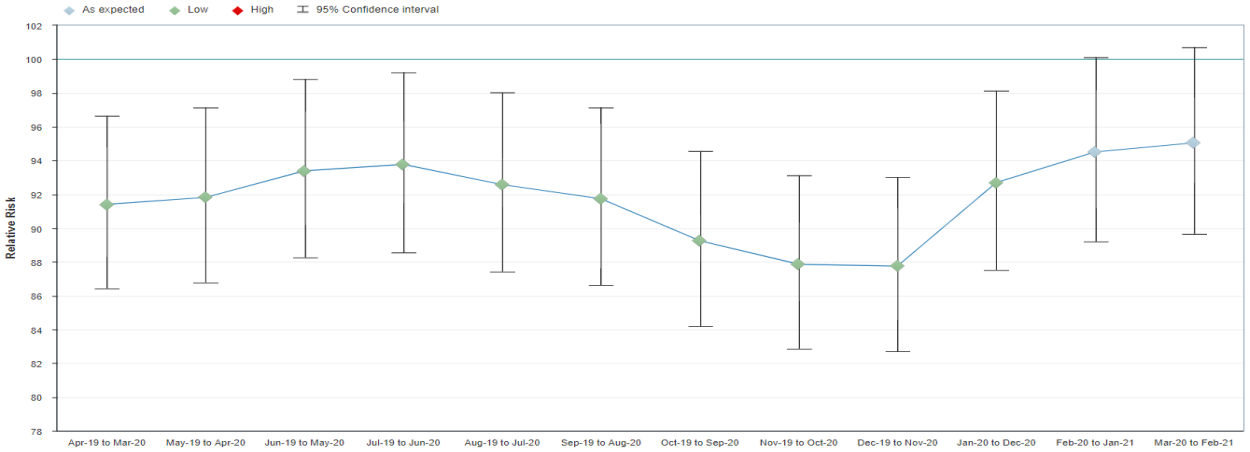
- HSMR has increased from previous month as we continue into wave 2 of Covid in the dataset – Rolling HSMR currently at **95.1** and still performing well against the standard ratio of 100
- Monthly HSMR shows a decrease in January 20 (**116.8**), as the peak of wave 2 of Covid is passed
- As a Trust we continue to perform well amongst our local peers as well as those trusts rated Good or Outstanding by the CQC
- CUSUM alerts for viral infections have increased further from November 20 – driven by Covid
- Deaths with no comorbidities are reducing slightly on a rolling 12 month basis. Those deaths with no comorbidities focussed on Geriatric and General Medicine
- Covid HSMR for the Trust is higher than our Kent peers, with investigations as to the driver of this continuing
- Trust SHMI continues to perform in the green for the 7th month running

MTW exceptional people, outstanding care

HSMR Overview

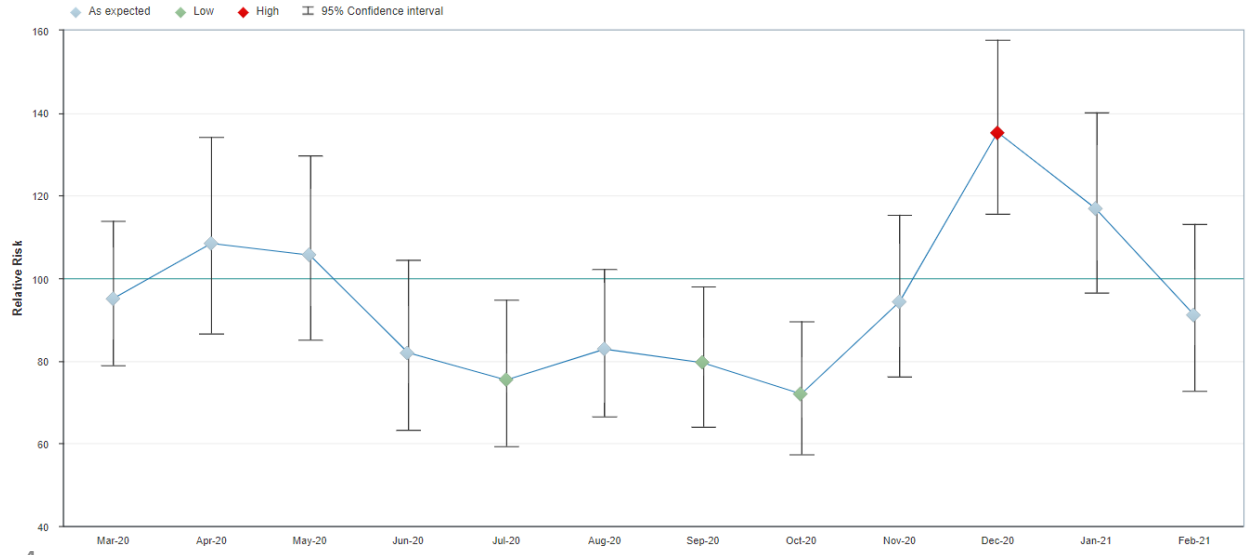
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Months



The 12 months **March 2020 to February 2021** show our HSMR to be **95.1**, which is higher than last month's figure of 94.2

Monthly View



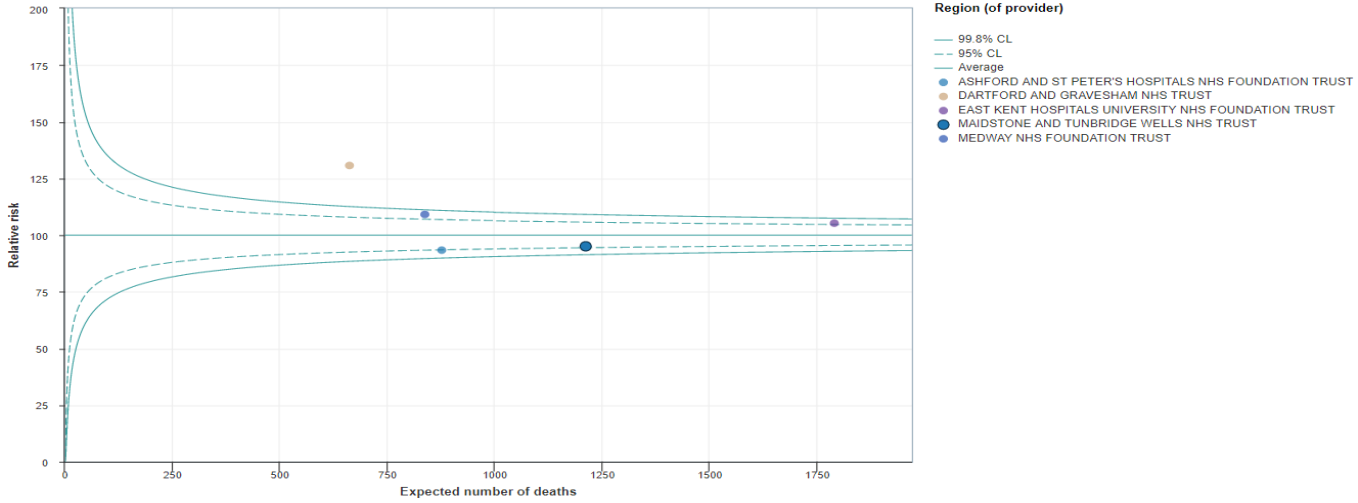
The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so **January 2021** in this case, shows that the Trust's position has **decreased** to 116.8 from 135.3 in December 2020. This decrease puts the HSMR back within the "as expected" bracket.

MTW exceptional people, outstanding care

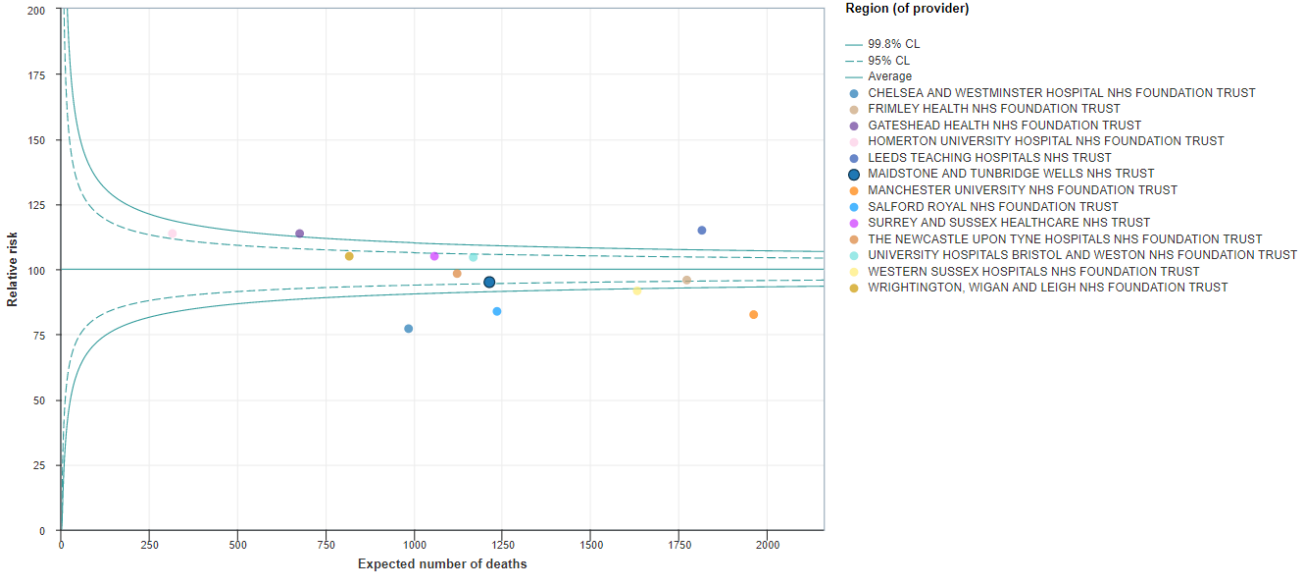
HSMR – Benchmarking

Maidstone and Tunbridge Wells NHS Trust

Kent Peers



Good & Outstanding Trusts



MTW continues to perform well both amongst it's local peers as well as with Good & Outstanding performing Trusts

MTW exceptional people, outstanding care

CUSUM Alerts - Overview

NHS
Maidstone and Tunbridge Wells
NHS Trust

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	2 6	107942	1854	1711.3	1.7	108.3				
HSMR (56 diagnosis groups)	9 2	42174	1153	1213.0	2.7	95.1				
Asthma	1	224	6	1.1	2.7	548.8				
Fluid and electrolyte disorders		541	30	19.6	5.5	153.1				
Pneumonia	1 2	1217	184	154.2	15.1	119.3				
Septicemia (except in labour)	1	737	153	117.1	20.8	130.7				
Skin and subcutaneous tissue infections	1	1552	25	14.1	1.6	177.4				
Viral infection	34	1990	461	210.5	23.2	219.0				
All Procedures	2 7	75037	1282	1222.2	1.7	104.9				
Diagnostic imaging (except heart)	6 4	12593	460	465.3	3.7	98.9				
Extirpation of lesion of external ear	1	6	1	0.0	16.7	8028.9				
Other drainage of peritoneal cavity	1	320	30	19.0	9.4	158.2				
Rest of Upper GI	1 8	848	212	152.0	25.0	139.4				
Surgical arrest of bleeding from internal nose	1	51	2	0.5	3.9	429.6				
Total excision of kidney	1	5	1	0.0	20.0	3715.1				
Urethral catheterisation of bladder	1	1063	122	93.3	11.5	130.8				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Viral infection	219.0	1990	461	210.5	250.5
Rest of Upper GI	139.4	848	212	152.0	60.0
Septicemia (except in labour)	130.7	737	153	117.1	35.9
Pneumonia	119.3	1217	184	154.2	29.8
Urethral catheterisation of bladder	130.8	1063	122	93.3	28.7

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Aortic and peripheral arterial embolism or thrombosis	237.2	8	3	37.5
Spinal cord injury	292.4	3	1	33.3
Cardiac arrest and ventricular fibrillation	50.2	29	8	27.6
Peripheral and visceral atherosclerosis	132.9	66	18	27.3
Amputation of leg	444.0	4	1	25.0

As the data continues into wave 2 of Covid we see more alerts under viral infection, with red alerts three months running (detailed in next slide).

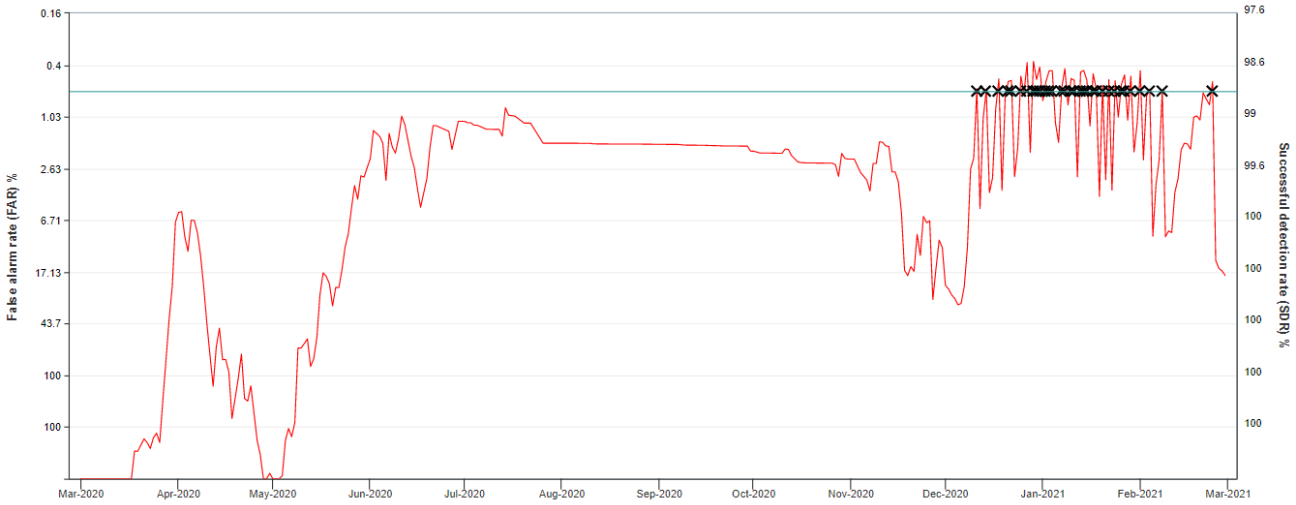
Residual Codes, Unclassified is no longer an alert.

MTW
exceptional people, outstanding care

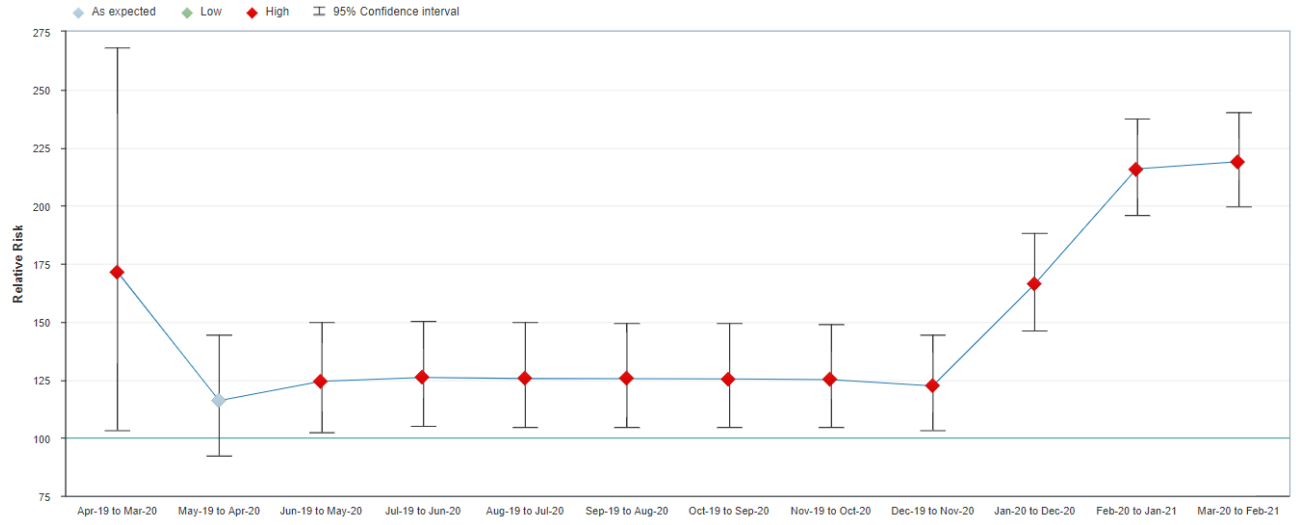
CUSUM Alerts – Viral Infection

Maidstone and Tunbridge Wells NHS Trust

CUSUM Alerts by Month for Viral Infection



HSMR - Rolling 12 Months – Viral Infection



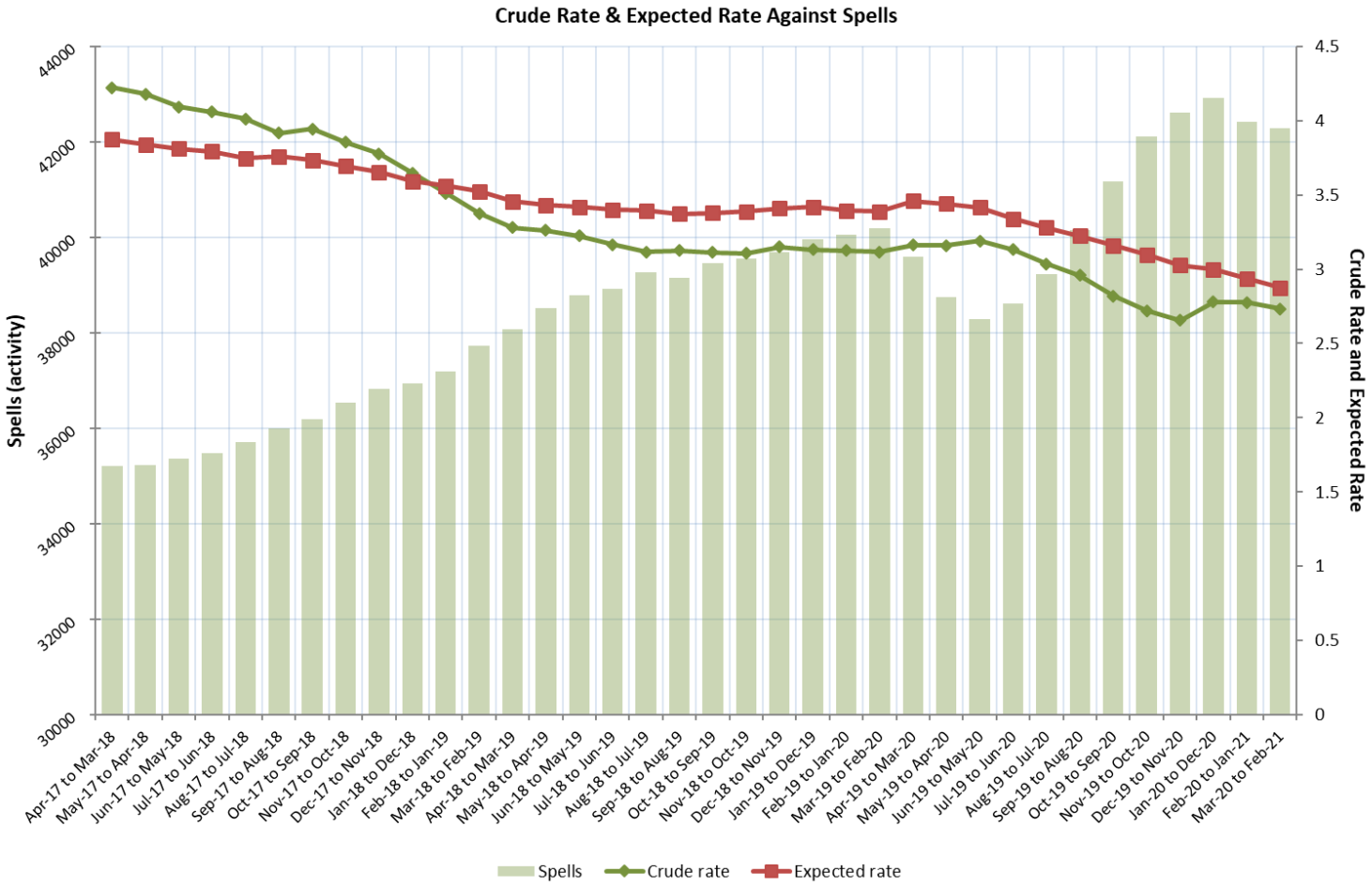
For the period of March 2020 to February 2021, Viral infection had a relative risk of 219.0**,** continuing to show a CUSUM alert as wave 2 of Covid progressed.

These relate to **1990** spells, of which **1728** are Covid-19

MTW exceptional people, outstanding care

Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust

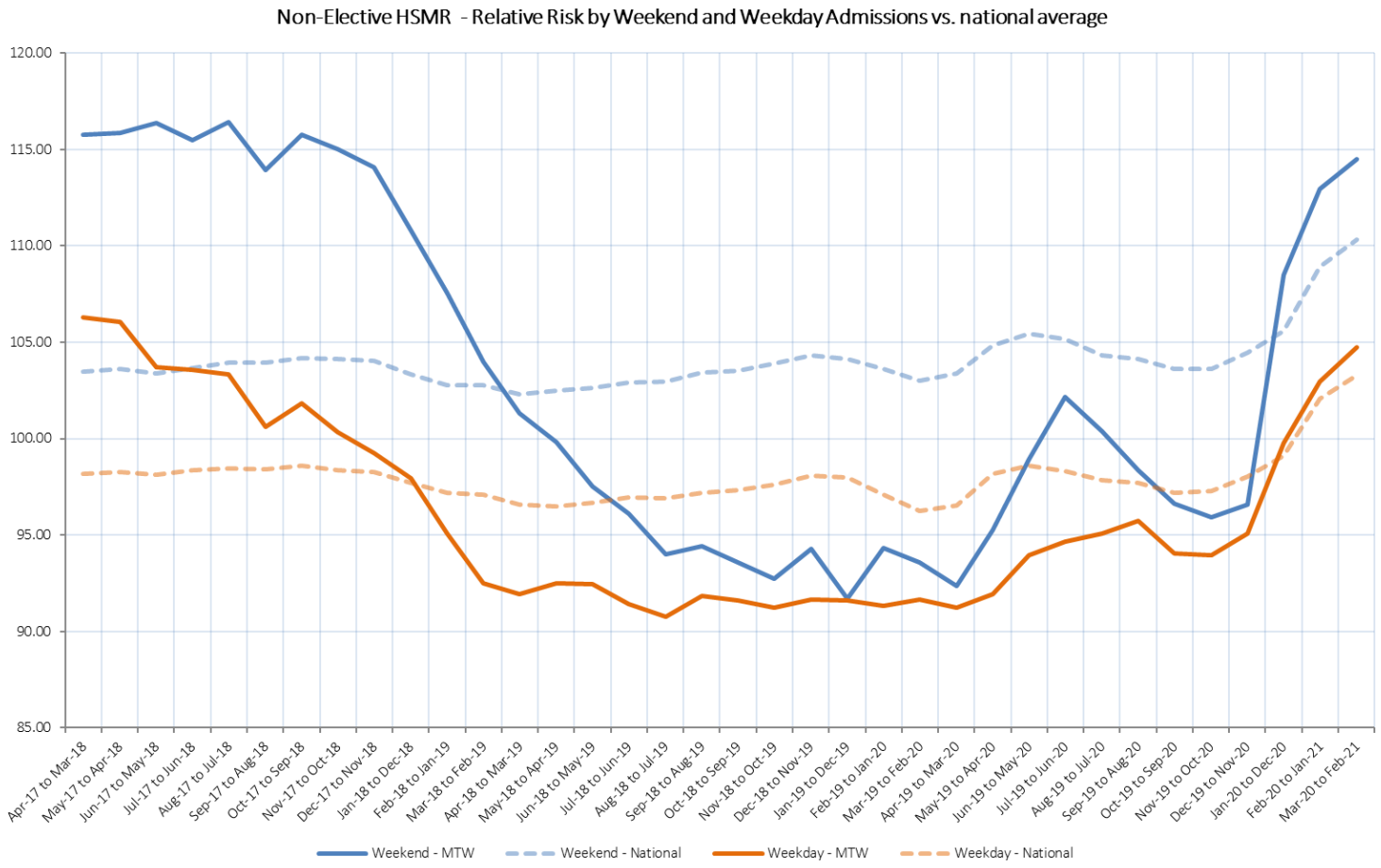


Crude and Expected Rates continue to improve. Reduction in spells continue.

MTW exceptional people, outstanding care

HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



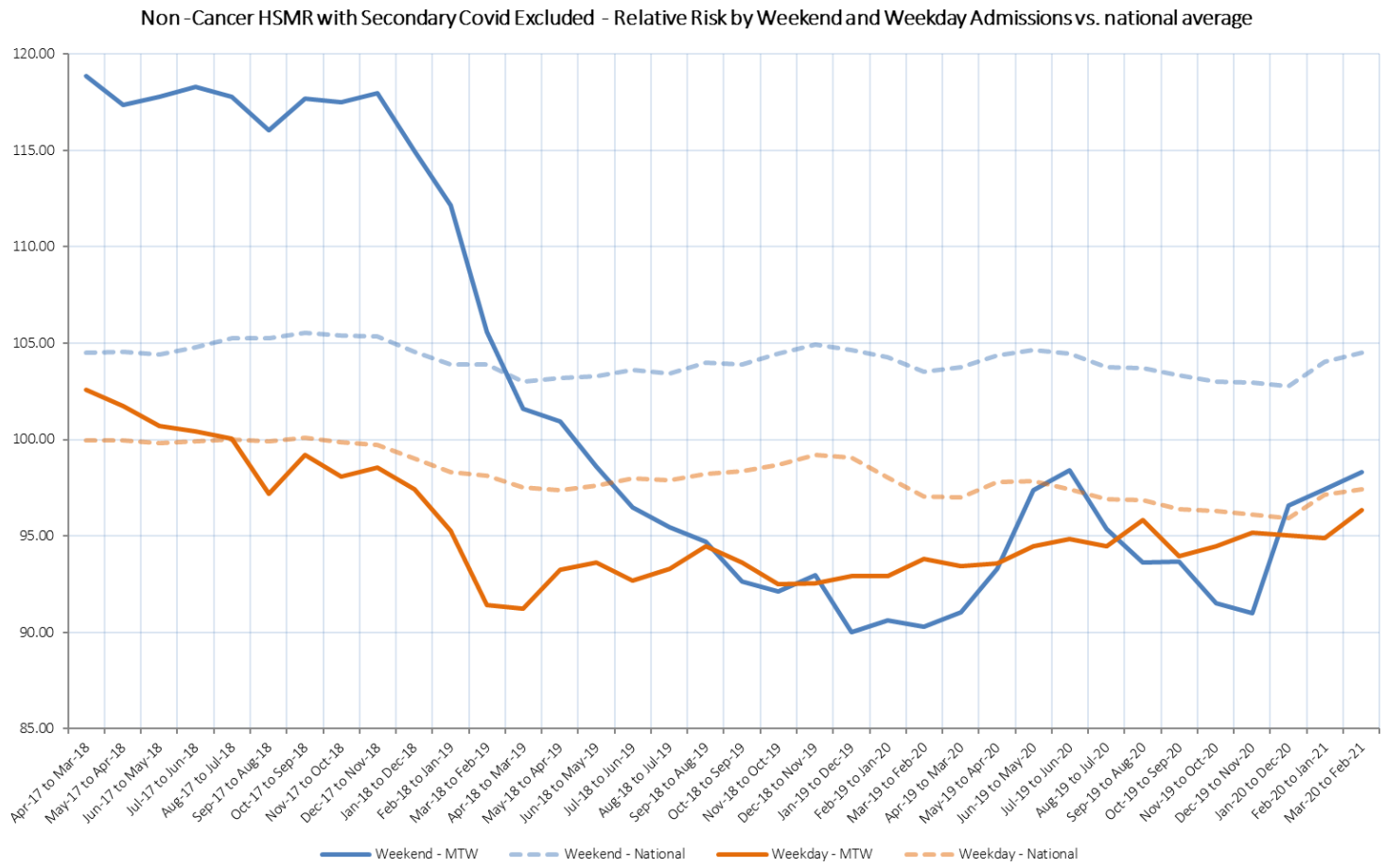
Weekend and Weekday HSMR for non-elective care are now above the national average. **Weekend** figures in particular have a larger gap with the national average for the period of **Mar 20 – Feb 21** compared to the smaller spike nationally with a relative risk of **114.51** vs **110.31** nationally.

Whilst HSMR does not include Covid, the increase parallels the prevalence of the Kent variant of Covid is a potential contributing factor for being above the national average.

MTW exceptional people, outstanding care

HSMR – Weekend & Weekday Comparison – Cancer & Covid Exclusions

Maidstone and Tunbridge Wells NHS Trust

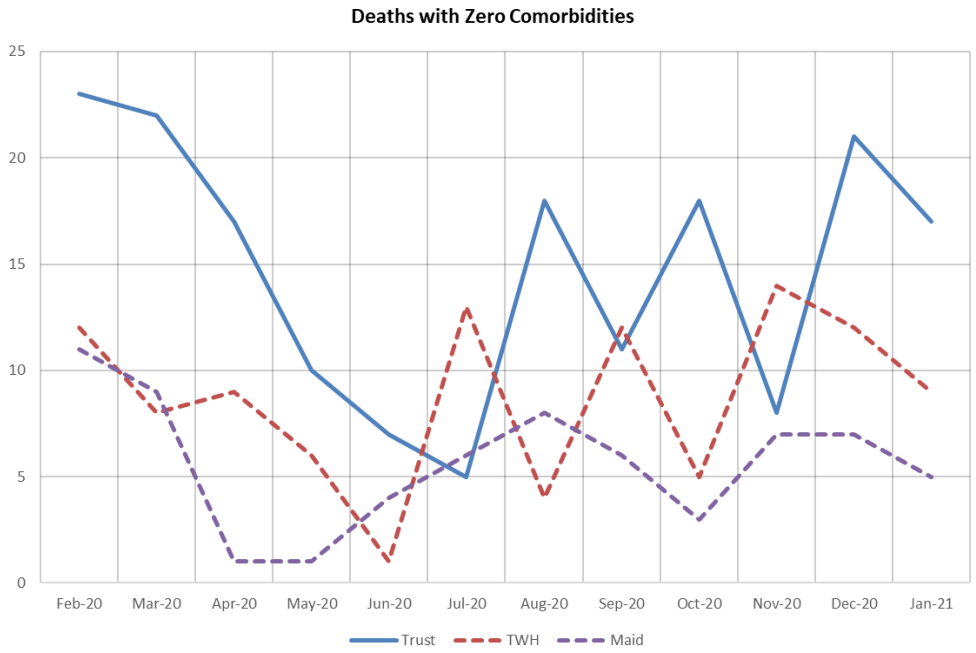


A deep dive into the drivers behind Weekend HSMR revealed an impact from being an Oncology Centre as well as secondary Covid diagnoses (increased by the Kent variant).

Excluding cancer and secondary Covid diagnoses show the trust favourably against the national rate

MTW exceptional people, outstanding care

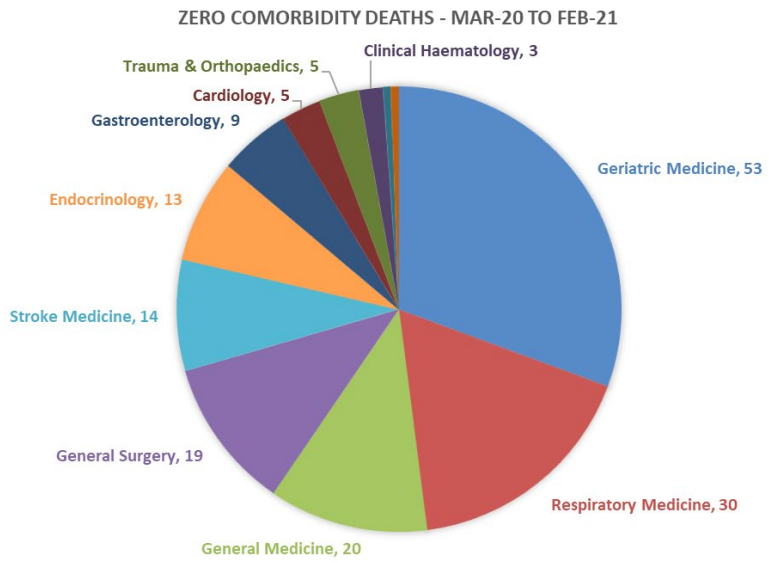
Deaths with Zero Comorbidities



Month	Trust	TWH	%	Maid	%
Mar-20	23	12	52.2	11	47.8
Apr-20	17	8	47.1	9	52.9
May-20	10	9	90.0	1	10.0
Jun-20	7	6	85.7	1	14.3
Jul-20	5	1	20.0	4	80.0
Aug-20	19	13	68.4	6	31.6
Sep-20	12	4	33.3	8	66.7
Oct-20	18	12	66.7	6	33.3
Nov-20	8	5	62.5	3	37.5
Dec-20	21	14	66.7	7	33.3
Jan-21	19	12	63.2	7	36.8
Feb-21	14	9	64.3	5	35.7
All	**173**	**105**	60.7	**68**	39.3

We can see that the number of deaths with zero comorbidities has increased as wave 2 of Covid continued. Of the **1,154** deaths recorded in the period of **March 2020 to February 2021**, **173** had no comorbidities recorded (**14.99%**). This rolling annual figure has dropped from last month.

Deaths with Zero Comorbidities – By Specialty

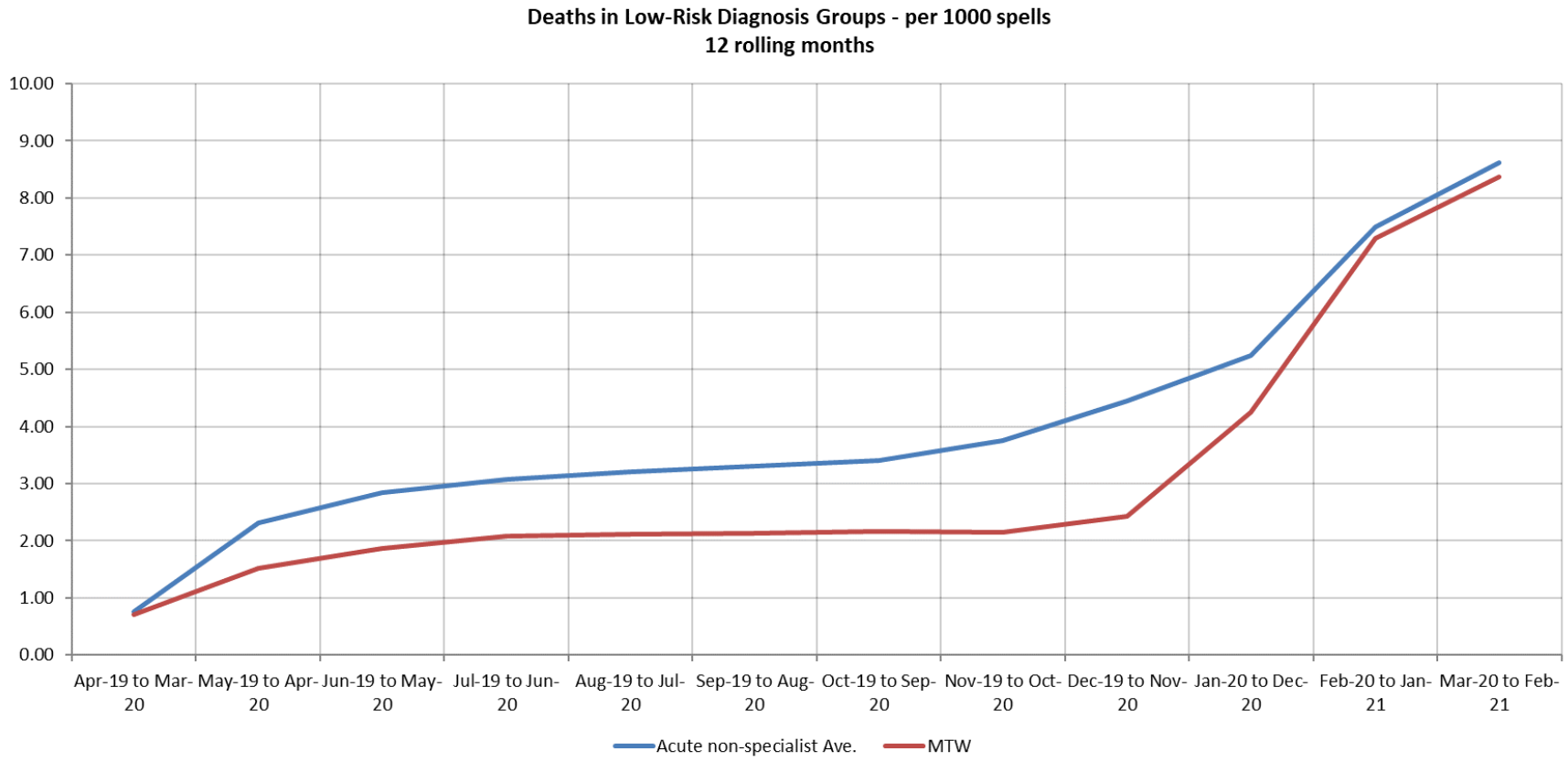


	Jan-20 Dec-20		Feb-20 Jan-21		Mar-20 Feb-21	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	57	33%	58	32%	53	31%
Respiratory Medicine	33	17%	31	17%	30	17%
General Medicine	24	15%	21	12%	20	12%
General Surgery	15	9%	16	9%	19	11%
Stroke Medicine	12	9%	14	8%	14	8%
Gastroenterology	11	5%	12	7%	9	5%
Endocrinology	12	3%	14	8%	13	8%
Cardiology	4	2%	4	2%	5	3%
Clinical Haematology	4	1%	3	2%	3	2%
Trauma & Orthopaedics	5	2%	6	3%	5	3%
Anaesthetics	2	1%	2	1%	1	1%
Accident & Emergency	1	1%	0	0%		0%
Paediatrics		0%	0	0%		0%
Neonatology	1	0%	0	0%		0%
Gynaecology	1	0%	1	1%	1	1%
Urology		0%	0	0%		0%
Obstetrics		0%	0	0%		0%
All	182		182		173	

Trends continue month on month, with almost half of the deaths with zero comorbidities being in the **Geriatric and Respiratory Medicine specialties**. The overall figures are showing a drop in volumes of deaths with zero comorbidities

Deaths in Low Risk Groups

Maidstone and Tunbridge Wells NHS Trust



As a Trust we continue to be below our peers in acute, non-specialist Trusts in Deaths in Low diagnosis groups per 1000 spells, though the gap is narrowing.

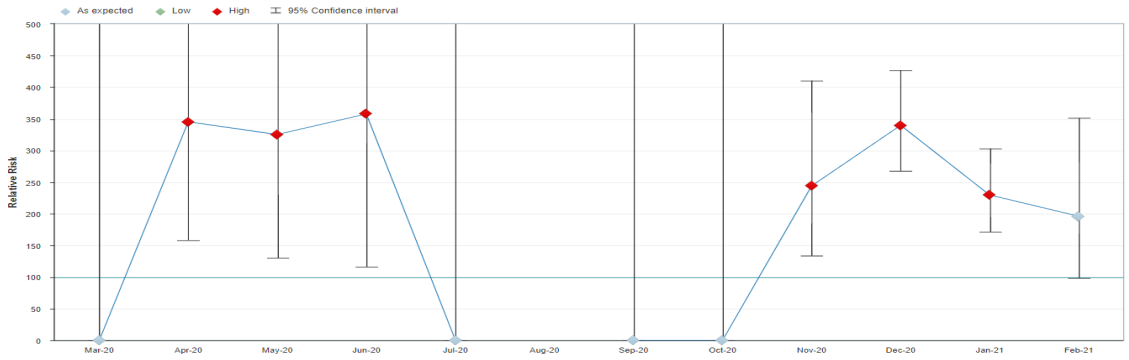
The volume of deaths in low risk diagnosis groups has increased to **293; 218** of these are attributed to Covid

MTW exceptional people, outstanding care

Covid 19 Mortality

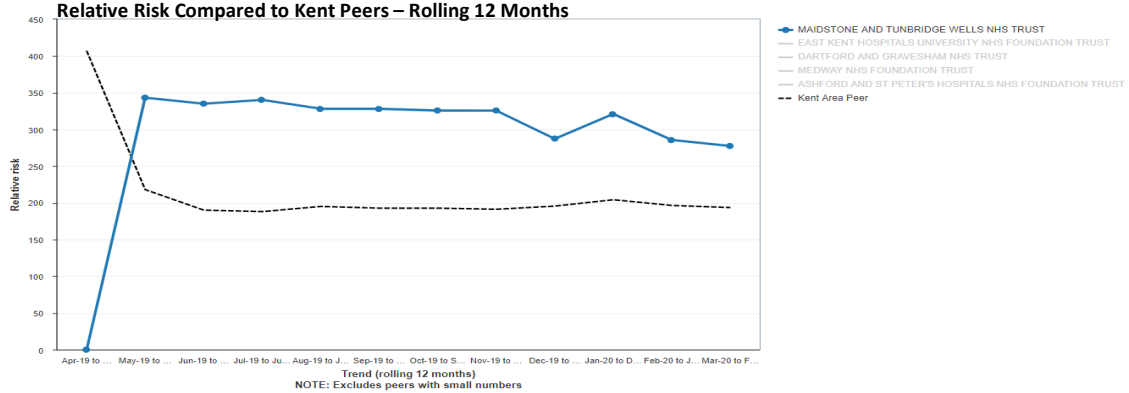
Maidstone and Tunbridge Wells NHS Trust

Monthly Relative Risk for Covid Diagnoses



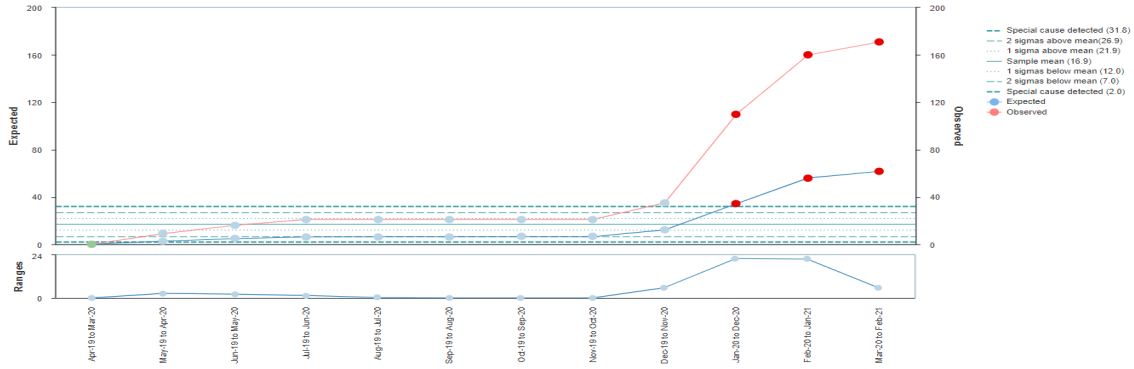
Relative Risk shows the Trust returning to "as expected" for Covid deaths in February. The benchmark is of course very unstable and is rebuilt each month by Dr Foster

Relative Risk Compared to Kent Peers – Rolling 12 Months



Our Relative Risk continues to be higher than that of our Kent peers at **277.5** against 193.6. Investigations continue as to the root cause of this – including recording anomalies and the impact of the Kent variant of Covid

Expected Deaths against Observed Deaths – Rolling 12 months

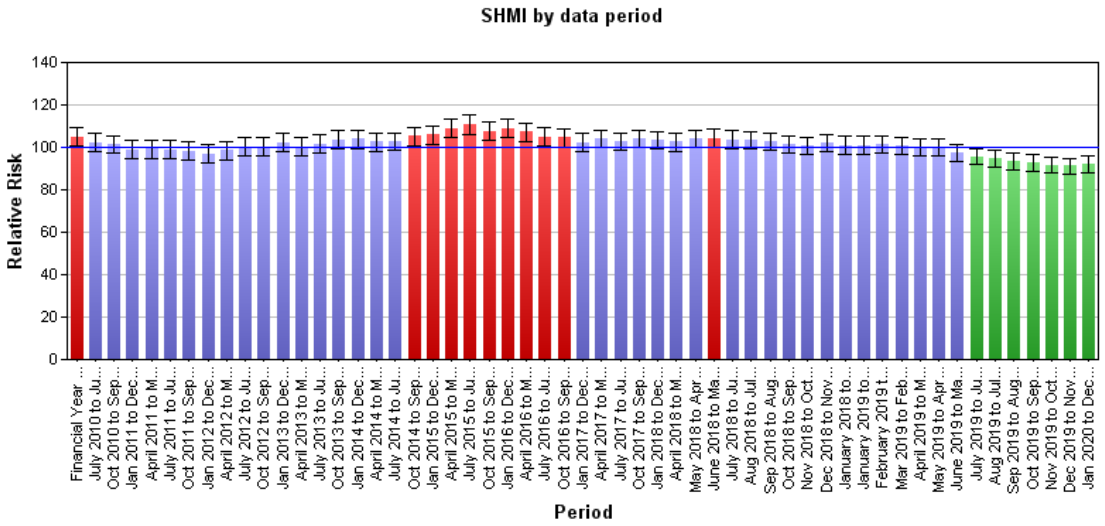


We can see that as wave 2 of Covid continued, our Observed Covid deaths is increasingly higher than Expected deaths.

MTW exceptional people, outstanding care

SHMI

Maidstone and Tunbridge Wells NHS Trust



As a Trust, our SHMI continues to be favourable, with a 7th month running being a positive outlier for the period of Jan-20 to Dec-20.

SHMI contextual indicators

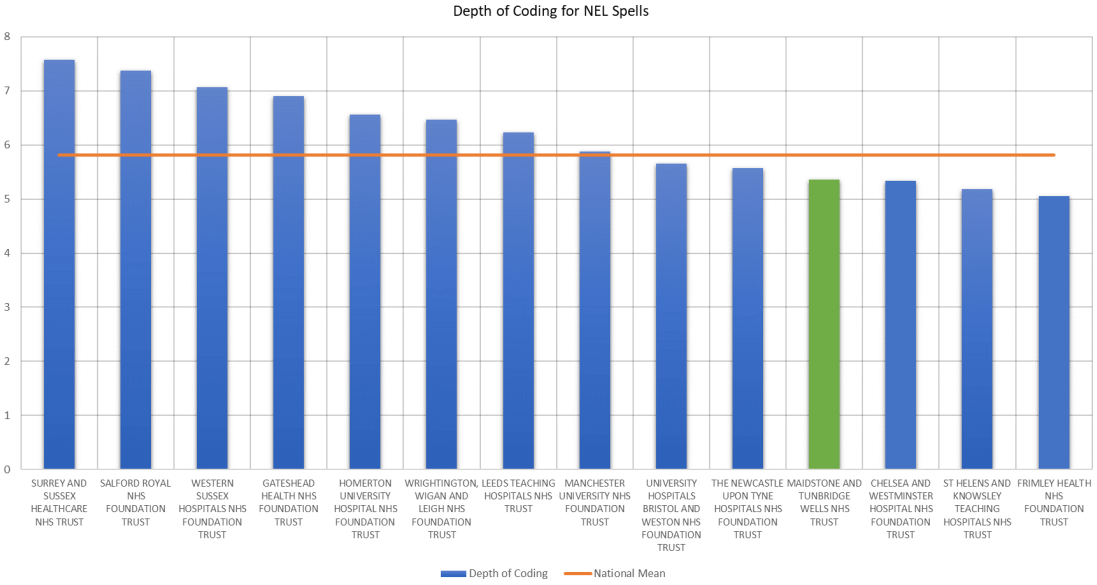
Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	1.9	1.8
Percentage of provider spells with palliative care coding	1.9	1.8
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	43.0	36.0
Percentage of deaths with palliative care coding	43.0	37.0
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	3.3	3.5
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	62.0	69.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	38.0	31.0

Within the contextual indicators, we continue to be an organisation with fewer deaths in hospital

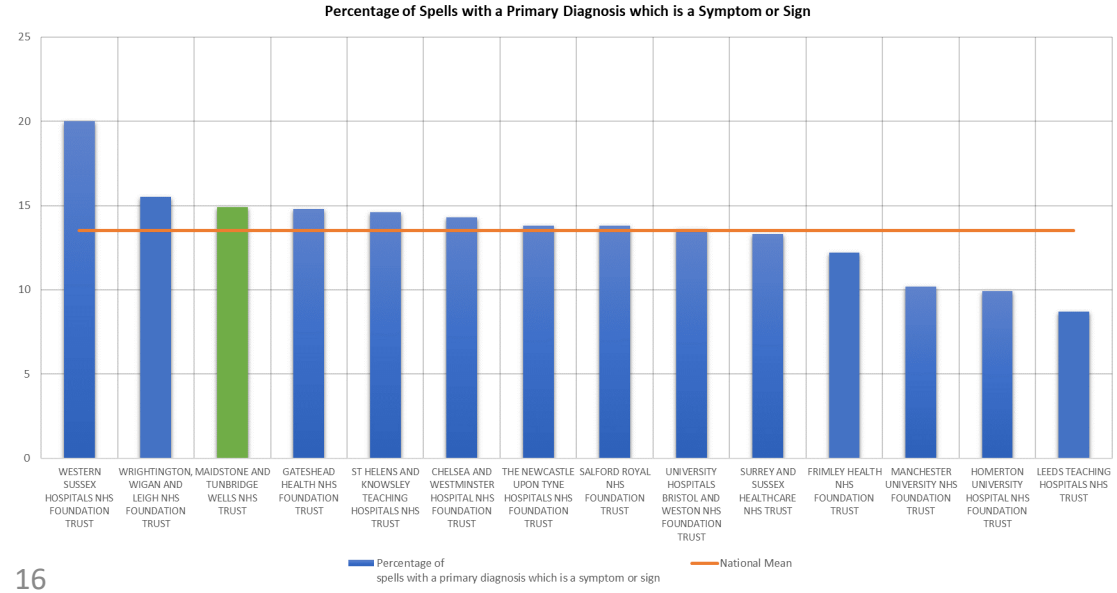
SHMI Reporting Link

MTW exceptional people, outstanding care

SHMI – Contextual Indicators

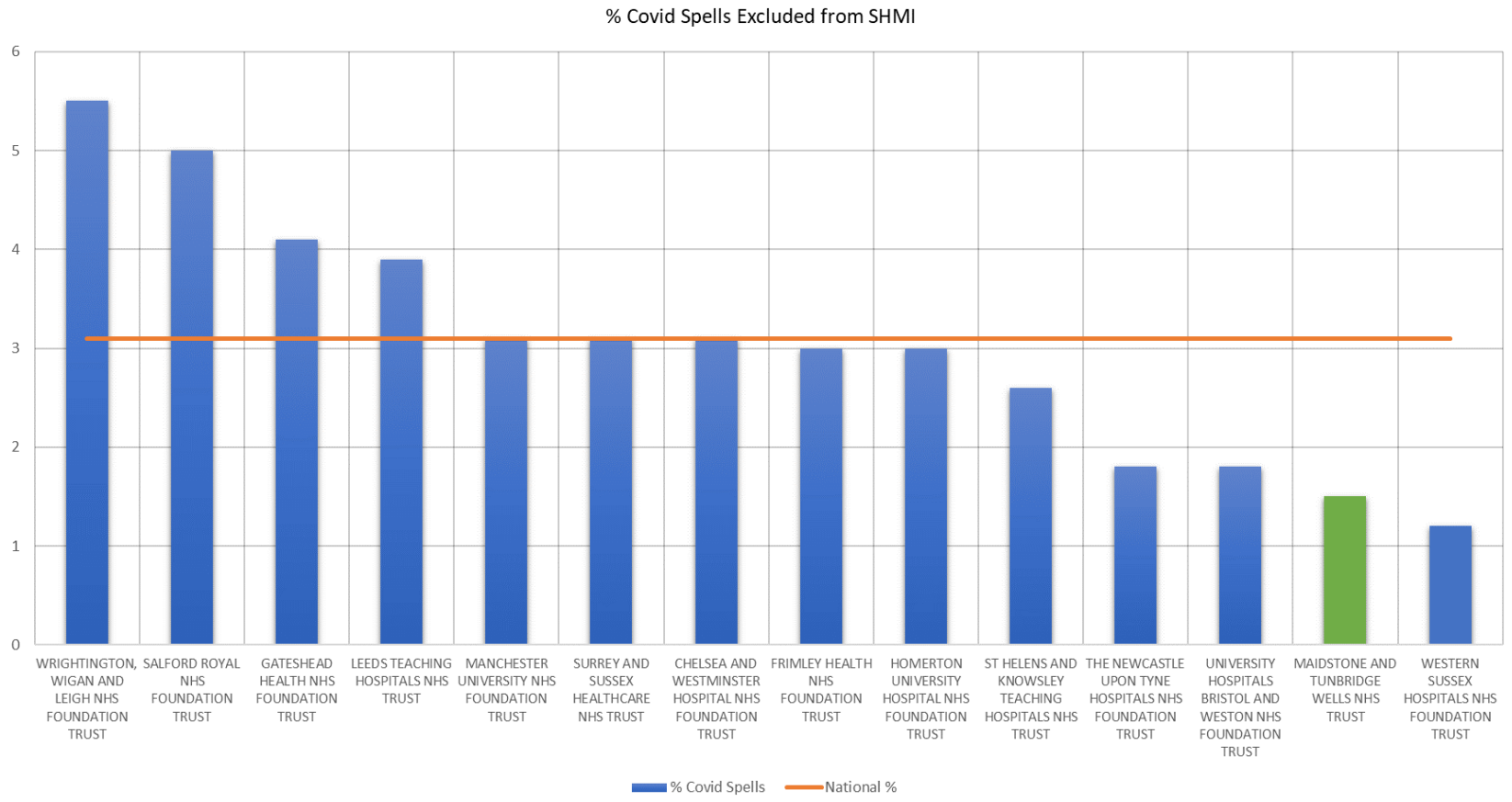


Depth of coding or the trust is below national average and in the lower half of our Outstanding and Good Rated peers, though we have improved on the previous month



The Trust's percentage of spells that have a Primary Diagnosis that is a symptom or sign is above the national average and the 3rd highest amongst our Outstanding and Good rated peers

SHMI – Contextual Indicators - Covid



SHMI excludes Covid Spells, but does track spells excluded due to Covid. We are an outlier on the number of spells due to Covid – excluding the 2nd smallest percentage amongst our Good and Outstanding peers. This points further to a recording issue to be resolved

Clinical Coding Update

Maidstone and Tunbridge Wells NHS Trust

Current month's Key activities / events:

- Audited SHMI patients with R00-R99 in primary diagnosis field
  - These were coded correctly
  - Identified data error where **R69 Unknown and unspecified causes of morbidity** has been submitted as primary diagnosis for a number of cases when this code has not been assigned*
  - Reviewed a number of the **R69 Unknown and unspecified causes of morbidity** cases and it appears to be auto-assigned as the spell is not coded by first sus submission (flex) due to delay in coding

***R69 Unknown and unspecified causes of morbidity** would never be assigned*

Next month's Scheduled activities / events:

- Continue to monitor R00-R99 coded in primary position
- Complete COVID Mortality audit as agreed week commencing 07th June

Summary of key Issues:

- Lag in coding due to workload at MGH

Summary of key Risks:

- Delay in coding leading to an increase of **R69 Unknown and unspecified causes of morbidity** being auto-assigned at first sus submission (flex) due to delay in coding

MTW exceptional people, outstanding care

Medical Examiners Service

Maidstone and Tunbridge Wells NHS Trust

ME Service Update

- Deaths scrutinised by the Service have significantly decreased and stabilised since February due to a reduction in COVID related deaths
- In April the ME Service achieved a 100% scrutiny of deaths and referred 10% of cases for a Structured Judgement Review (SJR)
- The Service has received compliments about the quality of the service and patient's relatives have expressed their appreciation
- Members of the ME Service attended a National Medical Examiners conference in April 2021 and a key message was the Medical Examiners Service is to be ratified into a statutory requirement.
- The project to roll out the ME Service into the community is fully underway with MTW and community stakeholders involved

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases	% Over 3 Calendar Days to Complete
Sep-20	123	43	35%	14	33%
Oct-20	105	97	92%	11	11%
Nov-20	152	149	98%	39	26%
Dec-20	319	238	75%	132	55%
Jan-21	353	347	98%	245	71%
Feb-21	149	147	99%	42	29%
Mar-21	127	125	98%	16	13%
Apr-21	122	122	100%	30	25%

Challenges faced by the ME Service

- Inability of the Service to complete scrutiny within 3 days is an ongoing problem. Two main reasons have been identified as contributing to this issue
    1. Lack of resilience within the ME Service to cover sickness and holidays, this will have more of an impact as we move into the August holiday season
    2. Delays in completion of summaries by doctors/Qualified Attending Practioners (QAPs)
- Adequate space and IT to support the Service

MTW exceptional people, outstanding care

Mortality Surveillance Group (MSG)

The role of the Mortality Surveillance Group involves supporting the Trust to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary investigated. A further responsibility of the group is to ensure lessons learnt from Mortality reviews are disseminated appropriately and actions implemented to improve outcome for patients and quality of services provided.

Directorate Mortality leads are currently feeding back learning around hospital deaths back into Directorates. A key focus now will be monitoring the effectiveness of information flow from MSG to Directorates and back.

Learning from Mortality reviews identified the following needs:

- Prior to transferring a patient it is important to ensure the receiving team are aware of the transfer and have accepted.
- Specialist teams based on one site should ensure they fulfil their cross-site duties and that management plans are communicated and documented in patient's notes on their behalf even if they are unable to physically attend to the patient
- Septic patients should be prioritised and not be left to the end of Trauma Lists
- Liaise with SECAmb Patient Safety team about oxygen treatment of COPD patients
- Staffing shortage and sickness impacts patient care and falls especially at the Tunbridge wells site
- Consultants need to see patients on elective admission during post operative care

The following practice was highlighted in :

- Good management, senior clinical input with consultant to consultant discussions
- Multidisciplinary team involvement in care plan with prompt input form palliative care team when needed
- Family involved in care and documentation in place when family could not be reached

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Structured Judgement Review (SJR)

An SJR is a standardised review of a patient's death undertaken by a trained clinician making safety and quality judgement of care phases. The SJR reviewer makes explicit comments about phases of care with scores attributed to each phase and the overall care received. The Medical Examiners Service in April 2021 have raised 10% of deaths scrutinised as SJRs.

Year	Outstanding SJRs	Completed SJRs
Apr 17 to Mar 18	2	21
Apr 18 to Mar 19	11	83
Apr 19 to Mar 20	22	75
Apr 20 to Mar 21	21	50
Apr 21 to Mar 22	12	13
SJR Total backlog	68	242

- The current SJR backlog of 68 pertains to SJRs allocated to reviewers, yet to be completed and have exceeded the 4 week stipulated SJR turnaround time.
- There are 24 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 92.

SJR Backlog Recovery Plan

- An SJR dashboard has now being created to maintain oversight of the backlog and monitor turnaround times
- SJR dashboard to be reviewed at monthly MSG meetings
- Additional funding is being sort to address the current backlog
- New SJR reviewers have been identified to support the review process, training is being scheduled

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Mar-21	9	0	0
Apr-21	10	2	0
May-21	6	3	0

- In March there were no SJRs with an overall assessments of 'Poor care' or 'Very poor care' reviewed at MSG
- In April there were 2 SJRs and in May there were 3 SJRs with a 'Poor care' assessment reviewed at both the April and May MSG meetings

Mortality Surveillance Group (MSG)

NHS Maidstone and Tunbridge Wells NHS Trust

Actions from 'Poor care' SJR Reviews

- All 5 SJRs with an overall assessment of 'Poor care' were discussed at MSG and with the Directorates and 1 SJR met the Serious Incident(SI) threshold and will be reviewed as part of the SI process
- Learning from these SJRs have been feedback to Directorates through Clinical Governance meetings.
- MTW Patient Safety team have contacted SECAmb Patient Safety team to highlight learning from SJR review.

Next steps

- Continue to address the backlog
- Work on TIAA action plan from audit nearly complete with the following outstanding items
    - Mortality Policy to be updated and ratified
    - Progress roll out project of the Medical Examiners Service to the Community

MTW exceptional people, outstanding care

NHS Maidstone and Tunbridge Wells NHS Trust

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

The infection prevention and control board assurance framework was submitted to the June 2020 meeting. It was noted at the Trust Board meeting in November 2020 that an updated infection prevention and control board assurance framework would be submitted to December 2020 and monthly thereafter. The latest report is enclosed.

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

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

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

Infection Prevention and Control board assurance framework

The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic
Changes are highlighted in red in the document.

Section 1:

- Clinically vulnerable patients are prioritized for side room in ED.
- Clinically vulnerable patients are prioritized for side room on inpatient wards depending on other IPC risks
- Risk assessment in place using the Hierarchy of Controls to allow staff to wear FFP3 masks when giving direct clinical care to Covid positive patients
- Staff caring for green pathway patients to use Standard Infection Control Precautions (PPE only for blood and body fluid risk)
- Updated national guidance published 1 June 2021
- Hierarchy of controls adopted for IPC risk assessments
- From July 2021, BAF to be reviewed by Board when new guidance is published or there is significant change to report
- No outbreaks in May 21

Section 4:

- Guidance clarified to allow accompanying partners even if no lateral flow test on a case by case basis.

Section 6:

- Green pathway PPE now stepped down to Standard Infection Control Precautions plus masks – informal training on wards by IPCT and circulated through Pulse
- Education centres enabled to use 1m+ distancing when seated. Masks to be worn when standing

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes and Symphony. Copy of ED notes in in-patient record for admitted patients. Pathway documented and agreed with CRG and ICC • Temperature checks in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • Obstetric patients and their partners have Covid PCR 48-72 hours prior to scan appointments • All patients and visitors have temperature check at front door. Mask provided to patients and visitors who do not have face coverings • Checks in place at oncology entrance • Clinically vulnerable patients are prioritized for side room in ED.		

• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	• Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only. • Stated aim is to keep confirmed cases in Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons, PHE guidance is followed. Patients must be 14 days post positive swab, be apyrexial for 48 hours without anti-pyretic medication and have some respiratory improvement. ITU and immunocompromised patients must have negative swabs prior to de-escalation • Suspected patients are isolated on admission pending the results of PCR tests. Medical review must be documented before PCR negative suspected patients are stepped down to green beds • Clinically vulnerable patients are prioritized for side room on inpatient wards depending on other IPC risks		
• That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid contacts are cohorted according to date of exposure • All contacts are nursed in side rooms or bays with the doors shut • All contacts are swabbed twice a week for 14 days • Cohorts with the same isolation date may be merged if necessitated by bed pressure • Level 4 cleaning and UVC		

	decontamination for areas stepped down from Covid to non-Covid		

• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice
  ○ Staff adherence to hand hygiene?
  ○ Staff social distancing across the workplace
  ○ Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:
  ▪ a) clinical
  ▪ b) non-clinical setting
	• IPC audits continue to monitor practice including PPE and hand hygiene. Ward audits and IPC triangulation audits reported through IPCC
	• PPE stocks closely monitored to ensure supplies available
	• PPE posters on all wards.
	• IPC policies available on the intranet
	• Concerns re new variant and high level of staff sickness have led to the Trust recommending FFP3 masks for all staff on Covid wards. Initially for a month but now extended due to delays in second dose vaccination.
	• Maximum occupancy notices on all non-clinical room doors and clinical offices
	• Risk assessment in place using the Hierarchy of Controls to allow staff to wear FFP3 masks when giving direct clinical care to Covid positive patients		

• Monitoring of compliance with wearing appropriate PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE and hand hygiene audits ongoing and reviewed at Infection Prevention and Control Committee • PPE officers on duty every day. Educational, supportive and monitoring role. Advise on PPE use. Induction training for new staff • Sessional mask wearing guidance implemented. Masks provided for non-		

	patient facing staff • PPE officers provide PPE training to new starters • Use of FFP3 masks for all direct care of non-AGP Covid patients has now been stepped down and remains under review • National guidance followed to enable FRSM to be worn for non-covid AGP • Staff caring for green pathway patients to use Standard Infection Control Precautions (PPE only for blood and body fluid risk)		
• Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organizational systems in place to monitor results and staff test and trace	• Symptomatic staff testing by PCR is in place and available both on and off site • Escalation plan in place with trigger points for increasing asymptomatic testing • Positive lateral flow followed up with PCR • Occupational Health and local managers assess risk of staff contacts of positive cases • All staff now have lateral flow kits except for those within 3 months of Covid infection • Results recorded on on-line platform • Weekly performance report to execs • Plan in place to refresh supplies for those running out of kit • Tests also available for bank and agency staff		
• Additional targeted testing of all NHS staff, if your Trust has a high	• All staff on outbreak wards have lateral flow checked and additional swabs as		

nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team	necessary for PCR • Outbreaks closely monitored by IPC team • Additional targeted testing has not been necessary to date		
• Training in IPC standard infection control and transmission-base precautions are provided to all staff • IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	• All staff receive infection control training at induction which includes a section on Covid-19 • National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits • Junior doctors have induction training including Covid delivered by DIPC		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to PPE that protects them for the appropriate setting and context as per the PHE national guidance	• National guidance on PPE implemented within Trust. FIT testing for FFP3 masks in place with resources identified and PPE project team managing resources on day to day basis. • Dedicated FIT testing team in place on both sites. • New staff FIT tested as part of induction as required • Regular discussion at executive level. • Procurement lead sits in ICC		

	• Active management of stocks by procurement leads. Electronic monitoring system in place • Active monitoring of PPE burn rate and stocks • Reusable masks and air powered respirators available for those who fail FIT testing • All patient facing staff trained in use of PPE and supported by PPE officers • Use of powered air respirators monitored through site offices with documented log and cleaning • Regular updates provided to staff through ICC and daily bulletin • PPE guidance available on Covid page of Trust intranet • Posters and signage with PPE information in donning and doffing areas. • Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask • Business case under development to make FIT testing team substantive as part of IPC team		
• There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• Extensive communication with staff on face masks, hand hygiene and space through staff Pulse publication, posters, social media etc. • All staff wear face masks • Hand hygiene audits reported to IPCC – no concerns • Posters widely displayed throughout		

	the Trust • Screensavers for Hands Space Face		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • Patient and Staff Safety work stream moved to BAU • IPC team support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • IPC leadership on key work streams • Emerging risk of *Burkholderia aenigmatica* infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented (risk stepped down but recommendations on u/s gel stand) • Updated national guidance published 1 June 2021		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda • ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings		

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place and in date for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic. • IPC team reinforce practice at ward level • IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised eg for C. difficile and Covid co-infection • IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet. • Hierarchy of controls adopted for IPC risk assessments		
• that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sit rep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		
• This Board Assurance Framework is reviewed and evidence of assessments are made available and discussed at Trust Board	• IPC Board Assurance Framework is updated by the DIPC and reviewed monthly at Trust Board. Evidence base is available as required • From July 2021, BAF to be reviewed by Board when new guidance is		

	published or there is significant change to report		
• ensure Trust board has oversight of ongoing outbreaks and action plans	• Ongoing outbreaks discussed at daily exec strategic command meetings • Twice weekly outbreak meetings for Trust chaired by deputy DIPC – stood down to weekly in January 21 – stood down end February 21– no active outbreaks • DIPC updates to execs and Board at every meeting • IPCC reports to Quality Committee • Daily sitrep of open outbreaks from IPCT • No outbreaks in May 21		
• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Execs and senior managers visit clinical and non-clinical areas regularly		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on both sites including respiratory HDU and ICU escalation areas. • ICU training programme for non-ICU trained staff required to work on ICU. • Consultant anaesthetist rota to provide		

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	24/7 on site ICU cover. • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist. • Covid wards fully staffed. Consultant of the week rota for senior medical cover • IPC team and PPE officer support to Covid wards • Respiratory HDU staffed by respiratory trained nurses and consultants • NIV patients cared for by trained staff • All suspected/ confirmed cases are admitted to side rooms on designated wards pending PCR results. • ITU on both sites have beds identified for Covid • Cleaning standards in place for cleaning during the pandemic. • Facilities staff trained in donning and doffing PPE and FIT tested where appropriate. • Decontamination and terminal cleaning completed according to national guidelines. • HPV and UVC decontamination available when required • All surfaces cleaned with Diff X including walls • In-house cleaning teams in place • Cleaning audits reported to IPCC and divisions • Lapses in cleaning standards reported as Datix incidents and investigated with shared learning		

	• Deep clean programme for wards as they are de-escalated is being planned • Existing UVC light decontamination technology to be employed • Additional robotic UVC resource (Thor) procured • Cleaning robot for public areas		
• Assurance processes are in place for monitoring and sign off for terminal cleans as part of outbreak management	• Nurse in charge checks cleans and signs off • IPC team advise on cleaning levels for outbreak management		
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Increased frequency of cleaning complies with national guidance • Regular cleaning audits undertaken and results monitored. • Audits reported to IPCC		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT		

• Manufacturer's guidance and recommended product contact time' must be followed for all cleaning/disinfectant solutions/products	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
As per national guidance: • 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place since June 20 • Ward staff clean high-touch surfaces including keyboards and telephones • Disinfectant wipes available for cleaning workstations in non-clinical areas		
• Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance. • Pre-existing guidance for clinical areas		
• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Regular twice daily cleaning in place		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards treated as infectious linen • Laundry is compliant with HTM 01-04 • Laundry report goes to IPCC and Health and Safety committee		

• single use items are used where possible and according to Single Use Policy	• Single use items used widely across the Trust. • Policy in place and available to staff on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy.		
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single		

	pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a "Nucleus Design" hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems. • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation		
• Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk	• A Covid-active disinfectant (DiffX) has been used throughout the pandemic response. • Cleaning audits carried out by domestic, nursing and estates MDT according to schedule. Reported to and monitored by IPCC • Wards also received audit results • Additional checks in outbreak areas		
• Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	• Commode cleaning audited with triangulation audits in addition. Reported to IPCC • Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks and included on MDT cleaning audits		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial			

resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Training for new doctors has continued • Ward pharmacists review prescribing • Guidance for antibiotic prescribing in Covid patients issued by ASG • Prescribing of antibiotics is low compared with peer K&M organisations • Audits and reporting restarted and maintained in second wave • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians • Ward based audits were suspended in March and April 2020 but reinstated for May 2020		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• Routine visiting re-started from 29 March 21 and extended 17 May. One hour per patient each day • Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements • Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this. • neonatal visiting extended to Grandparents • Outpatients have accompanying person only when required for care needs • All visitors have temperature checks at the front door • Mask provided to patients and visitors who do not have face coverings • Support in place for relatives to deliver patient property • Viewings of deceased patients have re-started in the Trust mortuary including for patients diagnosed with Covid-19 • Introduction of partners to antenatal scans following risk assessment, vaccination of staff, provision of FFP3		

	masks for sonographers and pre-scan testing for pregnant woman and partner • Partners able to attend all obstetric appointments • Guidance clarified to allow accompanying partners even if no lateral flow test on a case by case basis.		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Signage is in place to identify Covid areas and advise on PPE requirements on entry • Restricted access by swipe card only is in place • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information for staff is available on the Trust intranet Covid page • Coronavirus information for the public can be found at https://www.mtw.nhs.uk/2020/12/latest-information-on-the-coronavirus/	• Easy read version not yet available	• Information currently under review prior to submission to the Accessible Information Standard group for conversion into easy read.
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• For inter-departmental transfer, handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients is implemented. Local guidance based on national guidance is published on		

• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	trust intranet Covid page and has been shared through ICC bulletin. • Integrated discharge team manages discharge of patients to residential care facilities. • Designated care home beds now available • All patients being discharged to residential care have Covid test 48 hours before expected date of discharge with result available. • Any patients self-isolating following confirmed Covid contact receive a letter explaining their need to self-isolate. Medically fit patients may complete their self-isolation at home • Staff use appropriate PPE for all patient transfers • All patients have EDN on discharge • Posters prominently displayed in public areas • Hand, Face and Space logo on trust Covid internet pages • Posters in wards to encourage patients to wear face masks		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all			

patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Contacts of positive cases tested twice a week for 14 days whilst inpatients • All non-elective admitted patients (suspected and non-suspected) are tested for Covid-19 in ED, SAU, EGAU, Woodlands unit or delivery suite. Suspected medical patients are admitted directly to side rooms on Covid cohort ward awaiting PCR results. Non-suspected patients remain in AAU/AMU until rapid results available. Surgical, T&O, gynae, paediatric and obstetric patients admitted directly to single room on specialty ward pending results. Pathways in place and agreed through CRG and ICC. • All suspected patients who do not require admission are tested prior to discharge from ED. Positive cases are followed up by ED with results to provide anticoagulation therapy. Pathway approved by ICC • Patients screened day 1, 3 and 5-7 • Patients on non-covid pathway have Covid point of care test in A&E.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. • Triage nurse performs infection risk assessment and patient directed through red or green pathway for further assessment and separation. Pathway documented and agreed with		

	CRG and ICC • Red, amber and green pathways are accommodated separately in different zones of ED • Isolation room available for immunocompromised and shielding patients in ED • Temperature check and triage in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures • All patients and visitors entering through main entrances have temperature check and are given masks • Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • All pathways documented and agreed with CRG and ICC and published on Covid page of Trust Intranet		
• staff are aware of agreed template for triage questions to ask	• Standard triage template supported y electronic system (Symphony) and printed version		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and	• Triage carried out by senior nursing staff. • Immediate allocation of patient to		

patient is allocated appropriate pathway as soon as possible	pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds		
• face coverings are used by all outpatients and visitors	• All patients asked to wear a face mask on entering ED. • All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required • Information on Trust website to support		
• facemasks are available for all patients and they are always advised to use them	• Face masks available for all patients and patients advised to use them rather than own face coverings		
• provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	• Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside • Posters in ward bays and patient information available		
• ideally segregation should be with separate spaces, but there is potential to use screens eg to protect reception staff	• Reception staff are protected with screens in all areas • ED reception has physical separation of staff by Perspex screens • Perspex screens on outpatient reception areas, outpatient pharmacy and main entrance reception • Cubicles in ED majors are separated		

	by solid walls • Social distancing in place in waiting areas • Vaccination centre has been organized with social distancing and separate spaces		
• To achieve 2 metre social and physical distancing in all patient care areas	• 2m minimum bed spacing in all wards and ED • Outpatients waiting areas are socially distanced		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. • Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • All patients who test negative on admission are re-tested at 5-7 days in line with national guidance. Additional day 3 swab implemented in November • All laboratory results submitted to PHE for national track and trace		

• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid ward • Any patients with new symptoms after admission are tested and isolated until the result is known • All patients who test negative on admission are re-tested at day 3 then 5-7 days in line with national guidance. • National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet. • Negative patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer • Post-covid patients (14+days since diagnosis) are not re-swabbed prior to discharge unless immunocompromised. • Covid positive patients within 14 days of diagnosis requiring discharge to care facility are only discharged to designated centres • Revised guidance issued removing the need for negative swabs in de-escalated patients and restricting the requirement for negative swabs prior to		

• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	discharge • All outpatients have temperature checking at the front door. • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to	• Separate entrances for staff and patients • Stay left signs in corridors • Visitors and patients not permitted to use staff catering facilities		

communal areas • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • Online training for medical care of Covid patients • ICU training in place for non-ICU trained staff • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use • Donning and Doffing videos available on Trust intranet site. • PPE officers provide workplace training. • PPE helpers available in ICU • Donning and doffing stations provided on Covid wards • FIT testing available for all staff who require it and when available masks change. • Signage and posters displayed in donning and doffing areas • Green pathway PPE now stepped down to Standard Infection Control Precautions plus masks – informal training on wards by IPCT and		

• a record of staff training is maintained	circulated through Pulse • Fit testing records maintained • Records maintained for cleaning of reusable masks • Records maintained of formal IPC training • On line learning and development system records mandatory training		
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• PPE audits ongoing and reported to IPCC • Combined hand hygiene and PPE audit in place • Action plans for non-compliance • Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff • Provision made for staff with risk factors etc to continue to use FFP3. • Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will continue.		
Hygiene facilities (IPC measures) and			

messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as: • hand hygiene facilities including instructional posters	• Hand wash basins widely available. • Instructions on all splash backs • Sanitising gel widely available including entrances to all clinical areas		
• good respiratory hygiene measures	• All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside		
• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional breakout areas available • Covid secure offices identified • Training enabled to use 1m+ distancing when seated. Masks to be worn when standing		
• Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	• Staff advised of social distancing rules and to avoid car sharing • Reminders on intranet and in daily Pulse to follow public health advice at all times		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Disinfectant wipes available in both clinical and non-clinical areas • I am clean stickers in use • Domestic and nursing cleaning in place on wards		

• clear visually displayed advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions • The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets • staff understand the requirements for uniform laundering where this is not provided for on site	• High touch areas frequently disinfected • PPE posters widely displayed • Non-clinical areas assessed for Covid-secure status • Advice widely publicised through staff Pulse magazine and Trust internet and intranet pages • Ward based audits in place. • Triangulation audits completed monthly by IPCT. • Directorates report to IPCC • All hand wash basins are co-located with paper towel dispensers • All hand wash sinks have hand washing and drying guidance on back boards in both clinical and public areas • Scrubs are worn on all Covid wards and several other wards and clinical areas. • Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site		

• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • Uniform bags gifted to the Trust provided for staff to carry uniform home and launder with uniform. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites • Staff sickness line available to report symptoms • Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site • Staff testing available in drive through facility and on-site testing pods. On-line appointment system in place. Also available for family members and partner organisations • All staff members testing positive for Covid-19 have their result delivered by occupational health. • Occupational Health support and maintain contact with self-isolating staff • Staff testing positive self-isolate for a minimum of 14 days if symptomatic and 10 days if asymptomatic throughout. • Lateral flow testing available for all clinical staff. • Positive lateral flow tests confirmed by PCR		

• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals) • Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger and outbreak investigation and are reported • Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	• Post-vaccine infection followed up with additional swab and blood for antibody testing. Enhanced surveillance forms completed on-line • Community rates of infection are continuously monitored with information disseminated to senior managers • Discussed at strategic command meetings • Daily sitrep analysis available to managers • Outbreaks declared according to national guidance • All outbreaks are investigated and Serious Incidents declared. • Concise investigation and consistent Terms of reference developed –under review • Twice weekly outbreak meetings • IIMARCH forms completed for all outbreaks • Outbreaks reported via national online platform • Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list • Outbreaks declared as Serious Incidents		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Pathways clearly identified and approval process in place • Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors are not permitted in Covid positive areas except in compassionate circumstances		
• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas	• Signage in place • Wards accessible by swipe access • Restricted access to Covid areas		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated cohort wards. Suspected cases are placed in side-rooms until test results are available	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors with swipe card card access. • Not used as staff/visitor throughfare
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national	• Cohort bays have privacy curtains between the beds to minimise opportunities for close contact. • Separated from non-segregated areas by closed doors		

guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU) • Paediatric confirmed patients isolated in single rooms with en-suite facilities • Windows in all ward areas opened for 15 minutes three times per day to improve ventilation • Pre-existing IPC policies continue to apply. • Some variance required to meet the requirements of Covid levels of PPE and co-infected patients • Active management of side room provision by ICP team		

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Testing undertaken by registered BMS staff with documented competencies. • Method validated prior to diagnostic testing • In house testing turnaround time of less than 24 hours • Tests sent to Pillar 2 labs when demand outstrips capacity		

	• Extended laboratory working hours to deliver service • All non-elective patients are tested on admission • All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested 24-48 hours prior to admission • Online booking for staff and elective patient testing. • Weekly testing for all patient-facing staff by end of June 2020 • All staff positive results are delivered by Occupational health staff • Staff results sent by text message directly from on-line system • Antibody testing available to all patients and staff on request • Near patient testing available with 8 machines at Maidstone and 4 at TWH • 24/7 service for near patient testing across the Trust		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Turnaround times closely monitored • Results usually available within 24 hours		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email		

	• All positives reported to consultant microbiologists • Results directly authorized and available in real time		
• screening for other potential infections takes place	• MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile.		
• That all emergency patients are tested for COVID-19 on admission	• All patients on the green (non covid) pathway have point of care (SAMBA) testing on admission • All patients on the red pathway have point of care (LIAT) tests when available and/or PCR		
• That those inpatients who go on to develop symptoms of COIVD-19 after admission are re-tested at the point symptoms arise	• Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review		
• That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	• All patients who test negative on admission are re-tested in line with national guidance on day 3 and day 5-7 • Testing guidance is published in the daily Pulse and available on the intranet		
• That sites with high nosocomial rates should consider testing	• Trust nosocomial rate is in line with national experience.		

COVID negative patients daily	• Daily swabbing has not been implemented • Contacts of Covid patients are swabbed twice weekly for 14 days		
• That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge	• All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving care facility • Post-Covid patients are not tested further for 90 days unless they develop new symptoms		
• That those being discharged to a care facility within their 14-day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation	• All patients within 14 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting.		
• That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• All elective patients are tested 3 days prior to admission and asked to self-isolate until admission • Some patients are required to self-isolate for a longer period due to their underlying illness • Plan under development to return to national guidance for all patients following decrease in community prevalence		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily. Full range of policies and procedures in place. • Advice available from IPC team and consultant microbiologists. On call rotas in place. • All IPC policies reviewed and in date		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • IPC team support ward staff in implementing changes		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream. • New guidance for disposal of lateral flow tests and vaccination centres – current practice already in line with guidance • All linen from patients on amber and red pathways treated as infectious linen • PPE central stocks held on both main		

• PPE stock is appropriately stored and accessible to staff who require it	sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment developed with BAME network and Ethics committee • Redeployment opportunities and working from home enabled for high risk staff • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support. • Staff sickness phone line in use.		
• that risk assessments are undertaken and documented for any staff members in an at risk shielding group, including Black, Asian and minority ethnic (BAME)	• 93% of BAME staff have risk assessment completed • 80% of 'at risk' staff have had a risk assessment completed • Weekly return submitted		• HRBPs/divisions have plan in place to complete outstanding risk assessments

and pregnant staff			
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held in ICC		
• staff who carry out fit test training are trained and competent to do so	• Dedicated FIT testing team in place and fully trained		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required • A database of FIT testing outcomes is maintained. • Staff provided with information identifying the type of mask to be worn		
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re	• If all respirator options are unsuitable staff work from home wherever		

deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board • Consistency in staff allocation is	possible • Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available • Discussions are documented and records stored electronically • An electronic system is in place to record and store details for risk assessments and any necessary mitigation to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm • database of all staff maintained and includes record of all FIT testing • Weekly assurance template submitted by divisions against rotas • All staff not tested provided with FIT testing prior to shift • All areas have access to powered air respirators • ICC and site team receive assurance template for weekend shift		

maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance • All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Patient and Staff Safety workstream (part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways • Green pathways for elective care developed. • Weekly executive and divisional meeting to discuss progress and interdependencies • Staff screened for Covid-19 • Ward areas maintained as secure with minimal footfall • Theatre SOP in place designating green and red pathways to avoid cross over • Staff social distancing in corridors and queues. • Work to ensure that office spaces are socially distanced with risk assessments completed. • CCG review identified good practice in social distancing interventions • Staff working from home wherever possible • Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas. • All ward staff to wear masks at all times on wards from 1 June • Continual mask wearing guidance implemented for patient facing staff from 10 June 2020. Non-patient facing staff from 22 June • Computers on wheels provided in		

	some areas to support social distancing • Managers asked to review all office space to ensure social distancing in COO letter 12 June. • Managers also requested to review staff working patterns and breaks to reduce the number of non-clinical staff working on site at any time • Additional breakout areas created on both sites including outdoor space		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations • Homeworking support package including training and IT kit in place for staff who now work at home		
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Advice given to staff to don masks whenever moving around Covid secure areas • Continued communication via team brief, Pulse and Directors communications to re-iterate “hands – face – space” campaign		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support/		

	first aiders. • Staff sickness phone line in use and covered daily, 7 days from 1st December 2020, providing advice and information on sickness, swabbing and other COVID sickness questions. • Newly established "staffing hub" designed to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing. • Roll out of lateral flow underway • ICC monitors sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing • Weekly asymptomatic testing to be rolled out to all patient facing staff by end of June • Review of cases of staff Covid infection to identify any key themes and learning • Trust-wide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified • Staff vaccination centre established and vaccine available to all Trust staff and offered to some partner agencies		
• staff that test positive have adequate information and support to aid their recovery and return to	• Occupational health support Covid-positive staff and advise on return to work and re-testing		

work.	• Psychological support available • Occupational Health maintain a list of staff who test positive more than 10 days post-vaccination. Support provided and additional swab and blood tests arranged. Enhanced surveillance completed on-line		

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD – June 2021

X-XX	**SIRO ANNUAL REPORT ON INFORMATION GOVERNANCE AND DATA SECURITY AND PROTECTION TOOLKIT SUBMISSION RECOMMENDATION**	**PRESENTER (CHIEF NURSE)**

1. Background and Scope

There is a range of legal and professional obligations that limit, permit, prohibit, require or set out conditions in relation to the management, use and disclosure of information.

Information Governance covers all processing of data including the collection, retention, use, access to and decommissioning of information and data.

The purpose of this paper is to provide the Board with assurance that the Trust has robust Information Governance processes and frameworks in place that support the delivery of safe, high quality care enabling the Trust to act within the extent and limitations of its powers in relation to information and data and that identified risks are being properly managed.

2. What the Board needs to know in order to fulfil its responsibilities in respect of Information Governance

This section of the report provides a briefing and training for Board members on the key information needed to fulfil their duties with respect to information governance.

2.1 Key points

Key points for NHS Boards to note are that:

- An annual IG performance assessment using the Data Security and Protection Toolkit (DSPT) must be published for review by commissioners and care partners, citizens, CQC and the Information Commissioner.
- A Senior Information Risk Owner (SIRO) must be appointed to take responsibility for managing the organisation's approach to information risks and to update the Board regularly on information risk issues. In MTW this role is fulfilled currently by the Chief Nurse.
- A Caldicott Guardian, a senior clinician, must be appointed to advise the Board and the organisation on confidentiality and information sharing issues. In MTW this role is fulfilled currently by the Medical Director supported by a Deputy Caldicott Guardian, currently the Director of Infection Prevention and Control.
- A Data Protection Officer (DPO), must be appointed who must be independent and report to the highest management level. The role of the DPO is to assist with the monitoring of internal compliance, advise on data protection obligations, provide advice regarding Data Protection Impact Assessments and act as a contact point for data subjects and the Information Commissioner's Office. In MTW this role is fulfilled currently by the Trust Secretary.
- Appropriate annual IG training is mandatory for all staff who have access to personal data with additional training for all those in key roles. The Trust is required to evidence that 95%

of staff have received training in the 12 months covered by the DSPT. As at 11 June the Trust percentage compliance stood at 93.99%.

- Details of incidents involving cyber security, loss of personal data or breach of confidentiality must be published in annual reports and reported through the DSPT reporting tool
- All employees of the Trust have Information Governance responsibility detailed within their job description
- There is wide engagement with the Information Governance agenda throughout the Trust
- A wide range of Information Governance policies and procedures have been developed and are regularly reviewed and updated.
- Security issues related to confidentiality, integrity and availability of data are increasing. The Trust is registered with NHS Digital's 'Respond to an NHS Cyber Alert' service and is a member of the FutureNHS Collaboration community.

2.2 Information Governance Committee

The Information Governance Committee (IGC) is chaired by the Senior Information Risk Owner (currently Chief Nurse) and meets bi-monthly. The committee membership has wide representation from Divisions and Directorates across the Trust.

The IGC is a sub-committee of the Trust Management Executive and has the following sub-groups:

- Accessible Information Group
- Cyber Security Group
- Data Quality Steering Group
- Health Records Committee
- Information Asset Administrators Group
- Information Asset Owners Group

The key responsibilities of the IGC are:

1. To provide assurance that the Trust is compliant with the 19 policy statements detailed in the Information Governance Standards Framework – November 2010 (ISB 2010).
2. To ensure that Maidstone and Tunbridge Wells NHS Trust has effective policies and management arrangements covering all aspects of Information Governance in line with current legislation, NHS guidance/policies, professional codes of practice and the Trust's overarching Information Governance Policy, e.g.:
    - To maintain an appropriate balance between openness and confidentiality
    - To achieve and maintain compliance with legislation, including but not limited to the Data Protection Act 2018 and the Freedom of Information Act 2000.
    - To ensure there are policies and procedures in place to enable the organisation and staff to discharge their duties in regard to the use and disclosure of information
    - To ensure that records held by the Trust are accurate, kept confidential and secure, accessed only by those with legitimate need and available when required
    - To ensure records (paper and electronic) are disposed of in an appropriate manner relative to their confidentially when no longer required and in line with Records Management: NHS Code of Practice.

3. To ensure that Maidstone and Tunbridge Wells NHS Trust is compliant with the requirements of the Data Security and Protection (DSP) Toolkit across the ten Data Security Standards.
4. To provide support, advice and assistance to the Caldicott Guardian.
5. To ensure that the Trust undertakes or commissions annual assessments and audits of its Information Governance policies, procedures and arrangements.
6. To seek external assurance on the quality and validity of the DSP Toolkit submission.
7. To agree the DSP Toolkit return prior to approval by the Trust Board, in line with the timetable issued each year.
8. To monitor progress in programmes to achieve compliance/certification with Cyber Essentials Plus.
9. To establish an Information Governance improvement plan, secure the relevant resources and monitor implementation of the plan.
10. To receive and consider reports into breaches of confidentiality and security and where appropriate undertake or recommend remedial action and when appropriate recommend declaration of a Serious Untoward Incident and participate in investigations.
11. To promote a Trust wide culture that information governance is the responsibility of every member of staff and to promote learning that arises out of investigations into breaches in IG.
12. To liaise with other Trust groups/committees through work programmes in order to promote Information Governance and good practice.
13. To monitor the provision and uptake of training provided to support effective information governance to the Trust.
14. To ensure that staff are trained in Information Governance, comply with and understand the consequences of not adhering to Trust IG and IG related policies.
15. To keep abreast of national initiatives and development of policy and changes in legislation.
16. To maintain IG risks and issues log and discuss as a regular standard agenda item.
17. To assist the Senior Information Risk Owner (SIRO) in producing appropriate information for Board level reports and in the preparation of an Information Governance Annual Report.
18. To ensure the Trust develops and maintains an appropriate framework for the management and protection of information which is appropriately supported by information asset owners and administrators.
19. To ensure a register of all major Information Assets is established and maintained with responsibility or 'ownership' for each asset assigned to an Information Asset Owner. Lesser information assets should be managed through local policy and procedure.
20. To receive reports of audits and monitoring of issues pertaining to Information Governance, including Data Protection Impact Assessments and review progress against action plans as appropriate.
21. To ensure that information sharing protocols are in place with organisation with whom to Trust routinely and regularly shares personal information.
22. To ensure full and effective liaison with all external organisation such as the Information Commission, Care Quality Commission, NHS England, NHS Digital and other local Trusts and relevant partner organisations.

The Committee routinely monitor:

- IG breaches
- Freedom of Information Requests
- Subject Access and 3rd Party Information Requests
- IG Training status

2.3 Horizon Scanning
Covid19 resulted in a sudden switch to new, digital ways of working across health and care settings. This digital transformation is continuing at pace under the responsibility of NHSX.

This work will see the adoption and development of AI technologies, of robotic processing and greater use software as a service, of the Internet of Things and Smart technologies to further transform health and care services enabling them to be delivered flexibly, remotely and with the provision of better information which will cross organisational boundaries and that will require robust governance arrangements and processes to be fully embedded. The governance structures already in place as outlined in the Trust IT Strategy will enable the Trust to continue to meet its statutory and regulatory obligations.

---

3. Assurance
This report which aims to provide assurance in relation to five key areas:

3.1 Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisation to measure their performance against the National Data Guardian's 10 data security standards.
The 10 standards are as follows:

1 Personal Confidential Data
All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

2 Staff Responsibilities
All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

3 Training
All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

4 Managing Data Access
Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

5 Process Reviews
Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

6 Responding to Incidents
Cyber-attacks against services are identified and resisted and security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

7 Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

8 Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the IT estate.

9 IT Protection
A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually

10 Accountable Suppliers
IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

The 10 Data Security Standards detailed above are devolved into mandatory and supplementary 'assertions' that widen the scope of the previous toolkit requirements.

In order to achieve a fully compliant DSP Toolkit, all 42 assertions must be achieved by the organisation.

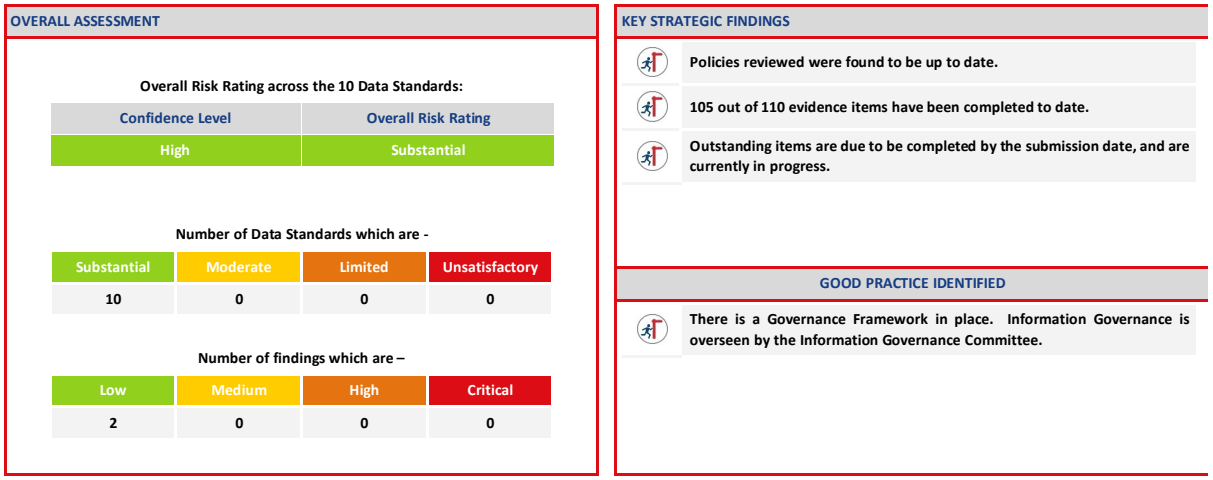
These standards address modern data security threats as well as inherent information governance processes developed over time in NHS organisations.

All organisations that have access to NHS patient data and systems are required use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Board are advised that the Trust has almost completed work towards gathering evidence to support the 110 mandatory evidence items of this year's Toolkit. We currently have completed 105 of the 110 mandatory requirements and aim to have the remaining 5 completed by 30 June.

In order to provide assurance that the organisation has in place effective data security and information governance controls and processes as directed by the DSPT, TIAA were requested to undertake an independent audit of the organisation's 10 Data Security Standards. The audit coverage was aligned to the mandated areas in the toolkit as selected by NHS Digital for 2020-2021. The DSPT submission will be considered by the CQC as part of the Well-Led inspections.

The TIAA review adopted a two stage approach and followed the draft Data Security and Protection (DSP) Toolkit Independent Assessment Framework and Guidance published by NHS Digital. TIAA reviewed 13 assertions across the 10 National Data Guardian Standards in the DSP Toolkit. The overall conclusions contained within the report state:



The Board are advised that throughout the year the Information Governance Committee has received regular reports on the Toolkit progress. It reviewed the latest Toolkit position on 21 May 2021. The Audit report from TIAA has been reviewed and agreed with myself.

The Committee are happy to recommend that a 'Standards Met' year-end submission be made prior to 30 June 2021. The Board are asked to support this position.

3.2 Cyber Security

Due to the operational impact of Covid work to upgrade the Trust IT estate and infrastructure was delayed. This meant that the Trust was not in a position in 2020 to renew its Cyber Essentials Plus accreditation and a strategic decision was made to defer application of the next assessment until Autumn 2021, by which time essential upgrades will be complete.

In January this year the Trust received a request from NHSX to supply an improvement plan to demonstrate what steps it was taking to address the risks posed by unsupported Windows 7 systems.

In March 2021 the Trust received an 'Information Notice' under the Network and Information Systems (NIS) Regulations from the Department of Health and Social Care. The notice acknowledged the information provided by the Trust to NHSX and requested a progress update to the improvement plan. The updated was provided on 6 April 2021. On 27 April 2021 the Trust received notification that the improvement plan had been reviewed and considered to adequately address the risk posed by unsupported Windows 7 systems in a suitable timeframe. Currently the anticipated completion date for the improvement plan is mid-July. This is 2 weeks later than the prediction for the NIS notice but has been discussed and agreed with NHSX.

The Trust has approved a business case supporting the development of a Cyber Security Team (with associated tools) with the aim of improving the standard of the cyber defence. The team will be responsible for ensuring that the Trust's various systems are kept secure and cyber compliant and will be responsible for user cyber training across the board, as one of the best forms of defence starts with our users being more cyber aware. The team will be responsible for running internal phishing campaigns, organising penetration testing, and will forms the centre of a 24/7 incident response team in the event of a cyber-attack.

3.3 Data Quality

The Data Quality Steering Group has been established as a sub group of the Information Governance Committee. The purpose of the Group is to ensure that the quality of all data held and used by the

Trust meets any relevant national standards, local and contractual requirements and ensure that all clinical and corporate divisions and individual users are engaged and focused on improving Data Quality in accordance with the Trust's Data Quality Policy.

The group will oversee:

- The development of a new Data Quality Strategy and delivery of an implementation plan.
- A baseline assessment of data quality within the trust to identify areas of weakness.
- The collation of evidence for relevant Data Security and Protection Toolkit (DSP Toolkit) requirements and the implementation of any action plans to improve compliance.
- Compliance with the Data Quality Improvement Plan within Schedule 6 of the contracts held by the Trust.
- Adherence to national, local and contractual data quality standards.
- Provision of assurance relating to the robustness of the data used corporately and clinically for decision making through the use of data quality 'kite marks'.
- The completion of any internal and / or external audit recommendations relevant to data quality.

3.4 IG Incidents

Since my last report to Board there have been seven incidents, the detail of which triggered the use of the Data Security and Protection Incident Reporting Tool.

Reference	What happened
23949	A patient handover list was found in a waste bin located on a public street not far from Maidstone hospital.
23436	A member of staff took a patient handover sheet home and once home did not ensure that the patient data was kept security and confidential. Another member of the household was able to gain access to the data and proceeded to further disseminate information to their own work colleagues
23261	A member of staff sent a PDF file containing multiple documents to a company, with whom the Trust does not have a contract, based in Switzerland, for splitting into the constituent documents.
22563	A quantity of patient handover sheets and other documents containing person identifiable data were found at the home address of a staff member.
22206	During the course of a grievance investigation data from a staff member's personnel file was shared with the investigating manager with the knowledge or consent of the data subject.
21937	A member of the clinical administration staff attempted to speed up throughput of typing by creating one letter and reusing that as a template for a number of other documents. The first letter contained a name and address as a 'copy to' which fell over onto a second page. When reusing the letter the staff member failed to remove the 'copy to' and as a result the recipient received letters relating to six other individuals.

21666	A patient received copies of their records which, on review, contained an anaesthetic procedure print out for another individual.

Four of the above incidents met the threshold for notification to the ICO and the Trust was required to provide further detail of the incident and actions taken by the Trust. On reviewing the cases the ICO considered the actions that the Trust had taken, made recommendations for further action which have been implemented and the cases were closed. Each of the incidents has been subject to the Trust internal incident investigation process whereby root causes are identified and remedial actions detailed and implemented. The IG Committee receives a report at each meeting of all IG incidents reported on the Datix system for the relevant period, discusses trends identified and possible actions that may be taken to prevent recurrence of incidents.

3.5 Information Risks

The Board are advised that no new Information Governance risks have been added to the Trust risk register since my last annual report in March 2020.

All Directorates and Departments have reviewed their Business Continuity Plans to ensure they have been updated to reflect to Trust's ongoing journey to a paper-light environment.

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

This report is provided to the Board for decision and assurance purposes.

The Board are asked to authorise the submission of a 'standards met' Toolkit submission.

Summary report from Quality Committee, 09/06/21 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 9th June 2021 (a Quality Committee 'deep dive' meeting).

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

- The Committee thanked the Chief Nurse for their exemplary contribution during their tenure at the Trust.
- The **progress with previous actions** was reviewed and it was agreed that the Assistant Trust Secretary should schedule an "update from the Nasogastric Tube working group" to the July 2021 'Main' Quality Committee meeting, and each 'Main' Quality Committee meeting thereafter.
- The Chief of Service for Women's, Children's and Sexual Health and the Divisional Director for Midwifery, Nursing and Quality attended for an update on the **review of maternity services** wherein the Committee acknowledged the significant operational pressures and increased scrutiny nationally on maternity services and it was agreed that the Divisional Director for Midwifery, Nursing and Quality should circulate the 'Matrix' which outlined the schedule for the review of Maternity Services guidelines to all Committee members.
- The Chief Nurse and Director of Infection Prevention and Control presented a **review of the lessons learned from COVID-19.** The presentation gave a comprehensive overview of the challenges experienced throughout COVID-19, the adaptations in working practice, the additional training which had been implemented to support the Trust's response to COVID-19 and the staff welfare support which had been provided by the Trust. A discussion was held regarding the lessons learned which would be expanded upon in the future should the Trust be required to respond to a similar situation and the importance of maintaining organisational memory was emphasised.
- The Deputy Director of Quality Governance presented a **review of the actions implemented in response to previous Never Events at the Trust** wherein the Committee acknowledged the further work that was required and the importance of continued monitoring in relation to the actions which had been developed. It was also agreed that the Deputy Director of Quality Governance should ensure that future "Update on Serious Incidents (SIs) (incorporating the report from the Learning and Improvement (SI) Panel)" reports to the 'Main' Quality Committee included an update on the recruitment of a Datix Systems Manager and the implementation of the actions module on Datix.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein it was agreed that the Assistant Trust Secretary should schedule a "Further review of maternity services" item at the Quality Committee 'Deep Dive' meeting in December 2021. It was also agreed that the Assistant Trust Secretary should schedule a "Review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record" item at the Quality Committee 'Deep Dive' meeting in August 2021.

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 10/06/21 (incl. an update on End of Life Care)	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 10th June 2021.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Deputy Director of Strategy, Planning and Partnerships attend to provide an **update on the progress with the development of the Kent and Medway Integrated Care System (ICS)** (incl. a summary of stakeholder engagement) wherein the Committee emphasised the importance of stakeholder engagement throughout the development process to ensure that the pathways which were developed were accessible and provided the optimum patient experience whilst enabling accountability. It was agreed that the Deputy Director of Strategy, Planning and Partnerships should ensure that the feedback received at June 2021 Patient Experience Committee in relation to the development of Kent and Medway Integrated Care System (ICS) was relayed to the appropriate parties.
- The Trust's Patient Experience Lead provided an **update on how are we ensuring the optimum patient experience (incl. lessons learned during COVID-19)** which included the impact of the One Team Runner programme throughout COVID-19, the work to increase patient feedback at the Trust, the renewed focus on 'always events' and the mechanisms which would be utilised to ensure that the Trust's 'always events' provided an improved patient experience.
- The Matron for Head and Neck and Divisional Business Manger for Surgery attended to inform the Committee of the **patient experience impact of the transfer of ophthalmology activity from Dartford and Gravesham NHS Trust** wherein the challenges associated with the identification of patients who would previously have been reviewed at Dartford and Gravesham NHS Trust were detailed.
- The Complaints and PALS Manager provided a comprehensive review of the **Complaints Annual Report for 2020/21.**
- The End of Life Care Clinical Nurse Specialist and Consultant for Palliative Medicine attended to provide an **update on End of Life Care** which included the challenges associated to COVID-19, the measures which had been implemented to support both staff and patients, and the improvement initiatives which had been developed. The report is enclosed in full at Appendix 1, for information and assurance.
- The Learning Disability Liaison Nurse attended to provide an **update on the provision of care for patients with learning disabilities** which focused on the mechanisms to ensure equitable practice for patients with learning disabilities.
- The Lead Nurse for Dementia Care attended to provide a detailed **update on the provision of care for patients with Dementia** which outlined the impacts of COVID-19 on patients with Dementia, the key themes which had emerged, and the benefits which would be provided by the implementation of the Sunrise Electronic Patient Record (EPR) in relation to the provision of care for patients with Dementia.
- The Committee considered its **Forward Programme** and it was agreed that the Committee Chair should ensure that Committee members were informed of the outcome of the discussions in relation to the future approach for the "Informal" and "Formal" Patient Experience Committee meetings.
- Under **Any Other Business** the Divisional Director of Nursing and Quality for Medicine and Emergency Care provided an update on Stroke Care and informed the Committee that the Trust's had achieved an A rating for the Sentinel Stroke National Audit Programme (SSNAP).
- At the end of the meeting Committee members thanked the Chief Nurse for their contribution during their tenure at the Trust.

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

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

PATIENT EXPERIENCE COMMITTEE – JUNE 2021

NHS
Maidstone and Tunbridge Wells NHS Trust

UPDATE ON END OF LIFE CARE	DIVISIONAL DIRECTOR OF NURSING AND QUALITY FOR CANCER SERVICES / END OF LIFE CARE CLINICAL NURSE SPECIALIST

It was agreed at the March 2021 Patient Experience Committee that the Divisional Director of Nursing and Quality for Cancer Services should submit an update on End of Life Care to the Committee's meeting in June 2021.

The report is enclosed.

Reason for submission to the Patient Experience Committee
Information and assurance

Patient Experience Committee
End of Life Care (EoLC)
Report 10th June 2021

Mandatory Training	EoLC Mandatory training- 89.4% of Trust staff completed at end of April 21.
Response to covid.	During the pandemic, specific documentation was developed to assist clinicians in caring for covid patients. This included symptoms control guidelines and guidance on how to approach difficult discussions and break bad new to patients, relatives and those important to them. In addition, the Individualised Care Plan for the Dying Patient was revised for ease of completion, ensuring key points were included. All relevant documentation was accessible via the intranet
Documentation	The Individualised Care Plan for the Dying Patient has been revised and is on its fourth iteration. It is now a sixteen-page document that includes the assessment of patient preferences with additional pages for documentation. It is intended to be used instead of the patient's medical records. The new version will be launched July/August 2021, with the revised Rapid EoLC Discharge Checklist. Both documents are waiting for final approval from Healthcare Records before being sent for printing. The documents have been attached for information (Appendix 1 and 2).
Department Audits	The National End of Life Care Audit (NACEL) was suspended during 2020 due to the pandemic. To ensure that the Trust had some auditable data during this period the palliative care team commenced a Covid EoLC audit following the first covid wave to evaluate care that was delivered to patients who died within our Trust during this period. The audit realms included communication, EoLC plans and clinical interventions. It was anticipated that the information would assist with planning in the event of a second wave. Initially it was intended that the team would audit all medical records of patients who died from covid from the first wave. Unfortunately, this took longer than expected and we then entered a second wave. The decision was then taken the EoLC Steering Committee that we would stop auditing the first wave, analyse the data and refine the tool in order to audit a proportion of medical records from the second wave. The rationale was to give us a greater understanding of care delivery during both waves in order for us to plan and prepare should a third surge occur. The National End of Life care Audit, 2021, commences from the 1/6/2021 and will be due for completion on the 30/9/2021. This year the audit will include a staff survey. MTW has opted not to complete the Quality Survey this year as we already undertake a "Bereaved carers" Survey.
Service Developments	**Palliative Care Team Extended Cover:** The palliative care team planned to pilot a six-day service from May 2020. However, this was started earlier in response to pandemic and extended to a seven-day service. This then reverted back to a six-day service as planned following the first wave. This was successfully evaluated and has therefore continued. This ensures that there is no more than a one-day gap in service.

	Enhanced Supportive care (ESC) Project: A two year Enhanced Supportive Care project funded by NHSE is due to commence in June 2021. The service will provide additional support for patients diagnosed with non-curative UGI and Gynae cancers. It is anticipated that more tumour site will be included as the project evolves. This has two pathways; Pathway 1- rapid access to ascitic drainage- this aims to responsively enhance the patients experience and is anticipated to reduce admissions or reduce the length of patient stay (LOS) if admission is required. Pathway 2- ESC Clinic and rapid access to telephone support. The aim of this pathway is to improve the patients QoL through early access to supportive services that provide good symptom management, optimises activities of daily living, prevent unnecessary hospitalisation, expedite discharge for appropriate admissions thus reducing LOS. In addition, it is an extra layer of support to assist with patients transition to Hospice care **AMBER Care Bundle:** Funding has been secured from the covid funds following approval from the Medical Director and Chief Nurse to implement the AMBER care framework across all adults' wards in the organisation. The framework is a national driver to improve communication for patients in the acute setting who have an uncertain recovery and who are at risk of dying during the episode of care. It facilitates open and honest discussion with patients, and where appropriate their families, to agree management plan and establish ceilings of care in the context of treating the patient actively. It elicits patients' preferences for end of life in case of deterioration and requires daily review and assessment and communication with the patient. A project plan detailing training and how it will be rolled out across key wards will be developed and it is anticipated that we will later this year.
Educational videos	The palliative and EoLC team have developed a number of short educational videos for staff, as one of the approachs to delivering education. These include; • Common questions asked at EoL • Ethical issues • Spirituality • Communication Skills- Am I dying?
Initiatives	An End of Life Screensaver is now on desktops across the trust reminding clinicians of the principle that underpin good EoLC (the priorities of care) and the relevant documentation to use. Phase one of the SWAN Initiative was implemented prior to the pandemic. The SWAN emblem is placed on the white board and in the patient areas to signify that the patient is receiving EoLC and highlights the need for staff to be especially sensitive. It also acts as a prompt to remind clinicians to use the correct EoLC documentation. Phase two of the initiative was introduced shortly before the second surge of the pandemic. This has not been evaluated yet as visiting has been restricted through the pandemic. This phase provides relatives with a comfort pack, key information including a leaflet on "What to expect when a patient is dying", how to access chaplaincy, free parking tickets

	and information regarding the hospital facilities. The initiative will be evaluated through questions on the “Bereaved Carers” survey.
Acquisitions	The EoLC Steering committee has aquired several relative guest beds across both sites to enable relatives to stay with patients who are dying when allowed to do so. A number of different children's books on death, dying & bereavement for different ages have also been acquired.
Dying Matters Week	During “Dying Matters” week this year a number of events were held for staff including; • Art therapy • Creative writing, • Art display • Communication workshop • Remembrance service Unfortunately, the planned Schwartz Round as part of these events “The day I made a difference” – had to be deferred until early July.
Future Plans	• Development of staff competencies for EoLC. • EoLC Repository on the trust Intranet- so clinicians can access guidance and key policies and information in one place. • Introduction of EoLC Volunteers • Implementation of ambulatory syringe pumps for EoLC patients across adult wards to promote dignity and comfort.

.

FAMILY NAME:	Appendix 1 NHS Maidstone and Tunbridge Wells NHS Trust
Given name:	
Preferred name:	
Title: Gender:	**Rapid Discharge Checklist for a patient going HOME or to a CARE HOME for End of Life Care (Recognised to be imminently dying within hours/days)**
NHS number:	
Hospital number:	
Date of birth: _ _ / _ _ / _ _ _ _	
Complete above in full or affix patient label	
Location:	

Criteria for use

- Patient is recognised to be within the last hours or days or week of life
- The patient wishes to die at home or a care home (other care setting options have been discussed & explored)
- The family or carers support the patient's preference and wishes where possible
- Aiming for discharge within 24 to 48 hours of the decision to go home

For all patients, Ward Nurses to consider:

□ Urgent referrals to Occupational Therapist (OT), Physiotherapist, Discharge Liaison Team & Respiratory Nurse Specialist
□ Fast Track application for package of care or Nursing Home placement
□ Referral to the Palliative Care Team (PCT)
□ Keeping the patient & relative up to date with plans and document any progress or changes
□ Commencing the Individualised Care Plan for the Dying Patient (ICP) if clinically appropriate & following MDT agreement (ensure a photocopy of the active ICP document accompanies the patient on discharge, if in use)
□ If discharge is cancelled, all stakeholders must be updated & planned visits cancelled

PROPOSED DATE OF DISCHARGE: _ _/ _ _/ _ _ _ _

Signature Log of Professionals involved in arranging rapid discharge & completing form:

Print full name	Professional Role	Initials	Signature	Contact Details (bleep/mobile)

Adapted with permission from Brighton and Sussex Hospitals NHS Trust
File in Nursing records, Version 6, Feb 2020, order number 396/565
7/24

Rapid Discharge Checklist Tasks (Initial, date & tick each box on completion)

Ward Doctors

- Confirm eligible for NHS CHC Fast Track ---------- ☐
- Complete Medical Statement on CHC Fast Track Form. Ensure patient & relatives/carers are aware they are for end of life care ---------- ☐
- Complete eDN & to include for injectable medication & water for injection* (where possible day before planned discharge date) ---------- ☐
- Complete community syringe driver prescription chart & for EoLC prn injectable medication* ---------- ☐
- Ensure there is a **valid** DNACPR form completed ---------- ☐
- Telephone GP- inform of the discharge for EoLC and request a home visit within 24 hours of discharge ---------- ☐

Discharge Liaison Team or OT

- Email completed CHC form ----------☐
  Confirm CHC have agreed funding and confirm no. of visits ---------- ☐
- Confirm PoC or Nursing Home arrangements for date of discharge ---------- ☐
- OT to confirm any equipment required is in place ---------- ☐

NOTE:

* Palliative care will advise teams on appropriate medication for discharge, completion of syringe driver prescription charts.

CHC= Continuing Health Care
PoC= Package of Care
CLT= Community Liaison Team

Ward Nursing Team

- Complete NHS funded CHC Fast track application ---------- ☐
- Liaise with the CLT to refer to District Nurses or Nursing Home & arrange syringe driver to be reset at home post discharge, (if appropriate) & confirm time of visit (Please give 24 hours notice if possible) ---------- ☐
- Refer to the Respiratory CNS if oxygen required ---------- ☐
- Inform the pharmacist of the need for injectable medication for TTOs and priority for dispensing. Ensure you include syringe and needles for subcutaneous use with TTO's. ----------☐
- Email a copy of the DNACPR & the community syringe driver prescription chart to the District Nurses. Ensure a copy accompanies the patient. ----------☐
- Update or complete a referral to the community palliative care team ----------☐
- Consider & discuss the need for hospice at home with community palliative care team (if available in local area) ----------☐
- Book ambulance ----------☐
- Update relatives/ carers with discharge plans ----------☐

Attach a copy of this completed checklist to the front of the CHC Application Form (unless completed previously).

Ensure receipt of application & checklist by a phone call within 30 minutes of sending- reiterate that this patient's case requires immediate attention.

Completed checklist to remain in patient's health care records.

ON DAY OF DISCHARGE DATE: - - /- - /- - - - WARD NURSES:

(Initial, date & tick box on completion)

- Ensure Doctor or PCT has reviewed the patient and deemed them fit for transfer within 2 hours of discharge (if there is any change in clinical state, request further assessment) ---------- ☐
- Ensure the electronic discharge notification (eDN) and the **original** community syringe driver prescription chart go with the patient ----------☐
- Ensure **Red** DNACPR form goes with the patient ---------- ☐
- Ensure the eDN is sent to the GP---------- ☐
- Ensure the syringe driver is discontinued prior to discharge and administer prn doses of medication given prior to travel, if required (if unsure, check with the PCT----------☐
- After discharge, call the District Nurse, Nursing or Care Home, community PCT and family to confirm patient has left the ward---------- ☐

Adapted with permission from Brighton and Sussex Hospitals NHS Trust
File in Nursing records, Version 6, Feb 2020, order number 397/565
8/24

Family Name: (last name)	Maidstone and Tunbridge Wells NHS Trust
Given name: (first name) **Preferred Name:**	**Individualised Care Plan for the Dying Patient**
Title: **Gender:**	
NHS Number:	
Hospital Number:	
Date of Birth: _ _ - _ _ _ - _ _ _ _	
Complete above in full or affix patient label	
Location:	
Age:	**Ethnicity:**
GP:	**Religion:**

Emergency Contact Details	
Family name:	Given name:
Relationship:	Next of Kin: No [ ] Yes [ ]
Daytime Telephone Number:	Evening Telephone Number:
Family name:	Given name:
Relationship:	Next of Kin: No [ ] Yes [ ]
Daytime Telephone Number:	Evening Telephone Number:

Admission Details		
Date:	Time:	(24hr Clock)
Admission Consultant:	Clinical area:	
Allergies:		
Disclaimer:		

Does the patient have money or valuables? No [ ] Yes [ ] if yes, complete section below

Maidstone and Tunbridge Wells NHS Trust and its staff do not accept any liability for loss, theft or damage to patient's personal property or money unless it has been handed in for safe keeping and an official receipt obtained. Patients are strongly advised to ask a representative to take home any money or property for safe keeping during their stay in hospital.

I have read the above notice and accept sole responsibility for any money or other property retained in my possession.

Patient/Carer: - Print name .....

- Sign name ..... Date: .....

Witness: - Print name .....

- Sign name ..... Date: .....

Name Appendix 1 - "Update on End of Life Care" report NHS No. __ __ __ __ __ __ __ __ __ __

Signature Log

Date	Print Name	Designation/Bleep No.	Initials	Signature

Specialist advice and support

If patient assessment or advice is required by the Palliative Care Team (PCT) please refer to the team on Patientcentre. If advice is required urgently please contact the team by bleep:-

Daytime Mon - Fri, 8.30am - 5.30pm

Maidstone Palliative Care Team:

Telephone: 01622 225024
Extn: 25024
Bleep: 1133 or 1425

Tunbridge Wells Palliative Care Team:

Telephone: 01892 635675
Extn: 35675
Bleep: 2346 or 2397

Out of hours:- After 5pm/weekend/Bank Holidays by Senior members of the patient's team:-

Maidstone Hospital call:
Heart of Kent Hospice: 01622 792200

Tunbridge Wells Hospital call:
Hospice in the Weald: 01892 820500

Refer to **Specialist Nurse Organ Donation (SNOD)** if patient is ventilated in Emergency Department or on Intensive Therapy Unit, with a treatment withdrawal plan on 07659 590529 (leave your name, hospital and full contact number) prior to withdrawing treatment/discussing withdrawal with Next of Kin.
For Tissue Donation Services, phone 08004 320559 - leave staff name, hospital and full phone number for a call back.

For Spiritual Support or advice please phone the Switchboard, who will contact a Chaplain.

Reference: This document is based on the five key principles for EoLC described in "One chance to get it right" – Leadership Alliance for the Care of the Dying People
June 2014

Date and time of decision made that patient is for End of Life Care……

Name of Consultant or Senior Doctor (designated deputy) making decision……

DNAR (Do not attempt cardiopulmonary resuscitation) completed **Yes** **No**

Implantable Cardioverter Defibrillator (ICD) deactivated **Yes** **No** **N/A**

DISCUSSION WITH PATIENT/FAMILY REGARDING EOLC- check for Advance Care Plan (ACP), Advance Decision to Refuse Treatment (ADRT) and/or Lasting Power of Attorney (LPA)

Does patient have capacity to participate in discussions on EoLC? **Yes** **No**

If No, has a mental capacity assessment been completed, if not please specify reason why:
……

Have the next of kin been involved in discussions? **Yes** **No**

If no, state reason why:……

Please document details of the communication undertaken with patient/relatives below OR state date and time of this documentation from the healthcare records:

……
……
……
……
……
……
……

SWAN symbols/magnets in use? **Yes** **No**

SWAN pack given to relatives? **Yes** **No**

NEXT OF KIN DETAILS:

Name: …… **Contact number/s:** …… ……

When to call:
……
……
……
……
……
……
……
……
……
……
……
……
……
……
……
……
……

Identify PATIENT'S WISHES AND KEY PRIORITIES. Tick when completed and state details and actions if required:

	Details and Actions	Print name	Signature	Design ation
What is important to the patient/specific preferences/ wishes □ **Preferred place of death** □ **Organ/tissue donation** □ Contact Specialist Nurse for Organ/Tissue Donation via switchboard **Spiritual support for patient** □ **Religion/faith**…… …… **Chaplaincy support offered** □ (Contact via switchboard 24 hours a day)				

FAMILY/CARER NEEDS. Tick when completed and state details and actions if required:

	Details and Actions	Print name	Signature	Design ation
Needs of children in family Names & ages: □ …… …… …… …… **Significant others details**…… …… …… …… **Spiritual support for family** □ **Religion/faith** (if different from patient)…… …… **Chaplaincy support offered** □ **Car parking exemption form/ticket** □ **Visiting rules explained** □				

RATIONALISE THE DRUG CHART and ensure all anticipatory EoLC PRN medications are prescribed (see intranet/ward guidance)

Have the indications for use & possible side effects of the PRN EoLC medication been explained to:

The patient: Yes No. If not, please state reason……..

The family: Yes No. If not, please state reason……...

RATIONALISE TREATMENT AND STOP UNNECESSARY INVESTIGATIONS AND OBSERVATIONS (circle as appropriate):

Routine Blood testing	Continue	Discontinue
Intravenous antibiotics	Continue	Discontinue
Blood glucose monitoring	Continue	Discontinue
Recording of vital signs	Continue	Discontinue
Oxygen therapy	Continue	Discontinue
Thromboprophylaxis	Continue	Discontinue

Assess the PATIENT'S NUTRITIONAL AND FLUID REQUIREMENTS; ensure the patient is supported/offered oral fluids/thickened fluids and nutrition where appropriate (circle as appropriate):

Continue SC/IV Fluids	Yes	No	NA
Continue current enteral or parental feeding	Yes	No	NA
Discussed and explained with patient	Yes	No	NA
Discussed and explained with family/carer	Yes	No	NA

Please explain your rationale for your decision

……
……

NURSING CARE- tick once assessed, initial and state actions & start separate care plan if required

Mouth Care □	
Pressure area care □	
Bowel/bladder care □	
Barrier Nursing □	
Side room □	**Discontinue side room checklist**

COMMENCE THE SYMPTOM ASSESSMENT RECORD FOR THE DYING PATIENT.

For specialist advice contact the Palliative Care Team and complete referral form via Allscripts. For urgent input, please contact via switchboard and bleep team

Completed by:

Signature of doctor: …… Name: ……..…..
Position/Grade: ……..… Date: ……..
GMC Number: …… Bleep/Tel no: ……
Signature of named nurse: …… Name: ……

Name Appendix 1 - "Update on End of Life Care" report NHS No. __ __ __ __ __ __ __ __ __ __

Multi Professional Records

Date/Time		Signature/Initials

Multi Professional Records

Date/Time		Signature/Initials

Multi Professional Records

Date/Time		Signature/Initials

Name Appendix 1 - "Update on End of Life Care" report NHS No. __ __ __ __ __ __ __ __ __ __

Multi Professional Records

Date/Time		Signature/Initials

Name Appendix 1 - "Update on End of Life Care" report NHS No. __ __ __ __ __ __ __ __ __ __

Multi Professional Records

Date/Time		Signature/Initials

Multi Professional Records

Date/Time		Signature/Initials

Name Appendix 1 - "Update on End of Life Care" report NHS No. __ __ __ __ __ __ __ __ __ __

Multi Professional Records

Date/Time		Signature/Initials

Multi Professional Records

Date/Time		Signature/Initials

Medication Guidance

This guidance does not replace clinical judgement and it is advised that clinicians access advice from the palliative care team as appropriate.

Key to abbreviations

PRN	When necessary	CSCI	Continuous subcutaneous infusion
BD	Twice a day	SC	Subcutaneous
TDS	Three times daily	mg	milligram(s)
QDS	Four times a day		

PAIN

Present

Is the patient already taking an oral opioid?

YES

- Review current analgesia.
- Consider converting to SC route
- Consider value of CSCI
- Continue to give PRN dose as symptom occurs

NO

Prescribe Morphine 2.5 – 5 mg SC PRN Maximum 2 hourly

- After 24 hours review the medication.
- If 3 or more doses are required PRN then consider use of a CSCI

Controlled on oral opioids

- Review current analgesia
- Consider converting to SC route if the patient is unable to take orally
- Consider value of Continuous subcutaneous infusion
- Continue to give PRN dose as symptom occurs

Absent

Prescribe Morphine 2.5 – 5 mg SC PRN Maximum 2 hourly

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs

- Review the patient regularly, particularly after a change in dose of analgesia.
- Calculate the total amount of medication given in previous 24 hours including PRN doses and titrate accordingly.

SUPPORTING INFORMATION

- **If patient requires repeated PRN doses and remains symptomatic - liaise with medical staff.**
- To convert from other strong opioids contact the Palliative Care Team/Pharmacy for further advice and support.
- If using opioids for the management of dyspnoea this should be taken into account when titrating opioids for pain.
- Consider dose reduction for elderly, frail or patients with dementia.
- **If renal impairment present please contact the Palliative Care Team for advice.**

AGITATION AND RESTLESSNESS

Present

Prescribe MIDAZOLAM 2.5 – 5 mg SC PRN QDS

- After 24 hours review the medication
- If 3 or more doses are required PRN then consider use of a CSCI

Continue to give PRN dosage accordingly

Absent

Prescribe MIDAZOLAM 2.5 – 5 mg SC PRN QDS

SUPPORTING INFORMATION

- **If patient requires repeated PRN doses and remains symptomatic - liaise with medical staff.**
- The management of agitation and restlessness does not usually require the use of opioids unless it is thought to be caused by pain.
- Exclude other reversible causes e.g. Urinary retention, constipation, opioid toxicity, hypercalcaemia, or infection. Consider dose reduction for elderly, frail or patients with dementia.
- If an agitated delirium is suspected use an antipsychotic rather than a BDZ e.g. Haloperidol 1.5mg prn

RESPIRATORY TRACT SECRETIONS

Present

GLYCOPYRRONIUM 200 micrograms SC.
Repeat if necessary after 60 minutes
If effective, give 0.6-1.2mg/24 hours SC over 24 hours

Absent

Prescribe GLYCOPYRRONIUM 200-400 micrograms SC PRN TDS.

SUPPORTING INFORMATION

- Acute pulmonary oedema should be excluded, or treated with furosemide.
- Try repositioning the patient on different sides.
- Consider dose reduction for elderly, frail or patients with dementia

NAUSEA AND VOMITING

Present

Prescribe
Cyclizine 50 mg tds
PO or SC

If symptoms persist after 24 hours consider using a syringe driver or change to an alternative anti-emetic.

Absent

Prescribe
Cyclizine 50 mg tds PRN
PO or SC

SUPPORTING INFORMATION

- Alternative anti-emetic may be prescribed ; e.g. LEVOMEPROMAZINE 6.25 mg SC PRN BD (12.5 mg via CSCI over 24 hours)
- Consider dose reduction for elderly, frail or patients with dementia

BREATHLESSNESS

Present

Is the patient already taking oral morphine for breathlessness?

YES

- Consider converting to the SC route if the patient is unable to take medication orally
- Consider the use of a CSCI titrate to the patient's individual needs.

NO

Prescribe
MORPHINE 1.25-2.5 mg SC PRN
4 hourly

Absent

Prescribe MORPHINE
1.25 – 2.5 mg SC PRN 4 hourly

SUPPORTING INFORMATION

- If the patient is breathless and anxious, consider Midazolam stat 2.5 mg SC
- Consider dose reduction for elderly, frail or patients with dementia

REFERENCES:

Palliative Adult Network Guidelines (2016) Fourth Edition. Watson et al.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 18/06/21	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on the 18th June 2021 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee welcomed the Deputy Chief People Officer for Organisational Development and the Deputy Chief People Officer for People and Systems to their first Committee meeting. The Committee then commended the Chief Nurse and Deputy Chief Nurse for their contribution during their tenure at the Trust.
- The Deputy Chief Nurse and Patient Experience Lead attended for an **update on the method by which the Committee should receive assurance in relation to the patient experience associated with staffing levels at the Trust** wherein it was noted that the experience of staff and patients during night shifts should be considered and the importance of in person patient feedback was emphasised. It was agreed that the Deputy Chief Nurse should inform the Committee of the outcome of the further discussions which will be held on the 23rd June 2021 in relation to the "update on the method by which the Committee should receive assurance in relation to the patient experience associated with staffing levels at the Trust" report.
- The Deputy Chief Nurse attended for a **review of the experience of trainees at the Trust during the second wave of COVID-19** wherein it was agreed that the Deputy Chief Nurse should consider, and confirm, the method by which the "update from the Director of Medical Education" and the "Review of the experience of trainees at the Trust" reports could be aligned, to provide assurance to the Committee in relation to the experience of all trainees at the Trust.
- The Committee reviewed the **draft A3 Scorecard and metrics** and a discussion was held regarding the key areas of focus, the importance of appropriate alignment with the 'people' and organisational development strategy, and ensuring that sufficient monitoring mechanisms where implemented. It was then agreed that the Assistant Trust Secretary should schedule a "review of the A3 Scorecard & metrics" at each Committee meeting from September 2021 onwards.
- The **monthly update on the latest People Key Performance Indicators (KPIs)** was given and the impact of operational pressures on staff were noted.
- The Human Resources Business Partner for Surgery attended for a **review of the workforce planning 'mock up' of the recruitment and retention required for Surgery** wherein the importance of ensuring action plans to reduce regretted losses was emphasized and it was agreed that the Chief People Officer should ensure that future "Update on employee engagement" reports provided the Committee assurance that examples of 'good' practice were utilised by other service areas
- The Head of Staff Engagement and Equality attended for an **update on Equality, Diversity and Inclusion (EDI)** which included details of activity levels within the Trust's Networks and the benefit of the safe space provided by the Senior Women's Network was noted. It was agreed that the Assistant Trust Secretary should schedule an "Update on Equality, Diversity and Inclusion (EDI) (incl. activity levels within the Trust's Networks)" item at the 'Main' People and Organisational Development Committee in September 2021, and quarterly thereafter.
- The Head of Staff Engagement and Equality attended for an **update on employee engagement** (Incl. progress with Divisional engagement plans and latest 'Climate Survey' findings), wherein a directive from NHS England and Improvement to include the National NHS Staff Survey questions in quarterly 'Climate' surveys was discussed at length and the following actions were agreed for the Head of Staff Engagement and Equality:
  - Investigate the incentives which could be implemented to increase the response rate for future 'Climate' surveys
  - Liaise with the Chief People Officer, Chair and Vice Chair of the Committee to consider, and confirm, the questions which should be utilised for future 'Climate' surveys
  - Liaise with the Director of IT to investigate the mechanisms which could be implemented on the Trust's IT System to increase the response rate for future 'Climate' surveys

- The Associate Director of Communications attended to provide an **update on Internal Communication plans for the NHS national staff survey for 2021** wherein Committee members emphasised the importance of ensuring the allocation of protected time for the completion of NHS national staff survey.
- The Freedom to Speak Up Guardian provided an **update on the Trust's Freedom to speak up: raising concerns policy and procedure and proposal on the definition of resolution before closure** wherein the Committee supported the resolution approach
- The **recent findings from relevant Internal Audit reviews (6-monthly report), review of the workforce plan for 2021/22** and **update on the relevant aspects of the Trust's risk register** were noted and it was agreed that the Assistant Trust Secretary should schedule a "review of the relevant aspects of the Trust's risk register (6-monthly report)" item at the 'Main' People and Organisational Development Committee in January 2022, and six-monthly thereafter
- The **Committee evaluation** at the end of the meeting acknowledged the improvement of the quality of the reports the Committee received and the data contained therein, however noted the further assurance required in relation to staff welfare.

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Audit and Governance Committee Annual Report 2020/21	Chair of the Audit and Governance Committee

Please find enclosed the Audit and Governance Committee Annual Report for 2020/21, which was approved at the Audit and Governance Committee meeting on the 13th May 2021.

The enclosed report forms part of the suite of assurances required, by the Trust Board, for approval of the Trust's Annual Report and Accounts for 2020/21

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

APPROVAL OF THE AUDIT AND GOVERNANCE COMMITTEE ANNUAL REPORT FOR 2020/21	CHAIR OF AUDIT AND GOVERNANCE COMMITTEE / TRUST SECRETARY

- The NHS Executive published an Audit Committee Handbook in 1995. The Department of Health (DH) then published revised versions in 2001 and 2005. The Healthcare Financial Management Association (HFMA) published further revisions in 2011, 2014 and 2018. The 1995 and 2001 versions of the Handbook regarded the production of an Annual Report of the activities of NHS Audit Committees as best practice. The 2005 version made this into a requirement, and set out the minimum content for such an Annual Report.
- The 2018 version emphasises this requirement ("…the audit committee should prepare an annual report to the governing body that sets out how the committee has discharged its responsibilities and met its terms of reference), and stated that the Report should summarise the committee's work during the year and (as a minimum), confirm that:
  - "The organisation's system of risk management is adequate in identifying risks and allowing the governing body to understand the appropriate management of those risks"
  - "The committee has reviewed and used the assurance framework and believes that it is fit for purpose and that the 'comprehensiveness' of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the governing body's decisions and declarations"
  - "There are no outstanding areas of significant duplication or omission in the organisation's systems of governance that have come to the committee's attention".
- The Handbook states that the Report should also highlight the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed. These could include:
  - "The reliability and quality of the organisation's financial reporting systems that 'sit' behind the financial position reported to the governing body"
  - "Any significant issues that the committee has considered in relation to the financial statements"
  - "Any major break-down in internal control that has led to a significant loss in one form or another"
  - "Any major weakness in the governance systems that has exposed. or continues to expose the organisation to an unacceptable risk"
  - "The reliability and quality of clinical information systems and clinical auditing processes and the extent to which the governing body can take assurance from these"
  - "An assessment of the performance of the external auditor"
  - "The value (financial and non-financial) of any non-audit services provided by the external auditors"
- The Handbook expects the Report to be presented to the Board promptly after the financial year-end and before it considers the main Trust Annual Report and statutory declarations. As a result, the Committee's Annual Report should make a general reference to the Committee's role in these matters
- The Handbook also lists the following as best practice for Audit Committee Annual Reports:
  - "The report should not be long (three or four pages should be sufficient) and may be drafted by the committee's secretary under the direction of the committee's chair"
  - "The committee chair should take overall responsibility for the report's preparation and share drafts of the report with committee members"
  - "The final draft report should be shared with the internal and external auditors, to ensure that it is consistent with their understanding, and with any other regular attendees to the committee, such as the CFO. However, the report must be owned by the committee itself"
  - "The report should go to all members of the governing body in advance of the meeting to agree the annual report and accounts"
  - "If the report includes any significant issues, these should be discussed by the audit committee chair with the chair of the governing body prior to the report being presented to the full governing body"
  - "Rather than just focus on process and the number/type of assurances considered during the

year, the report should seek to identify the outcome of the committee's work, its conclusions and actions taken".

- The draft Annual Report from the Audit and Governance Committee for 2020/21 is therefore enclosed, for approval. The draft covers the minimum content outlined above.
- Once approved, the Report will be submitted to the Trust Board meeting scheduled for 24/06/21, at which the Board will be asked to approve the Trust's Annual Report and Accounts for 2020/21

Reason for submission to the Audit and Governance Committee

Review, comment and approval

1. Introduction

This report summarises the key work areas of the Audit and Governance Committee during the period from 01/04/20 to 31/03/21. The report supports the primary role of the Committee in ensuring the adequacy and effective operation of the organisation's overall internal control system. The format of the report is informed by the guidance contained with the NHS Audit Committee Handbook (2018), and highlights work and outcomes in the following areas: Meetings and administration; Governance, Risk Management and Internal Control; Internal Audit; External Audit; The Audit and Governance Committee as Auditor Panel; Audit and Governance Committee assessment; and Audit and Governance Committee statement/declaration.

2. Meetings and administration

During 2020/21, the Audit and Governance Committee met five times, on 26/05/20, 18/06/20 (to recommend the approval of the Annual Accounts for 2019/20), 30/07/20, 04/11/20 and 19/03/20. The Committee did not meet as the Trust's Auditor Panel[2] during 2020/21.

All of the Trust's Non-Executive Directors (apart from the Chair of the Trust Board) are members of the Committee. The membership of the Committee during 2020/21 was as follows:

- David Morgan, Non-Executive Director (Chair)
- Maureen Choong, Non-Executive Director
- Sarah Dunnett, Non-Executive Director
- Neil Griffiths, Non-Executive Director
- Emma Pettitt-Mitchell, Non-Executive Director

The attendance at each Audit and Governance Committee meeting in 2020/21 is shown below:

	Meetings in 2020/21				
Member	**26/05/20**	**18/06/20**	**30/07/20**	**04/11/20**	**03/03/21**
David Morgan, Non-Executive Director (Chair)	✓	✓	✓	✓	✓
Maureen Choong, Non-Executive Director (Vice Chair)	✓	✓	✓	✓	✓
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	Apologies	✓
Emma Pettitt-Mitchell, Non-Executive Director	Apologies	✓	Apologies	✓	✓

The Committee's Terms of Reference were reviewed and agreed at the Committee meeting on 04/11/20, and approved by the Trust Board on 26/11/20. The Terms of Reference will next be subject to an annual review at the November 2021 Audit and Governance Committee meeting (and then be submitted for approval to the Trust Board in the same month). The Terms of Reference deliberately do not incorporate clinical audit processes, as this is left to the oversight of the Quality Committee and Trust Clinical Governance Committee.

3. Governance, Risk Management and Internal Control

a. Board Assurance Framework (BAF) and Risk management

The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. The

[2] The Trust Board 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.

2020/21 BAF was reviewed at the Committee on 04/11/20 and 03/03/21. An update on the development of the BAF was also given at the Committee's meeting on 30/07/20, while a year-end review report for the 2019/20 objectives was received at the meeting on 26/05/20. The Committee also considered a review of the Trust's risk management process at its meeting on 26/05/20. The annual Internal Audit review of "Assurance Framework and Risk Management", undertaken at the end of 2020/21, gave an overall assessment of "Reasonable Assurance".

During 2020/21, the Trust embarked on a "Strategy Deployment" programme which would transform the method by which the Trust selected, implemented, and monitored its objectives. The Audit and Governance Committee has been apprised of progress during the year, and it was then confirmed by the Trust Board on 25/03/21 that the "Strategy Deployment" process, and the monitoring and reporting of the objectives therein, would replace the BAF from 2021/22 onwards. The Trust Board and its sub-committees will receive assurance on the delivery of the Trust's objectives via different means from 2021/22 onwards (these means are still being finalised at the time of this report).

b. Counter fraud

The Committee has reviewed activity relating to counter fraud measures in 2020/21, via reports from the Local Counter Fraud Specialist (LCFS). The 2020/21 Counter Fraud "Risk Assessment & Annual Work Plan" was approved at the meeting held on 26/05/20, and the "Counter Fraud Annual Report 2019/20" was received at the same meeting.

c. Relationship with the Trust Board

The reporting from the Committee to the Trust Board takes place via a written summary report of each meeting, presented by the Committee Chair. The report is based on a template, and covers the key matters considered at the meeting; details of the Internal Audit reviews that were discussed; any "high" priority outstanding actions from Internal Audit reviews; the actions agreed at the Committee; and any issues that need to be drawn to the attention of the Board.

d. Head of Internal Audit Opinion

The Head of Internal Audit Opinion for 2020/21 states that "My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk". The last sentence of the Opinion reflects the fact that some reviews undertaken by Internal Audit during 2020/21 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

e. Annual Governance Statement

The Annual Governance Statement for 2020/21 was reviewed at the Audit and Governance Committee on 13/05/21, as part of the draft Annual Report and Accounts for 2020/21.

Based on this, the detailed work of the Audit and Governance Committee summarised above, and its Internal and External Auditor work programme, the Annual Governance Statement is consistent with the view of the Audit and Governance Committee on the Trust's system of Internal Control, and the Committee supports the Trust Board's approval of the Statement, which is scheduled to take place on 24/06/21.

4. Internal Audit

The 2020/21 Internal Audit plan was agreed by the Audit and Governance Committee at its meeting on 19/03/20. The output from the plan at the date of this Annual Report is listed below.

System reviewed	Type	Assurance assessment (substantial, reasonable or limited?)
Data Quality of Key Performance Indicators (RTT and Stroke Best Practice Tariff)	Assurance	Reasonable Assurance
Clinical Governance Arrangements	Assurance	Reasonable Assurance
Mandatory Estates Safety Checks	Compliance	Reasonable Assurance
Oncology ICT Healthcheck	Assurance	Limited Assurance
Training System including Appraisal Processes	Assurance	Reasonable Assurance
Patient Involvement and Experience	Assurance	Reasonable Assurance
Mortality Review Process	Assurance	Reasonable Assurance
Critical Financial Assurance – Financial Accounting and Non Pay Expenditure	Assurance	Reasonable Assurance
Critical Financial Assurance – Payroll	Assurance	Reasonable Assurance
Assurance Framework and Risk Management	Assurance	Reasonable Assurance
Processes for the Management of Post	Assurance	Limited Assurance
Effective Use of ESR	Assurance	Limited Assurance
Data Security and Protection Toolkit (Part 1)	Assurance	N/A (part 1 of the review does not include an assurance opinion. The opinion will be provided once part 2 is completed in May 2021 due to the national timeframe for submission being delayed)
Care Quality Commission	Assurance	Reasonable Assurance
Roche Managed Service Contract	Appraisal	Limited Assurance
Data Quality of Key Performance Indicators (RTT and Clinic Cancellations < 6 weeks)	Assurance	Not yet available

In 2020/20, the Committee undertook a formal assessment of the performance of the Trust's Internal Auditors (Tiaa Ltd), and a report of the findings was considered at the Committee meeting held on 03/03/21. No significant issues or concerns were identified, but a response to the review/survey will be considered at the meeting on 13/05/21.

The Committee reviews the reliability and quality of clinical information systems via the Internal Audit process, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. However, as is noted above, although the 2020/21 review started, it was not completed at the time of this report.

5. External Audit

The Committee received the Annual Audit Letter for 2019/20 on 30/07/20. The key issues reported were as follows:

- An unqualified opinion on the Trust's financial statements was given on 23/06/20
- The Trust presented draft financial statements for audit in accordance with the national deadline and pandemic lockdown restrictions that existed at the time. The financial statements were supported by a good set of working papers. The finance team responded promptly and efficiently to queries during the course of the audit

- The Trust's Annual Report, including the Annual Governance Statement. was provided on a timely basis with the draft financial statements with supporting evidence
- The external auditors issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider
- The external auditors referred a matter to the Secretary of State on 22/06/20 under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust's continued breach of its break-even duty for the three year period ending 31/03/20.
- The completion of the audit of the financial statements of the Trust was certified in accordance with the requirements of the Code of Audit Practice on 22/06/20.

The "Overall Value for Money conclusion" within the Letter was that "We are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2020."

The government did not require external auditors to complete a review of NHS Trusts' Quality Accounts for 2019/20, as a result of the COVID-19 pandemic.

The External Audit plan and fee for 2020/21 was approved by the Committee on 03/03/21.

In 2020/21, the Committee undertook a formal assessment of the performance of the Trust's External Auditors (Grant Thornton LLP), and a report of the findings was considered at the Committee meeting held on 03/03/21. No significant issues or concerns were identified, but a response to the review/survey will be considered at the meeting on 13/05/21.

6. The Audit and Governance Committee as Auditor Panel

As noted above, the Trust Board has appointed the Committee as the Trust's Auditor Panel in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014. The Audit and Governance Committee as Auditor Panel advises the Trust Board on the selection, appointment and removal of external auditors, and on the maintenance of independent relationships with such auditors.

The Chair and Vice-Chair of the Audit and Governance Committee act as Chair and Vice-Chair (respectively) of the Auditor Panel, and when undertaking the role of the Auditor Panel, the membership comprises 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. The Auditor Panel generally meets on the same day as the Audit and Governance Committee, but Auditor Panel business is identified via a separate agenda (with separate minutes taken), and members deal with these matters as Auditor Panel members, not as Audit and Governance Committee members.

The Committee did not meet as the Trust's Auditor Panel during 2020/21, as the contract with the external auditors is not to expire until the end of March 2022. The Auditor Panel will therefore need to meet during 2021/22 regarding that contract.

7. Audit and Governance Committee assessment

At the Committee's meeting on 04/11/20, the process for the Committee's self-evaluation was reconfirmed, which, as was the case in 2017, 2018, and 2019 would consist of:

1. An initial assessment, through the completion of a checklist of fact-based questions by the Trust Secretary and
2. Individual, evaluative feedback through completion of a self-assessment form by Committee members and routine attendees

A report of the findings of the evaluation was then considered at the Committee's meeting on 03/03/21, and it was confirmed that no actions were required in response, as no specific areas for improvement emerged.

8. Examples of the outcome of the Committee's work, conclusions and actions taken

Although the Committee inevitably has a focus on obtaining assurance from processes, the following examples illustrate the outcome of the Committee's work, its conclusions and the actions taken:

- The Director of Estates and Facilities was invited to attend the Committee's meeting on 04/11/20 to respond to the "Estates Procurement" Internal Audit review and data from the July 2020 "…latest single tender/quote waivers data" report.
- The Director of IT was invited to attend the Committee's meeting on 03/03/21 to respond to the "Active Directory Outstanding Audit Recommendations" within the November 2020 "Update on progress with the Internal Audit plan for 2020/21…" report.
- The Committee's meeting on 03/03/21 considered consider what, if any, action was required by the Committee following the discussion on the Integrated Care System/Integrated Care Partnership that was held at the Trust Board 'Away Day' on 02/12/20. As a result, it was agreed to review and consider, what, if any, amendments were required to the Committee's Terms of Reference, to ensure they accurately reflected the Committee's role in governance at the Trust. The Terms of Reference were duly reviewed, and some proposed amendments were submitted to the Committee's meeting on 13/05/21 for agreement.

9. Audit and Governance Committee statement / declaration

The Audit and Governance Committee can confirm that:

- The Trust's Annual Governance Statement for 2020/21 is consistent with the view of the Audit and Governance Committee on the Trust's system of internal control, and the Committee supports the Trust Board's approval of the Statement.
- The Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the 'comprehensiveness' of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Trust Board's decisions and declarations[3].
- The system of risk management in the Trust is adequate in identifying risks and allowing the Trust Board to understand the appropriate management of those risks.
- There are no areas of significant duplication or omission in the systems of governance in the Trust that have come to the Committee's attention and not been adequately resolved.
- There has been no major breakdown in internal control that has led to a significant loss in one form or another for 2020/21.
- There has been no major weakness in the governance systems that has exposed, or continues to expose, the Trust to an unacceptable risk.

David Morgan,
Chair of the Audit and Governance Committee,
Maidstone and Tunbridge Wells NHS Trust
May 2021

[3] However, as noted in the "Board Assurance Framework (BAF) and Risk management" section above, the Trust Board confirmed, on 25/03/21, that the "Strategy Deployment" process, and the monitoring and reporting of the objectives therein, would replace the BAF from 2021/22 onwards.

Approval of Annual Report 2020/21 (including Annual Governance Statement)	Chair of the Audit and Governance Committee

NHS Trusts are required by statute[1] to produce an Annual Report. The minimum content for such Annual Reports is prescribed by the Department of Health and Social Care, through its Group Accounting Manual (GAM). The GAM also states that "Beyond this [minimum context] however, the entity must take ownership of the document and ensure that additional information is included where necessary to reflect the position of the NHS body within the community and give sufficient information to meet the requirements of public accountability".

The Annual Governance Statement (which is included within the Annual Report) is subject to separate guidance, issued by NHS England / Improvement. The Executive Team Meeting (ETM) is required "To review and endorse the Trust's Annual Governance Statement, prior to it being considered at the Audit and Governance Committee and Trust Board", however given the amended timescale and the impact of COVID-19 the Chief Executive reviewed and endorsed the Trust's Annual Governance Statement on behalf of the ETM.

The Annual Report (including Annual Governance Statement) for 2020/21 was duly written to ensure compliance with the aforementioned guidance, and using a similar template/format used for the 2019/20 Annual Report.

The draft Annual Report is required to be provided to the external auditors, as part of their audit of the financial accounts. Certain information contained in the "Remuneration and Staff Report" section is "subject to audit" and is referred to in the audit opinion. This content is marked in the Report as "subject to audit". Other quantitative aspects of the Annual Report are reviewed by auditors to ensure consistency with the accounts, and to ensure that the requirements of the GAM have been met.

The Audit and Governance Committee reviewed an earlier version of the Annual Report on 13/05/21 and requested some amendments. Such amendments have been made in the enclosed version, which is submitted for approval. The same version will be reviewed at a further meeting of the Committee on the morning of 23/06/21. The Committee will be asked to review the Annual Report in detail, and recommend that the Trust Board approves the document. The outcome of the Committee's review will be reported at the Trust Board meeting on 24/06/21.

The "full final text of 'audited' annual report" is required to be submitted to NHS England / Improvement by noon on 29/06/21, with the audited annual accounts. This text does not need to have final formatting for printing, but should be the final text". There may be some minor layout/design changes between then and the publication date[2], which has now been confirmed to be 20/09/21. However, any such changes will be cosmetic, and not material to the content. The Trust Board should also note that:

- The Trust's Annual Report usually contains a summary of the Trust's Quality Accounts. This is not mandated, but considered to be beneficial for readers. However, following the COVID-19 situation it was felt to be more appropriate to replace the summary with a cross reference to the Quality Accounts for 2020/21, which will available on the Trust's website, once approved by the Trust Board.
- As was the case for the 2019/20 Annual Report, in response to the impact of COVID-19, it was stated that the "performance analysis" section of the "Performance Report" was "optional to omit". However, the Trust has opted to include this section.
- The financial Accounts will be inserted in full, at the back of the Annual Report, once finalised (these have been submitted to the Trust Board under a separate item)
- The Auditors' report will be added once received, after the audit has been completed

[1] The National Health Service and Community Care Act 1990

[2] The Department of Health and Social Care requires each NHS Trust to publish its 2020/21 Annual Report and Accounts available on its website, and also send to NHS England / Improvement as a single document.

Which Committees have reviewed the information prior to Trust Board submission?
▪ Audit and Governance Committee, 13/05/21 (earlier draft of the Annual Report) and 23/06/21 (the enclosed draft)

Reason for receipt at the Trust Board (decision, discussion, information, assurance etc.) [3]
To review and approve the Annual Report (including Annual Governance Statement) for 2020/21

[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

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual report and accounts

2020-2021

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. Its content and format must follow the guidance issued by the Department of Health and Social Care (in the form of a 'Group Accounting Manual'). The specific requirements for Annual Reports for 2020/21 are that NHS bodies must publish a single Annual Report and Accounts (ARA) document, comprising the following:

- A Performance Report (which must include an overview, and a performance analysis)
- An Accountability Report (which must include: a Corporate Governance Report and a Remuneration and Staff Report[1])
- The Financial Statements

Beyond the minimum content required by the Department of Health and Social Care (DHSC), the Trust is expected to include additional information to reflect the position of the Trust within the community and meet the requirements of public accountability. The Report is divided into the following sections:

- "Performance Report for 2020/21", which is split into:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; a 'snapshot of the year'; key developments; the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2020/21; and a review of financial performance for 2020/21
  - A summary of the Trust's Quality Accounts for 2020/21
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit.
- "Accountability Report for 2020/21", which is divided into the following sections:
  - "Corporate Governance Report for 2020/21", which includes:
    - A Directors' report (providing details about the Trust Board; a Statement regarding Directors' disclosure to auditors; attendance at Trust Board meetings; Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - A "Statement of Directors' responsibilities in respect of the accounts"
    - The "Annual Governance Statement for 2020/21"
  - "Remuneration and Staff Report for 2020/21" (including details of 'off-payroll' engagements)
  - The "Parliamentary Accountability and Audit Report"
- "Financial Statements for 2020/21", including details of Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust.

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 24th June 2021.

[1] The Trust is not required to produce a Parliamentary Accountability and Audit Report, and therefore the required disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included within the Financial Statements and Notes to the Accounts where relevant.

Contents

Performance report for 2020-2021:
Overview

The purpose of the overview section

This overview aims to equip the reader with a broad understanding of the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during 2020/21. For those wishing to read in more detail about the Trust's achievements, the issues it faced and its financial situation, further detail is provided in the rest of the Annual Report and Accounts.

The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[2], and provides a full range of general hospital services and some areas of specialist complex care to around 760,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs over 6,500 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations.

In January 2021 the provision of opthamology services which were previously provided by Moorfields Eye Hospital under Dartford and Gravesham NHS Trust was transferred to the Trust.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital[3] and the majority of the site provides single bedded en-suite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women's and Children's, and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre, providing specialist Cancer services to around two million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines. The Trust also provides sexual health services to the population of Kent and Medway. The Maidstone site also has a state-of-the-art Birth Centre, a dedicated ward for respiratory services and an Academic Centre with a 200 seat auditorium. The Education Centre at Tunbridge Wells

[2] See The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000
[3] The PFI Project Company is "Kent and East Sussex Weald Hospital Ltd" (KESWHL)

Hospital, with its full resuscitation simulation suite, enables the Trust to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are nationally recognised for excellence in their fields.

The Trust is registered with the Care Quality Commission (CQC) to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at Maidstone and Tunbridge Wells Hospitals)
- Diagnostic and screening procedures (at Maidstone and Tunbridge Wells Hospitals)
- Family planning services (at Maidstone and Tunbridge Wells Hospitals)
- Maternity and midwifery services (at Maidstone and Tunbridge Wells Hospitals and Crowborough Birthing Centre)
- Surgical procedures (at Maidstone and Tunbridge Wells Hospitals)
- Termination of pregnancies (at Tunbridge Wells Hospital)
- Treatment of disease, disorder or injury (at Maidstone and Tunbridge Wells Hospitals)

For further details of the Trust's CQC Registration, see www.cqc.org.uk/provider/RWF/registration-info.

The Trust's objectives and organisational structure are detailed elsewhere within this Annual Report. Details of the Trust's business model and environment, organisational structure, objectives and strategies can be found within the Performance Report Overview and Performance Analysis.

A message from the Chair of the Trust Board and Chief Executive

When we reflect on 2020/21 it is clear this has been an unprecedented year, dominated by the impact of Covid-19 on both the country and the NHS. The pandemic presented a number of major challenges to the Trust and we are moved and incredibly impressed by the response of all our staff. Across our organisation colleagues demonstrated skill, innovation and dedication – quickly developing new ways of working, adapting patient pathways, and rapidly increasing critical care capacity. Never have the words exceptional people providing outstanding care been so clearly shown each and every day. We are so proud of what staff have achieved, during what was a very stressful time for them and their families, and we want to once again say a heartfelt thank you to each of them.

Despite these challenges, throughout the last year the Trust remained one of the best performing hospital providers in the country. Continuing to provide urgent and emergency care and meeting national performance targets by treating ED and cancer patients quickly and with the highest quality, compassionate care.

Following the first wave of COVID-19, the Trust launched an ambitious, NHS leading, 'reset and recovery' programme. This enabled the Trust to return to pre-COVID-19 levels of activity more quickly than other health organisations both locally and nationally, and focused on restarting routine and non-urgent care in a safe and sustainable way.

In December 2020 the effects of the second wave began to be felt across the Trust and the number of COVID-19 patients far exceeded the first wave. During this time and in response to the immense pressures on staff, the Trust implemented the very successful One Team Runner programme. This provided volunteers to support the wards in non-clinical roles, enabling frontline staff to focus on the delivery of the very best patient care. At the peak of the programme over 250 volunteers were involved across the Trust.

The Trust's vaccination programme started at Maidstone Hospital on 22 December 2020 and within just nine days 6,400 healthcare staff had been vaccinated. In one single day alone 1,284 doses were administered – an average of one person every 30 seconds. Throughout the programme the Trust has continued to work with partners to vaccinate healthcare workers from other organisations as well as making the vaccination available to the Trust's most vulnerable patients. By the end of March 2021, the Trust had successfully vaccinated over 90% of the workforce with their first dose and over 70% with their second dose.

Despite the many impacts of the COVID-19 pandemic we would like to particularly highlight the following key achievements:

- Finance – achieved the financial plan for 2020/21 and executed one of the largest capital programmes in the history of the Trust
- Performance – continued delivery of the 62-day cancer access standard and consistently featured in the top 10 nationally for Emergency Department performance
- Staff engagement – the overall response rate for the NHS national staff survey saw an increase from 2019/20, despite being undertaken during the second wave of COVID-19. Quarterly 'climate surveys' were also rolled out to enable real time improvements to be delivered

- Service developments – a new purpose built Surgical Assessment Unit (SAU) was constructed at Tunbridge Wells Hospital, the provision of stroke care for Medway and Swale patients was transferred from Medway NHS Foundation Trust, ophthalmology services were transferred from Dartford and Gravesham NHS Trust and the Trust continued the development of the business case for the Kent and Medway Medical School Accommodation, laying the foundations for the future delivery of exceptional patient care
- Shortlisted in the 'Acute or Specialist Trust of the Year' category in this year's prestigious Health Service Journal (HSJ) Awards

Looking forward, we will focus on the lessons learned from COVID-19 which will be built into the Trust's plans for 2021/22, continue to ensure the delivery of the financial plan and restore elective care. During this period strong leadership will be more important than ever which is why 2021/22 will see the delivery of a number of key programmes to support staff and organisational development.

By working together and demonstrating a truly great team spirit, colleagues have built really solid foundations which will ensure even more success in 2021/22. Finally, we would like to thank the public and our local communities for their continued support and the generosity they have shown to the Trust over the last 12 months. From letters of support, appreciation and encouragement to non-financial donations – each have played an important role in helping to maintain staff morale during what has been a truly unique year.

Insert signature

Insert signature

Miles Scott, Chief Executive

Insert date

David Highton, Chair of the Trust Board

Insert date

Snapshot of 2020/21

April 2020

Following the arrival of COVID-19 in the UK, the Trust began to care for increasing number of COVID-19 patients during the first wave of the pandemic. A Channel 4 film crew led by BAFTA winning and Oscar nominated filmmaker Waad Al-Kateab visited our hospitals and MTW featured in a one hour feature-length special report - 'Are We Winning The Battle Against Coronavirus? This documented emotional first-hand accounts from COVID-19 patients and their families as well our staff working in Intensive Care and on respiratory wards.

May 2020

Our exceptional staff enjoyed a first class service from airline crew when Project Wingman visited our hospitals. Offering teams a luxury space to rest and recharge before, during and after shifts, Project Wingman was organised and delivered by furloughed and grounded cabin crew volunteers. The crews arrived at MTW in May to provide their services in both Maidstone Hospital and Tunbridge Wells Hospitals, so all Trust staff could enjoy refreshments in specially set up break out areas.

June 2020

As the pandemic continued, and the number of Covid patients increased each day, people who had recovered from the virus shared their stories and experiences of the care provided by our clinical teams. This included the story of Peter Ananicz, who spent 17 days on a ventilator at Maidstone Hospital and went on to talk to the Good Morning Britain presenters about his recovery and reunion with wife, Ruth.

July 2020

In support of the MTW Charity's 'Go The Distance' campaign to keep people moving during the pandemic and raise money for NHS colleagues, the Chief Executive, Miles Scott, ran an incredible super-marathon to help hit the £10,000 target. Miles ran from Crowborough Birthing Centre, to Tunbridge Wells Hospital before heading on to the Trust's Healthcare Records base at Paddock Wood and then on to the finish line at Maidstone Hospital, covering a distance of almost 29 miles in under 4 hours.

August 2020

A local coin collector donated special fifty pence pieces to staff in the Trust's Emergency Department who saved his life following a heart attack. Coin collector Warren Light was hospitalised and underwent an operation to have a stent fitted to help open one of the valves of his heart which was partially blocked. He was discharged and returned home just two days before the country went into lockdown.

September 2020

Celebrating outstanding care was a highpoint in September with the Trust providing some of the fastest access to treatment in England. MTW hit the national standard for treating patients within 62 days for twelve months in a row. The accomplishment signified a huge turnaround in performance for MTW, who until August 2019 had not hit the target for five years. The Trust also met the two week wait referral target for eleven consecutive months – meaning even more patients were seen within 14 days of being referred by their GP.

October 2020

For the first time ever, the Trust was rated the best performing trust for emergency care across the country. At MTW staff saw, admitted or discharged over 97% of people attending its emergency departments within the four hour national standard. Since this achievement, the Trust went on to be the top performing departments again at various points throughout the year while also regularly ranking highest in the region.

November 2020

Maidstone Hospital and Maidstone Borough Council (MBC) joined forces to recognise all key workers across the borough who continued to work during Covid-19 by planting over 18,000 bulbs to create a flower garden at the entrance of Maidstone Hospital. The plants would go on to bloom the following spring – almost a year to the day when the Covid-19 pandemic began in the UK

December 2020

A new Surgical Assessment Unit (SAU) opened at Tunbridge Wells Hospital as part of the Trust's ongoing commitment to ensure patients access emergency care services in a prompt and timely way. SAU, which was based inside the hospital, is now located in a new modular building adjacent to the Emergency Department (ED). The move forms part of the Trust's plans to enhance its Same Day Emergency Care (SDEC) pathway so that more patients can benefit.

January 2021

The Trust marked the tenth anniversary of the opening of Tunbridge Wells Hospital in Pembury. Today, the hospital is seen nationally as an example of best practice in design of patient-safe facilities and has attracted widespread international interest. The Trust provides general hospital services and some areas of complex care to around 500,000 people living in the south part of West Kent and the north part of East Sussex.

February 2021

The purchase of a new bladder scanner by former cancer patient, Stephen Stamp benefited patients and staff in the Kent Oncology Centre. Stephen was diagnosed with prostate cancer in early 2020 and credits the treatment he received at the centre with saving his life. He generously donated nearly £7,000 to the Cancer Services Fund, through the Maidstone and Tunbridge Wells NHS Charitable Fund for the new scanner for the Radiotherapy Department.

March 2021

The Covid-19 vaccination programme continued to go from strength to strength as the Trust's vaccination centre at Maidstone Hospital operated to issue thousands of doses. In one single day alone 1,284 doses were administered – equating to one person every 30 seconds for the opening hour. Since the opening in December, the Trust continued to work with partners to vaccinate healthcare workers from other organisations as well as making the vaccination available to the Trust's most vulnerable patients including those within Oncology.

Key issues and risks affecting delivery of the Trust's key objectives

The Trust Board agreed the following key objectives for 2020/21:

- 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.
- 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.
- To deliver high quality care to our patients and carers and be recognised as an outstanding organisation.
- Delivery of the Allscripts' Electronic Patient Record (EPR) solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming the Trust to improve patient outcomes through providing safer and more efficient care.
- To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (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.
- To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams.
- To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.
- To oversee and enable the Integrated Care Partnership (ICP) Development in West Kent and ensure appropriate stakeholder engagement and participation in the Trust's work (e.g. in clinical strategy development).
- To make the Trust a great place to work - For the Trust 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.

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2020/21" (pages 52 to 64) are outlined below. Details of how the Trust actually performed against these objectives are provided in the "Performance analysis" section (pages 18 to 26).

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

The key recognised risks to delivery of this objective were uncertainty of the change in the finance regime for 2020/21; if there was a lack of senior leadership and commitment; if there was poor financial controls (or if good controls were poorly applied); the additional funding to support COVID-19 could reduce

the focus on meeting the financial plan; if the Trust's plans for 2020/21 had been developed without consideration of best practice elsewhere; if there was insufficient engagement with external stakeholders, particularly given the Clinical Commissioning Group (CCG) restructuring taking place in 2020/21; and if there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand.

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

The key recognised risks to delivery of this objective were lack of managerial focus or clinical engagement; COVID-19; additional out of area demand; lack of discharge capacity; and shortage of capacity during winter.

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

The key recognised risks to delivery of this objective were the potential for teams to lose focus on quality improvement plans due to competing priorities; a further surge of COVID-19 cases resulting in potential redeployment of staff; uncertainty in the future changes in the Care Quality Commission (CQC) inspection methodology; over-reliance on the corporate team leading on the improvement work; and reduced local ownership and engagement with action plans.

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

The key recognised risks to delivery of this objective were the Trust's capacity and capability to manage the volume of change required for EPR & other high-priority initiatives; 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; a lack of operational management engagement resulting in subject matter experts and clinical staff not being made available to the EPR Programme Team; a lack of clinical engagement leading to the Trust's requirements not being properly understood and poor-quality solutions being provided; Windows 10 rollout and its alignment with Sunrise; and the capacity and capability of the IT Team to deliver and support the Sunrise infrastructure .

To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (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

The key recognised risks to delivery of this objective were lack of timely information from KMMS regarding student numbers, curriculum and learning objectives, to enable early resource planning and accommodation

scoping; availability of resources required by individual specialities/Departments to provide for student placements; inadequate infrastructure / space (in particular outpatient/ clinic space) to support teaching; the need to co-ordinate where possible to maximise opportunities to develop learning environment with other developments in the Trust; job plan risks regarding the incorporation of additional Programmed Activities (PAs) for medical student Educational/Clinical Supervisor responsibilities; and insufficient accommodation available for students' arrival on placement in September 2022 .

To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams

The key recognised risks to delivery of this objective were previously failure to perform in the allotted time scale was a risk however the Estates Strategy has now been drafted and is complete, apart from the incorporation of the capital expenditure allocations which are unknown at the time of drafting this document.

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

The key recognised risk to delivery of this objective was failure to perform in the allotted time scale..

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

The key recognised risks to delivery of this objective were Lack of Sustainability and Transformation Partnership (STP) /Clinical Commissioning Group (CCG) funding for essential purposes (e.g. clinical backfill); lack of appropriate population health data for decision making and priority setting; lack of Trust between system partners; and lack of delegated authority to support streamlined and quick decision making.

To make the Trust a great place to work - For the Trust 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

The key recognised risks to delivery of this objective were the impact of the COVID-19 pandemic and 'reset and recovery' needs, especially in light of the second wave and the impact on wellbeing on staff, especially fatigue, psychological wellbeing and the risk of 'burnout'; The ability of staff to be able to create the interventions at the pace required, especially with the engagement, wellbeing & staff experience agenda or broader 'People Strategy'[4]; a national shortage or unavailability of certain staff groups; The need to join up and ensure governance oversight of the transformation agenda for Strategy Deployment[5] ; Organisation

[4] 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)

[5] Specifically Strategy Deployment through the Western Sussex Partnership (Patient First Improvement System (PFIS) / PFIP for Leaders) agenda; digitalisation and the implementation of the Elecronic Patient Record (EPR); delivery of the

readiness for and timing of Strategy Deployment initiatives; Lack of support or visibility of senior leaders to ensure alignment of the golden thread of 'Board to Ward' and the 'People Agenda' on Key Themes; Insufficient or non-aligned communications of narrative, actions and information to staff; Insufficient investment to date in senior leadership development, middle management development or Culture and Leadership Programme actions; and Staff not empowered to implement or deliver service changes .

Adoption of the 'going concern' basis

The DHSC Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts. In para 4.13 it states: "For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up".

The Executive Team Meeting and Finance and Performance Committee have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and have prepared the 2020/21 accounts on a "going concern" basis following consideration of the following:

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body
- The funding regime that has existed for 2020/21 will continue for at least the first half of 2021/22. NHS organisations will submit a formal plan in May.
- The Trust has agreed its 2021/22 capital plans with the Kent & Medway STP which now manages the overall resource level within the patch. The Trust has submitted its five year capital plans to NHS England/Improvement (NHSE/I) in April 2021.
- The Trust continues to fully participate in the STP planning and assurance process. The STP has developed its role as local system lead in ensuring that the patch organisations work collaboratively in delivering income and expenditure and capital control totals. The Trust is a key player in Integrated Care Partnership (ICP) and STP/Integrated Care System (ICS) work on reconfiguring services in the patch for the future e.g. it is one of the selected sites for Hyper Acute Stroke Unit (HASU) as part of the STP-wide Stroke services consultation.

- The Trust will have contracts in place for provision of healthcare services for 2020-21 albeit at this stage they will be at least in part block contract arrangements nationally determined in response to the COVID-

Exceptional People Outstanding Care Programme, including the staff welfare programme and Culture and Leadership Programme (CLP) and associated staff engagement plans; and the Exceptional Leaders programme

19 pandemic. The Trust's main commissioner is NHS Kent & Medway Clinical Commissioning Group (CCG) with other main sources of income from NHSE Specialist Commissioners, NHS East Sussex CCG, NHS West Sussex CCG, NHS Brighton and Hove CCG and NHS Surrey Heartlands CCG. The current financial regime provides certainty for income and cash flows in 2021/22 for at least the first half of the financial year.

- Following the conversion of the working capital loan to Public Dividend Capital (PDC) in 2020/21 the Trust has no working capital loans and has not required any support during 2020/21 and not anticipating requiring support in 2021/22
- The Trust does not consider that there are any material uncertainties to the going concern basis.

For these reasons, the Trust has prepared its 2020/21 annual accounts using the going concern basis in line with the GAM guidance.

Performance summary for 2020/21

Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2020/21" section (pages 20 to 22). The Trust's performance activities can be found in full within the monthly Trust Board reports, which are available for review at https://tinyurl.com/MTWTBReports. Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2020/21, which will be made available in full on the Trust website (www.mtw.nhs.uk).

Performance report for 2020-2021:
Performance analysis

How the Trust measures performance

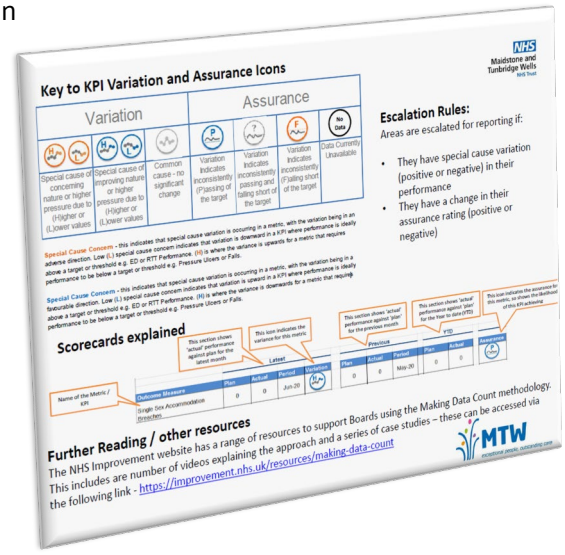
The Trust's Performance Management framework recognises that a high performance culture will only be achieved when performance is managed in a positive and non-punitive way. The Framework aims to ensure that striving for excellence is an integral part of organisational culture. The key focus areas for performance management are:

- Quality - Service safety and quality requirements;
- Performance - National and local standards and performance targets;
- Financial - financial, efficiency and business objectives.

A 'Ward to Board' approach is applied and monitored through a sign-off process at Directorate, then Divisional, level before presentation at monthly Divisional Performance Review meetings and ultimately, the Trust Board.

A whole day each month is devoted to Trust-wide performance management, attended by members of the Executive Team. The Clinical Divisions and Corporate services are accountable for the delivery of their key indicators for Quality, Performance, Finance and Workforce, together with their strategic and Trust-wide programme responsibilities.

The monthly Integrated Performance Report encapsulates the result of these processes and provides the Board with a rich source of information that has been reviewed and substantiated at all levels of the Trust. "The dashboard contains details of all key aspects of performance, under the CQC domains of "Safety", "Effectiveness", "Caring", "Responsiveness" and "Well-Led". In July 2020 the Trust transitioned from a traditional 'Red, Amber, Green' (RAG) rating system which was used to highlight variances against Trust plans for the year and/or the required national target; wherein "Green" indicated "Delivering or exceeding target", "Amber" indicated "Underachieving target"' and "Red" indicated "Failing target"; to a Statistical process control (SPC) process which employs statistical methods to monitor and control a process". Additional performance information is provided on financial matters and clinical quality. These reports are available on the Trust's website, as part of the information provided for Trust Board meetings (see www.mtw.nhs.uk/about-us/trust-board/).



The content of the Performance Dashboard is discussed at meetings of the Executive Team Meeting and Trust Board. At the latter, the person responsible for each domain is asked to highlight key issues of note, and explain areas of under/failing performance. Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more detail in the "Annual Governance Statement for 2020/21" later in this Annual Report. In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys and national clinical audits.

The Trust monitors its progress against the recommendations from its most recent CQC report (March 2018) through an Action Plan "Tracker" which is monitored through the Trust's Quality Improvements Committee.

The link between Key Performance Indicators (KPIs), risk and uncertainty

The Trust uses a wide range of KPIs to identify areas of risk and uncertainty. Where these risks and uncertainties can be controlled, these are aimed to be included within the Trust's plans. However, if monitoring of KPIs reveals that performance is at variance from the Trust's plans, mitigating actions may be implemented. The wide range of information collated means that the relationship between different pieces of information is very complex and the Trust engages the specialist analytical skills of staff within the Finance, Human Resources and Business Intelligence departments to identify themes, variance from plans etc., and to advise on potential actions to address variances, or recommend enacting of mitigations.

Development and performance in 2020/21

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report (pages 13 to 16). The Trust's actual performance against each of its 2020/21 objectives is described below.

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

This objective was fully achieved (rated green within the Board Assurance Framework) as The Trust has delivered its financial plan for 2021/22 (subject to audit)

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

This objective was partially achieved (rated amber within the Board Assurance Framework) as the Trust is in the top five best performing Trusts for the Emergency Department (ED) 4-hour and 62-day cancer waiting time targets; however the adverse impact of the COVID-19 pandemic has meant that the Trust has not achieved the 18-week Referral to Treatment (RTT) waiting time standard, and the number of patients waiting about 52 weeks for treatment has increased.

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

This objective was partially achieved (rated amber within the Board Assurance Framework) as the Trust has delivered its plans in relation to the project aim, in relation to action plans, Key Lines of Enquiry (KLOE) and the work of the Quality Improvement Committee and is also able to demonstrate that it delivers high quality care to patients and carers, via oversight of quality and safety from the Divisional Directors of Nursing & Quality; the Matrons' quality assurance reviews; monitoring of key quality and safety indicators (which are included in a 'heat map' which we have developed this year); and the development and monitoring of action plans that have been identified through the self-assessments of the Care Quality Commission KLOEs (which are monitored at the Quality Improvement Committee). However the Trust has not yet received an external validation of an "outstanding" rating as the Trust was not inspected by the Care Quality Commission in 2020/21, so is unable to rate the project aim as "Fully achieved".

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

This objective was partially achieved (rated green within the Board Assurance Framework) for the following reasons:

- Stage 3 and 4a of the programme has been completed, which includes the design, build and validation of the Emergency Department (ED), outpatients, order comms, core clinical, therapies and Paediatric workstreams
- The custom code required for the Pathology interface has been delivered by Allscripts
- User Acceptance Testing (UAT) 4 and 5 has been completed, and all 'go live' blockers identified have been addressed
- The Sunrise 18.4 upgrade has been completed.
- All five rounds of Data Priming planned in 20/21 have been concluded
- The Ive programme / Windows 10 rollout, which was scheduled to support the Sunrise 'go live' commenced on time in January 2021. A number of issues during Quarter 4 were identified with the roll out of Windows 10 and plans were put in place. At the end of March 2021 the Ive programme was on track to meet the requirements of the Technical go live in mid-April 2021.
- Due to the second surge of COVID-19, the 'go live' for April 2021 was reviewed and reset to mid-June 2021.
- The design and configuration of the initial Electronic Prescribing and Medicines Administration (EPMA) functionality to 'go live' in December 2021 is currently on track.
- A managed service solution continues to be explored with Allscripts to support IT capacity and capability post go live

To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (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

This objective was fully achieved (rated green within the Board Assurance Framework) as the Trust is on track to achieve the final objective by September 2022 when the first KMMS students arrive on placement, and the KMMS have confirmed student placement numbers at the Trust of 40 in Year 3 starting in September 2022. There is also tentative agreement for similar numbers in years 4 and 5, but these have not yet been confirmed. The Programme Specification Curriculum was received 23/11/20 and detailed planning and identification of resource implications is underway through the Specialty Lead Groups starting with Year 3. Clinical teaching facilities have been defined and included in the design of new build facilities at Tunbridge Wells Hospital. The facilities at Maidstone Hospital are being considered as part of the overall post-COVID-19 estate rationalisation work. The medical school accommodation build design and location was agreed with the Non-Executive Director oversight group on 02/02/21 and formal planning approval was submitted on 05/03/21.

To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams

This objective was fully achieved (rated green within the Board Assurance Framework) as the Trust Estates strategy has been drafted, but it is awaiting the confirmed details of the Trust's capital funding allocation for 2021/22. Once that allocation has been confirmed (via the Kent and Medway Sustainability and Transformation Partnership), a Trust Board Seminar will be scheduled to discuss the draft strategy, prior to it being submitted for approval to a formal Trust Board meeting.

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

This objective was fully achieved (rated green within the Board Assurance Framework) as although all clinical reconfiguration projects were paused during the COVID-19 second wave, these have now restarted and all are delivering against their agreed timelines. A timeline has been agreed for the cardiology reconfiguration with an 18-month timeline developed and being implemented against for the move of inpatient cardiology services and catheter laboratory to Maidstone Hospital. A timeline has been agreed for gastroenterology reconfiguration with agreement through the Kent County Council Health Overview and Scrutiny Committee (HOSC) by August 2021. Engagement has begun with local members and patients, and an options appraisal has been successfully completed with clinicians. The development of a Tier IV Bariatrics service has been agreed with the Executive Director of Strategy and Population Health at NHS Kent and Medway Clinical Commissioning Group (CCG), and a joint Business Case is being developed for consideration at the Trust Board and CCG Governing Body in May 2021. A Full Business Case (FBC) for a managed MRI service is being developed with approval targeted at the Trust Board in July 2021 and contract award in August 2021.

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

This objective was was fully achieved (rated green within the Board Assurance Framework) for the following reasons:

- 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 for the year ahead has been agreed with NHS Kent and Medway CCG.
- Cross-organisational discussions on resourcing within the ICP have resulted in a clear implementation and resourcing plan with a trebling of the Joint Project Management Office (JPMO) resource.
- New roles and assigned clinical and professional backfill are allowing integrated models of frailty, health inequalities and Primary Care Network (PCN)-focused workstreams (e.g. primary care demand and capacity) to progress.
- The first new roles have been successfully recruited to and the rest are in the course of being advertised.
- The stakeholder advisory forum and elected members forum are being supported by the NHS Kent and Medway CCG locality team, to ensure appropriate input into ICP work.
- The next stage of development will be to dovetail with the Kent and Medway ICS end state workstream, to ensure that the ICP continues to develop in accordance with the Kent and Medway ICS.

To make the Trust a great place to work - For the Trust 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

This objective was partially achieved (rated amber within the Board Assurance Framework) as The Trust has seen improvements in its results from the NHS staff survey in a number of domains, and positive feedback has been provided via the in-year climate surveys; however, several of the Trust's interventions will not start to deliver improvements until 2021/22 (although these have started to be implemented during 2020/21)

Financial performance in 2020/21

For the financial year 2020/21 the Trust reported a surplus of £0.3m, which was £5.3m better than plan. The finance regime for 2020/21 was different to previous years in response to the Covid 19 pandemic. The first half of the year the Trust was retrospectively funded for all costs. The second half of the year the Trust had to work within the Kent and Medway system envelope for funding. The planned £5m deficit related to outstanding annual leave not taken by staff due to the pressures of the pandemic. The final value for this was £4.7m, which was funded in full by NHSE/I.

There were some aspects of the plan which were not met. The key drivers of this variance are:

- There was an underspend in pay due to shortfall in workforce availability
- There was a one-off benefit in non pay of £3.3m for a rate rebate.
- Clinical income was reduced and returned to the system to offset the underspend in pay and non pay.

The variances to plan were offset by Public Dividend Capital (PDC) being less than planned by £1.1m. The Trust didn't hold a contingency in 2020/21, a system contingency was held by Kent and Medway CCG.

Income and Expenditure (financial performance)

The table below compares the Trust's income and expenditure plan to the year-end financial position.

Statement of Comprehensive Income	2020/21 (plan) £m	2020/21 (actual) £m	Variance £m
Income	540.2	564.2	24.0
Operating expenses	(529.2)	(550.3)	(21.1)
Operating surplus / (deficit):	**11.0**	**13.9**	**2.9**
Finance income	0.0	0.0	0.0
Finance expense	(14.7)	(14.7)	0.0
PDC dividend charge	(2.4)	(1.3)	1.1
Net finance costs	**(17.1)**	**(16.0)**	**1.1**
Other gains / (losses)	0.0	0.0	0.0
Surplus / (deficit) for the year before technical adjustments	(6.1)	(2.1)	4.0
Technical adjustments	1.1	2.4	1.3
Surplus / (deficit) for the year after technical adjustments	**(5.0)**	**0.3**	**5.3**

The Trust incurred additional expenditure pressures arising in the year after the plan was set. The Trust also received funding to support these pressures. The two main pressures were the employers' NHS pension

contribution increase of £12.8m and COVID-19 PPE costs of £7.7m. These were both funded by NHS England/NHS Improvement.

Income

The Trust's income was £564.2m which was above plan by £24.0m by the end of the financial year. The main variances relate to centrally received income of £26.3m. This was £12.8m for the uplift in employers' NHS pension contribution, £4.7m for annual leave accrual, £7.7m PPE push stock received and £1.1m donated assets for COVID 19 equipment. This was offset by a reduction in the CCG income to deliver a breakeven position.

The majority (92%) of the Trust's income is from CCGs or NHS England.

Operating expenses

The Trust's expenditure was £550.3m which was £21.1m adverse to plan. The main variance was an increase in expenditure of £12.8m as a result of the 6.3% uplift in employers' NHS pension contribution. In addition there were non-pay costs of £7.7m for PPE pushstock. The Trust received funding to cover both these costs. The expenditure included an additional £32.8m of costs to respond to COVID-19.

Finance costs

The PDC charge was lower than planned by £1.1m. This was principally driven by a lower than planned year end property valuation and higher average daily cash balances during the year.

Cost Improvement Programme (CIP)

The Trust suspended its Cost Improvement Plan for 2020/21 as part of the changes to the national financial regime.

Capital expenditure plan

During the year the Trust made capital investments of £33.3m including £1.4m of assets funded from donated or charitable fund sources. Significant elements of the programme were:

- £3m for Covid-19 equipment, ICT and estates costs;
- £2.9m for the ongoing EPR programme; £8.9m relating to ICT schemes, mainly the IVE programme on device replacement (£5.5m) and replacement of network infrastructure (£2.9m). In addition, national programme funding enabled spend on the Think 111 project (£0.5m) and Kent and Medway Care Record development (£0.45m).
- Expenditure of £2.8m was invested in the Urgent and Emergency Care projects (including the new SAU at TWH); and £2.9m related to Estates backlog, renewal and PFI Lifecycle.
- Equipment replacement schemes included: £1.7m spent on the endoscopy equipment funded from national PDC; £2.2m replacing a Linear Accelerator at Canterbury; £1.0m replacing major breast screening equipment including the mobile units; £0.9m to update and expand critical care and testing equipment to support Covid-19 treatment; £0.7m to renew the Interventional Radiology room at Maidstone Hospital. This project will be completed in 2021/22; £0.6m for a new CT simulator for Radiotherapy patients and £0.2m on a new Pharmacy robot at Maidstone Hospital; £0.7m for Ophthalmology equipment supporting the service transferred from Moorfields Hospital, and £1.8m of general Trustwide replacement of overage equipment, mostly clinical.

The donated spend of £1.4m includes £1.1m of centrally procured equipment transferred to the Trust during the pandemic. DHSC are proposing to transact these donations during 2021/22 to transfer them formally to Providers as donated assets. For 2020/21 Providers were instructed to recognise the assets in final accounts.

The Trust's statutory (i.e. legal) duties

As an NHS Trust, the organisation has a number of statutory financial duties, which are explained below.

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying within an agreed limit on the amount of cash it can borrow and spend. In 2020/21 the Trust met its target with a year-end position of an underspend of £4.29m on the EFL.

Capital Resource Limit (CRL)

The Trust is expected to manage its capital expenditure within its agreed CRL. For 2020/21 the Trust's CRL was £32.36m and the Trust spent £31.95m, and underspend of £0.41m. This underspend related to the reimbursement in 2020/21 of Covid-19 capital claims from 2019/20.

Break-even duty

Each NHS Trust has a statutory duty to break-even taking one year with another, measured as the Income and Expenditure position adjusted for specific technical exclusions. This duty is formally measured over a three-year period or a five-year period if agreed with the Department of Health and Social Care.

The Trust's last formal three-year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust has achieved break even surpluses and met its NHSEI control totals in each of the last three financial years. The Trust is not in any financial recovery regime relating to its historic accumulated deficit but is required to achieve the in year break even position agreed as part of the Kent and Medway STP system control totals. The Trust has achieved an in-year break-even duty surplus in 2020/21 of £0.33m which was slightly better than plan and its system control total requirement.

Accounting Issues

The Accounts have been prepared in accordance with guidance issued by the Department of Health and Social Care and in line with International Financial Reporting Standards (IFRS) as applied in the Department of Health and Social Care Group Accounting Manual. The accounts were prepared under the "Going Concern" concept in line with the Department of Health and Social Care Group Accounting Manual requirements for management consideration. This has been set out in the "Overview" section above.

External Auditors

The Trust's External Auditors are Grant Thornton UK LLP. Their charge for the year was £82,100 excluding VAT (in 2019/20 this was £73,000 excluding VAT). There was no audit of the Quality Accounts in 2020/21 under a variation of arrangements made nationally in response to the COVID-19 pandemic. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2019/20.

Looking forward to 2021/22

The impact of COVID-19 has delayed the business planning process both nationally and internally within the Trust. Nationally mandated interim contracting arrangements are in place between the Trust and Commissioners from April to September 2021. The financial plan will be Kent and Medway system based and the Trust will work with its partners to deliver a breakeven position for the first half of the year. A further planning round is expected to take place in the first quarter to agree financial plans for the second half of the year.

The financial regime for capital was updated in April 2020 to move to a more STP/ICS-led system approach to managing capital allocations and expenditure. For 2021/22 the Trust's agreed initial resource is £10.2m comprising £8.7m of internally generated and financed resource, £1.2m of PFI lifecycle for the Tunbridge Wells Hospital and £0.3m of system PDC to finance the design fees for the Hyper Acute Stroke Unit.

Countering fraud, bribery and corruption

The Trust has a range of policies and procedures in place to identify and respond to risks of fraud, bribery and corruption, including an "Anti-Fraud, Bribery and Corruption Policy and Procedure"; "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure"; "Standing Financial Instructions", "Risk Management Policy and Procedure", "Serious Incidents (SI) Policy and Procedure", and the "Freedom to speak up: raising concerns policy and procedure" as well as policies relating to, for example, employee verification checks etc. Such Policies are available to all staff via the Trust's Intranet system. The Trust's Local Counter Fraud Specialist (LCFS) is a mandated consultee for such Policies. In addition, the LCFS undertakes a programme of work for the Trust which aims to prevent, deter and detect fraudulent activity. The outcomes of the work are reported to the Audit and Governance Committee, which in turn provides a summary report on its own activity to the Trust Board.

Equality, Diversity and Human Rights

The Trust's activity and policies in this area are explained in the Accountability Report (page 36 onwards).

Quality Accounts 2020/21

The Trust's Quality Accounts for 2020/21, which are scheduled to be approved by the Trust Board in June 2021, can be found on the Trust's website (www.mtw.nhs.uk), or the Trust's page on the NHS England and Improvement website (https://www.england.nhs.uk/publication/maidstone-and-tunbridge-wells-nhs-trust/).

Performance report for 2020-2021:
Sustainability report

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. The commitment to this agenda was reaffirmed in the NHS Long Term Plan with clear targets on carbon and air pollution. Demonstrating that we consider the social, economic and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Maidstone and Tunbridge Wells NHS Trust has the following sustainability mission statement located in our Green Plan):" The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".

As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law.

We recognise that the pandemic has led to an increase in some of our emissions, and that our waste, recycling and reuse figures have been negatively affected due to infection prevention protocols. We are committed as a Trust to reversing these trends as soon as possible.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

One of the ways which we embed sustainability is through the use of a Green Plan within the Trust. Our Green Plan has been reviewed in the last 12 months and approved by the Trust board.

We also recognise that our procured services have a substantial sustainability impact. Part of the tender process identifies the key elements of every product to ensure that it is suitable for the Trust. The Trust also requires suppliers to confirm the products adhere to the NHS terms and conditions. This ensures compliance with the environmental and sustainability requirements

Our statement on Modern Slavery is that the Trust uses NHS terms and conditions. The Modern Slavery act is included within these terms and Conditions and suppliers must confirm they comply as part of any contract they sign with us.

We comply with the Public Services (Social Value) Act by including a section within our tenders that relates to social and environmental impact of the services being procured. If they are critical to that service, then they will be included within the KPI's for ongoing monitoring and management.

As an organisation that acknowledges its responsibility towards creating a sustainable future we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Adaptation

Climate change brings new challenges to our organisation, both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies.

Green Space and Biodiversity

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. In the last year the Trust has commenced working with Kent Wildlife Trust to further develop and maintain the site in a manner that is sympathetic to nature and wildlife.

We continue to work with a wide range of volunteers and partners to provide spaces within the hospital grounds where patients and visitors can access non clinical environments to improve mental and physical wellbeing.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

For commissioned services our CCG's are NHS Kent and Medway CCG and NHS East Sussex CCG.

Performance

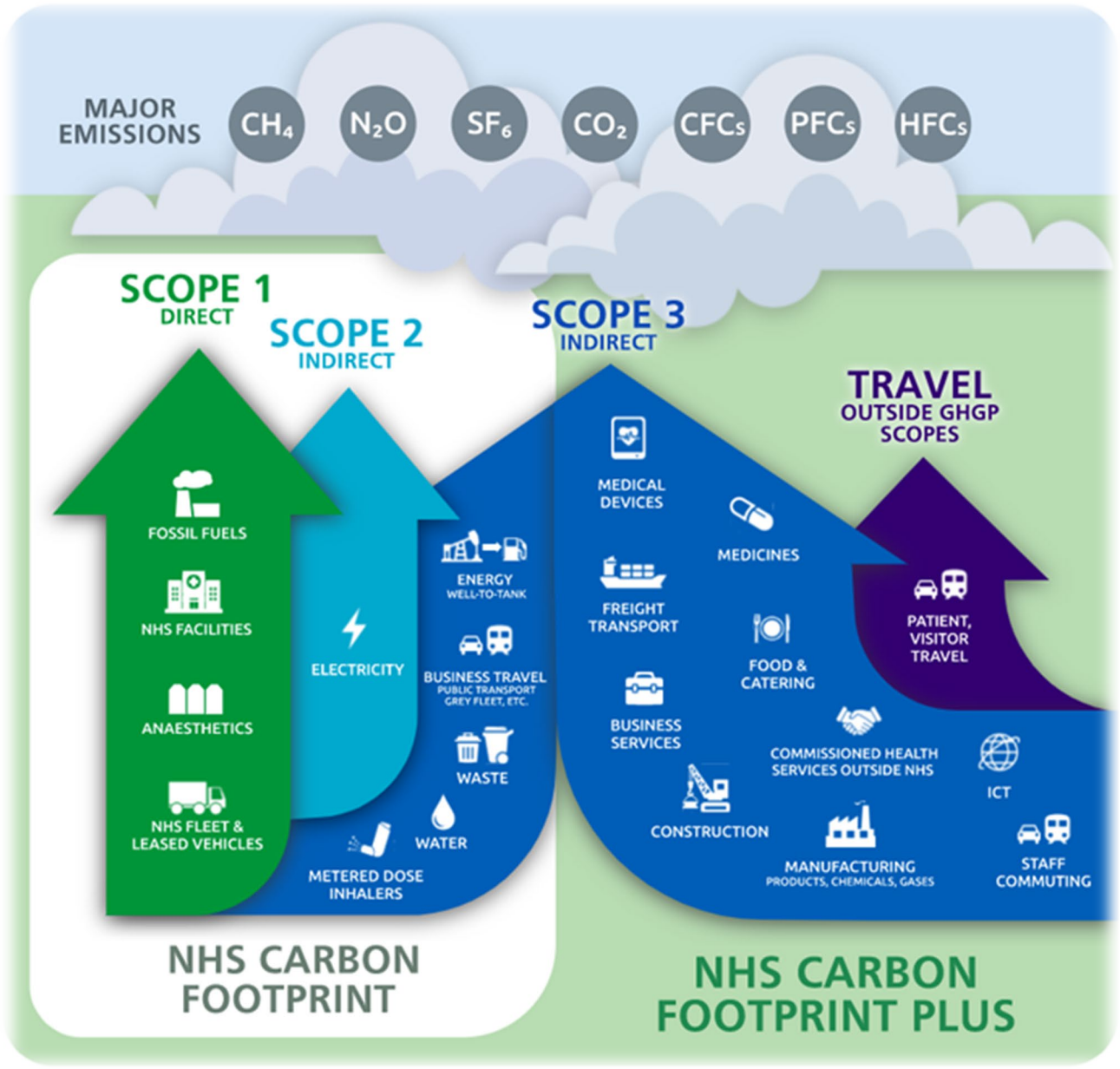
Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

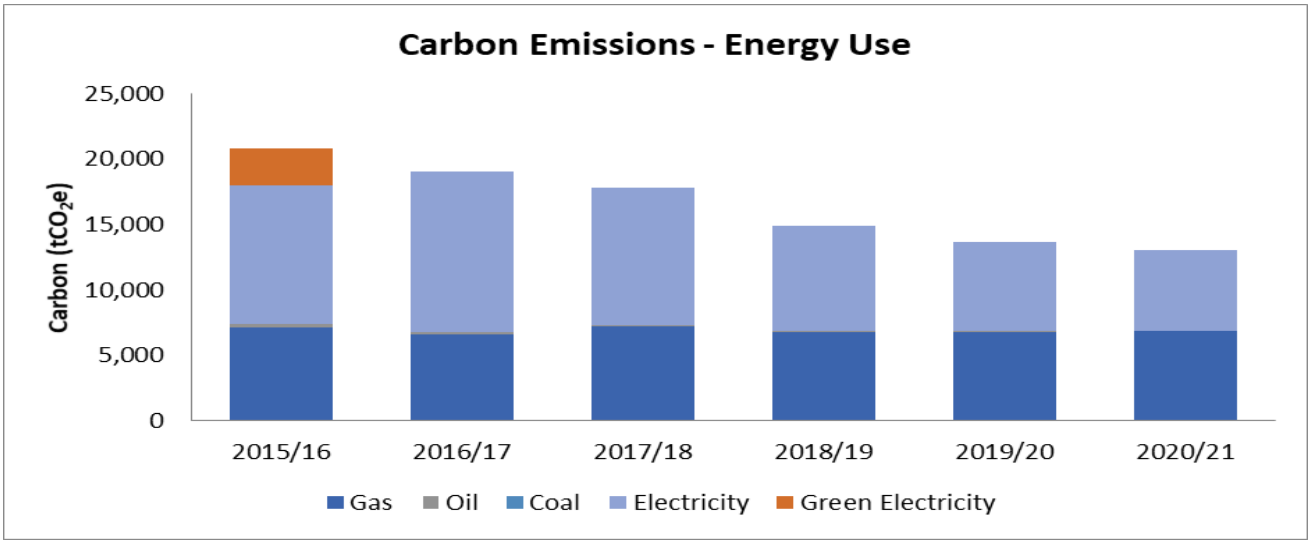
Context info	2007/8	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533	134,083	133,111
Number of staff (WTE)	3,969	4,678	5,130	5,022	5,153	5,313	5,866[6]

[6] Readers will note that this figure is different to the WTE figure reported in the "Staff numbers and costs" table within the "Remuneration and Staff Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers and costs" table is an average over the year and is based on when staff are paid (therefore any staff on unpaid leave i.e. maternity leave, long term sickness absence etc. do not feature)

The NHS has responded to the amended Climate Change Act by committing to be net zero by 2040 for the emissions that are directly controlled, called the NHS carbon footprint, and the net zero by 2045 for the emissions that are influenced, called the NHS carbon footprint plus.



Energy



Managing energy is one aspect of reducing carbon emissions. Maidstone and Tunbridge Wells NHS Trust has spent £4,263,339 on energy in 2020/21, which is a 10.5% decrease on energy spend from last year.

The Trust has gained a marginal reduction in electrical consumption in the last year against 2019/20, this can be partially attributed towards continued good practice and also partially due to the changed dynamic of the hospital during the pandemic.

The gas consumption in the Trust has increased overall, whilst there has been a reduction at Maidstone this has been offset by an increase at Tunbridge Wells. The Trust is committed to reversing this increase where possible in the coming years.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Gas	Use (kWh)	34,139,781	31,546,328	33,930,120	31,855,591	32,476,847	32,920,550
	tCO_2e	7,145	6,593	7,194	6,766	6,747	6,840
Oil	Use (kWh)	635,116	532,926	313,362	280,800	273,640	224,294
	tCO_2e	203	169	102	90	87	58
Coal	Use (kWh)	0	0	0	0	0	0
	tCO_2e	0	0	0	0	0	0
Electricity	Use (kWh)	18,564,756	23,801,508	23,652,117	22,899,149	21,576,328	21,452,491
	tCO_2e	10,673	12,301	10,542	8,078	6,818	6,181
Green Electricity	Use (kWh)	4,892,105	0	0	0	0	0
	tCO_2e	2,813	0	0	0	0	0
Total energy CO_2e		20,833	19,062	17,838	14,934	13,652	13,079
Total energy spend		£ 3,919,681	£3,835,790	£4,535,611	£4,912,381	£4,762,269	£4,263,339

N.B. tCO2e = Tonnes of CO_2 equivalent. This is used to measure the equivalent CO_2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

Re-use

Whilst we recognise that the reuse of goods and materials is vitally important for the sustainable future of the NHS, the effects of the pandemic has meant that this project has been suspended because of potential cross contamination issues.

The Trust is committed to restarting this project as soon as conditions allow us to.

Category	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Internal reuse of durable goods (£)	Not Recorded	Not Recorded	2,000	2,000	2,000	0
External reuse of durable goods (£)	Not Recorded	Not Recorded	2,500	5,000	2,500	0

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security. The progress made by the Trust in the last year has been reversed slightly.

Paper		2017/18	2018/19	2019/20	2020/21
Volume used	Tonnes	61	90	62	68
Carbon emissions	tCO_2e	58	85	58	64

Travel

We can improve local air quality and carbon emissions through the way we design travel and our services. We have a clear policy on healthy travel for our organisation and we promote healthy and sustainable travel to our stakeholders (staff, patients and the public).

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

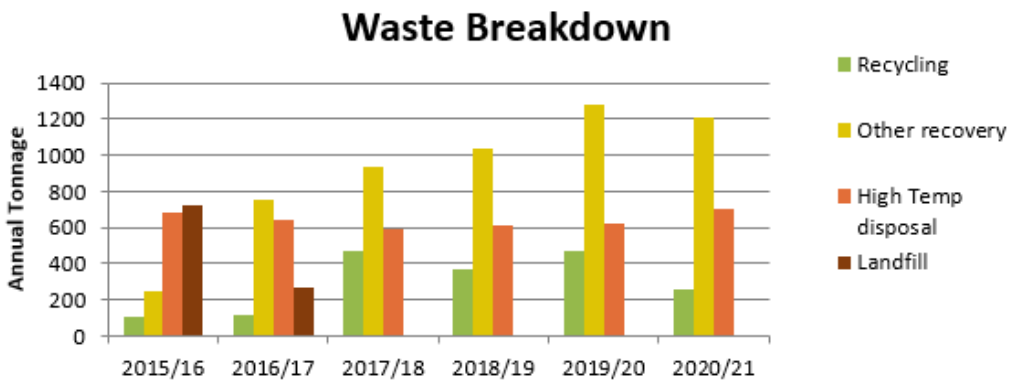
Category	Mode	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Patient & visitor travel	Miles ℒ	107,404,988	112,158,231	115,563,332	121,747,529	118,743,943	110,617,477
	Miles	38,841.48	40,535.15	41,178.09	44,890	41,040	38,232
Business travel & fleet	Miles	1,319,789	1,037,636	1,059,360	0	569,989	265,695
	tCO_2e	477	375	377	0	197	92
Staff commute	Miles	4,493,769	4,927,968	4,824,221	4,824,221	5,105,793	5,637,226
	tCO_2e	1,625	1,781	1,719	1,779	1,765	1,948

N.B. tCO_2e = Tonnes of CO_2 equivalent. This is used to measure the equivalent CO_2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

ℒ Totals for previous years have been re-stated due to patient & visitor travelled mileages and associated carbon footprint being automatically calculated using externally provided intensity figures

Waste

The recycling performance within the Trust has suffered due to the pandemic.



Because of infection concerns, recycling facilities were unable to handle and sort materials which led to a large proportion of waste that would normally be recycled being diverted to energy from waste facilities..

N.B. High temperature ("High Temp") disposal is the incineration of clinical waste. There is no energy recovery from this process at the current time. The Trust sends domestic waste to an 'energy from waste' facility, and this is classed as "Other recovery". Energy from waste cannot be classed as recycling, as that refers to taking a used item, turning it into a raw material and using that as a basis to manufacture a new product. 'Energy from waste' is about recovering the embedded energy within a product and is lower down the waste hierarchy, this being: reduce (the amount of waste being produced); reuse (items in their existing form); recycle (into new products); recover (the embedded energy); or dispose (through landfill).

Waste		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Recycling	(tonnes)	107	115	468	372	472	258
	tCO_2e	2	2	7	8	8	5
Other recovery	(tonnes)	248	756	937	1040	1281	1206
	tCO_2e	16	16	15	15	27	25
High Temp disposal	(tonnes)	679	639	592	614	621	704
	tCO_2e	149	141	190	192	137	155
Landfill	(tonnes)	724	265	0	0	0	0
	tCO_2e	177	82	0	0	0	0
Total Waste (tonnes)		1758	1775	1997	2026	2374	2168
Total Waste tCO_2e		333	241	211	215	174	186

Finite resource use - water

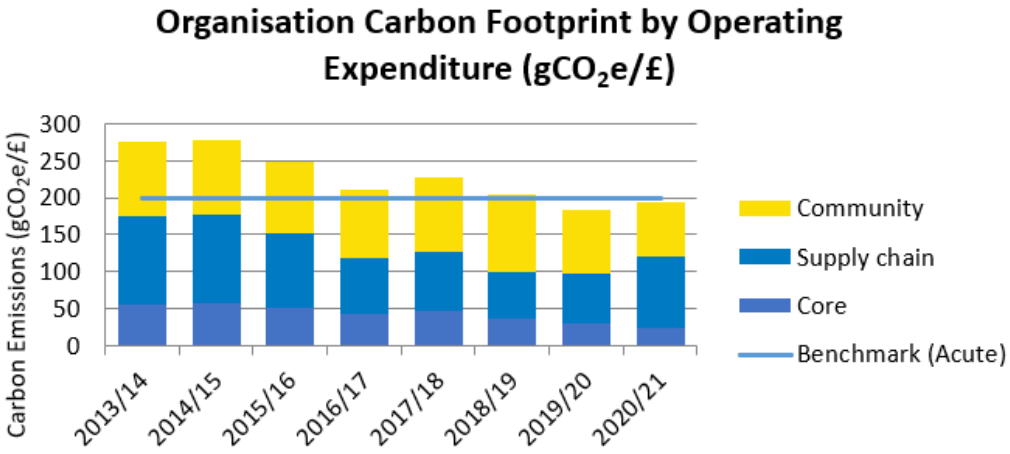
The water consumption has decreased from previous years, partially due to the reduces footfall through the hospitals owing to the pandemic.

Water		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Mains	m^3	205,246	209,205	225,383	211,936	237,616	219,389
	tCO_2e	187	190	205	193	216	199
Water & Sewage Spend		£582,869	£661,990	£761,100	£758,895	£959,889	£959,889

Modelled Carbon Footprint

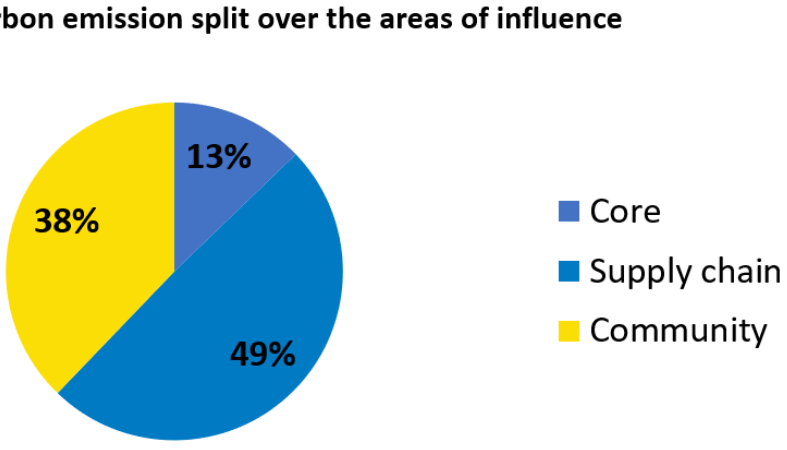
The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in

2009/10. More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx. The application of this model results in an estimated total carbon footprint of 106,292 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 193 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.

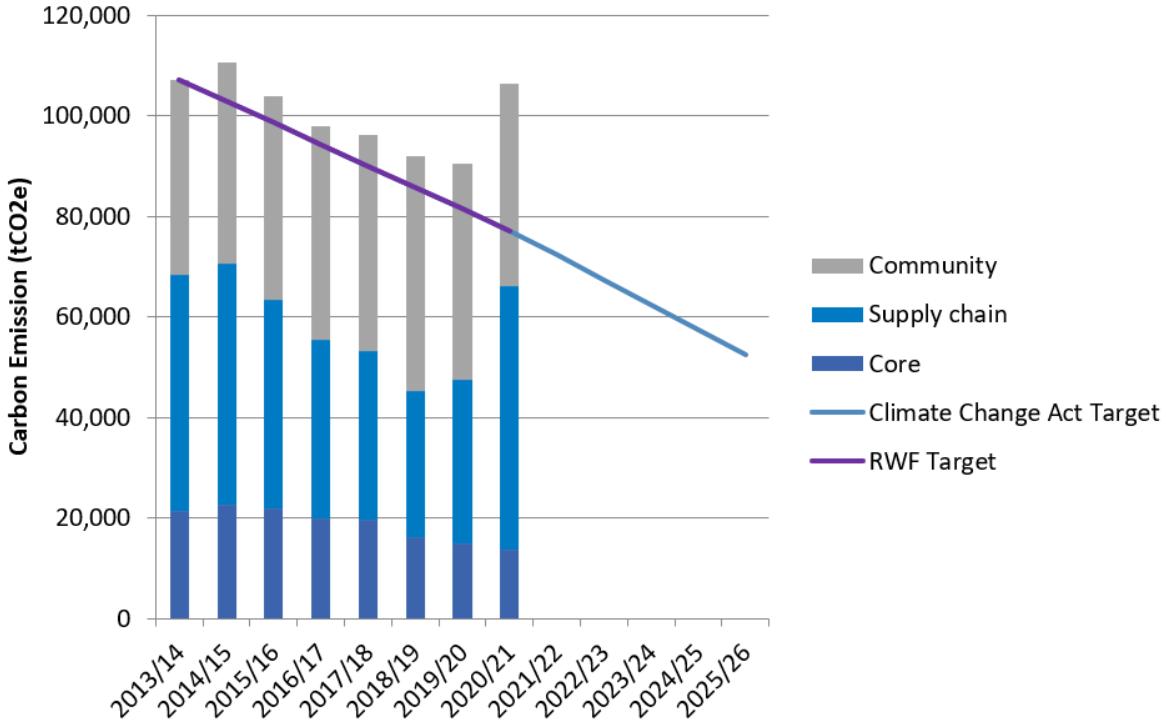


N.B. "Core" emissions are the emissions from the direct activities of the Trust. They include emissions from electricity, gas, fuel from vehicles and generators, biomass, water and sewerage, fugitive emissions from anaesthetic gases, and business travel and mileage. They are calculated by applying intensity metrics to the available data. "Community" emissions are calculated by taking the patient contact caseload figure and applying a similar metric to represent patients' travel to and from the hospitals. "Community" emissions also include a value to cover the commute of Trust staff to and from their workplace.

The distribution of our carbon emissions through our different areas of influence clearly demonstrates that the emissions associated with the supply chain and procurement are the largest component of our carbon footprint. This is reflective of the fact that the goods and services spend profile was 140% higher in 2020/21 than in 2019/20.



Modelled trajectory



We are committed to meeting the legal requirements of the climate change act by reducing our emissions in line with the trajectory above.

We acknowledge that whilst the core emissions of the Trust have been steadily and consistently falling since 2015/16 the emissions associated with our supply chain have grown significantly. This is attributable to the pandemic and the increased level of procurement and operations.

Declaration

I confirm adherence to the reporting framework in respect of the Performance Report.

Insert signature

Miles Scott, Chief Executive Insert Date

Accountability report for 2020-2021:
Corporate governance report

Directors' report

The Trust Board

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting), following HM government's guidance on social distancing the Trust Board meeting has been 'livestreamed' to the Trust's Youtube channel (https://www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ) to enable members of the public to observe the proceedings. The agenda and reports for the meetings, which took place via a webconference, were made available via the Trust's website (see www.mtw.nhs.uk/about-us/trust-board/). The Trust Board formally operates in accordance with its Terms of Reference, the Trust's Standing Orders, Scheme of Matters Reserved for the Board and Scheme of Delegation, and Standing Financial Instructions.

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against plans, to ensure accountability by holding the organisation to account for the delivery of strategy, and to ensure the Trust is well managed and governed. The Trust Board comprises the roles of Chair (Non-Executive), five other Non-Executive Directors (voting members), the Chief Executive, and four other voting member of the Executive Team. Six other non-voting Directors also attend Trust Board meetings, and contribute to its deliberations and decision-making. The Non-Executive Directors (NEDs) bring a range of skills and expertise from outside the NHS; their role is to hold the members of the Executive Team to account.

The Trust Board membership underwent the following changes during the course of the year

- Simon Hart, Director of Workforce left the Trust Board on 13/08/21
- Cheryl Lee, Interim Director of Workfroce, joined the Trust Board 07/09/20, and subsequently left the Trust Board on 31/03/21

Although outside of the reporting period the following Trust Board membership change should be noted

- Sue Steen, Chief People Officer, Joined the Trust Board on 01/04/21

The Trust Board also held one 'away day' in the year, in December 2020 (which focused on The development of the Kent and Medway Integrated Care System (ICS) and West Kent Integrated Care Partnership (ICP)). The programme of Trust Board Seminars that was established in 2017/18 also continued, and three such Seminars were held (in July and September 2020 and February 2021). The issues discussed at the Seminars included the development of system partnerships; a digital leadership session provided by NHS Providers; and the Strategy Deployment Process and Outcomes.

Trust Board Members

Taking into account the wide experience of all Trust Board Members, the balance and completeness of the Board is considered to be appropriate. At the end of 2020/21, the Trust Board had the following members:

David Highton

Chair of the Trust Board*

David joined the Trust Board on 8th May 2017. Prior to this he was Ministerial Advisor on Private Sector Involvement and Public Private Partnership to the Minister of Public Health in Qatar. From 2011, he was Executive Director of Corporate Development at Hamad Medical Corporation, the main public hospital provider in Qatar. Prior to moving to Qatar, David worked in the independent health sector, and was an NHS Chief Executive from 1991 to 2003, including at the Chelsea and Westminster Hospital NHS Trust and the Oxford Radcliffe Hospitals NHS Trust. Originally a Chartered Accountant, David worked in publishing, property services, the brewing industry, an industrial starches business, and in the City before joining the NHS as a Finance Director in 1990. David, who is married and has a grown up family, has strong links with Kent, having spent his childhood in Meopham & Sittingbourne, and currently lives in Whitstable.

Miles Scott

Chief Executive*∑

As the Trust's "Accountable Officer", Miles is responsible for the overall development and performance of the Trust. In addition to being a Board member, he attends several Board sub-committees. Miles joined the Trust on 8th January 2018. Miles has over 30 years' experience in the NHS encompassing acute, community and mental health services, the Department of Health and the King's Fund. Most recently, he worked at a national level with NHSI, focusing on its establishment as a new national organisation and leading the national Ambulance Improvement Programme with NHS England. He was previously Chief Executive of St George's University Hospitals Foundation Trust (2011 to 2016) and prior to that Chief Executive at Bradford Teaching Hospitals NHS Foundation Trust (2005 to 2011) and Harrogate and District NHS Foundation Trust (2001 to 2005). Miles is married to Abbie and has two children. He lives in south west London with his family.

Maureen Choong

Non-Executive Director*

Maureen joined the Trust Board in August 2017 as an Associate Non-Executive Director, and was then appointed as a substantive Non-Executive Director in November 2017. She is a Registered Nurse with over 40 years of clinical and leadership experience within the NHS, prior to her retirement in 2016 from her role as Clinical Quality Director with NHSI. Her previous roles included Deputy Chief Nurse with NHS London and both clinical and Director roles in NHS trusts. Since retirement, Maureen has worked with Health Education England as an Improvement Associate. In addition to her role on the Trust Board, Maureen chairs the Patient Experience Committee, is Vice-Chair of the Quality Committee and Audit and Governance Committee; and a member of the Remuneration and Appointments Committee. Maureen is married with two stepchildren and lives in Kent.

Sarah Dunnett OBE

Non-Executive Director*

Sarah joined the Board in January 2014. Sarah arrived from Dartford and Gravesham NHS Trust, where she had been Chair for the previous 12 years. Sarah's previous experience was in the oil industry, where she held a variety of senior management roles. Her contribution to the NHS was recognised in the 2013 Queen's birthday honours list, when she was awarded an OBE. Sarah is married with three sons. In addition to her role on the Trust Board as Vice Chair, Sarah chairs the Quality Committee, and is the Vice-Chair of the Charitable Funds Committee, Finance and Performance Committee and Remuneration and Appointments Committee and is a member of Audit and Governance Committee. Sarah is also the Senior Independent Director (SID).

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Sean Briggs

Chief Operating Officer*Σ

Sean joined the Trust as Chief Operating Officer designate in October 2018 and became the substantive Chief Operating Officer and member of the Trust Board in December 2018. Sean has a broad experience working within a variety of healthcare settings, but has spent most of this time in the acute setting in hospitals such as St George's NHS Foundation Trust and Epsom and St Helier Hospital where he held a number of senior managerial roles. Sean is passionate about improving clinical engagement and patient care across the Trust, and has a strong track record in improving hospital operational performance whilst delivering a number of high profile clinical strategic changes, most notably the development of the 24/7 Thrombectomy service at St George's.

Karen Cox

Associate Non-Executive Director

Professor Karen Cox joined the Trust Board at the end of June 2019. Karen is currently Vice-Chancellor and President of the University of Kent. Karen graduated from King's College London with a BSc (Hons) and her Registered General Nurse (RGN) qualification in 1991. She has held a number of clinical posts in Oxford, Southampton, Gloucestershire and Nottingham, specialising in Oncology and Community Health Care (District Nursing). Karen completed her PhD at the University of Nottingham, funded by the Cancer Research Campaign and was appointed a Professor in 2002. She served as Head of the School of Nursing from 2002 until 2007, joined the senior leadership team as a Pro Vice-Chancellor from 2008 until 2013 and became Deputy Vice Chancellor from 2013 to 2017. Karen is also a board member of the Nursing and Midwifery Council (NMC). In addition to her role on the Trust Board, Karen is a member of the People and Organisational Development Committee.

Richard Finn

Associate Non-Executive Director

Richard Finn joined the Trust Board in November 2019. He is currently Managing Director of Richard Finn Ltd, an international management consultancy, where he specialises in providing advice on change, organisation development, governance and leadership. Previously he was a Managing Director at Penna PLC, a Director at Crane Davies and Marketing Director at Henley Distance Learning, a division of Henley Management College. Richard has a London BSC(Econ) and Cert Ed (FE), an MA in Management from the University of Kent and C.Dir from the Institute of Directors. He has been a Fellow of the Chartered Institute of Personnel and Development, Institute of Directors and the Chartered Institute of Marketing. He is a member of the Kent Business Advisory Board. Richard was Chairman of Kent Music from 2007 to 2017, he is a member of the Nominations and Governance & Audit Committees of the Lord's Taverners and as a Liveryman was Chairman of the Pro-Bono Committee of the Livery Company of Management Consultants. Richard has lived all his married life in Kent and currently lives in Detling.In addition to his role on the Trust Board, Richard is the Vice Chair of the People and Organisational Development Committee.

Neil Griffiths

Non-Executive Director*

Neil joined the Board as an Associate Non-Executive Director in June 2018, and was appointed a substantive Non-Executive Director in February 2019, when he also assumed the chair of the Finance and Performance Committee. Neil is a career healthcare executive and Board leader with over 25 years public and private sector experience. His career has included strategic, operational, change management and commercial roles in and around hospitals in the UK. Neil was previously a Board member and Deputy Chief Executive at University College London Hospitals NHS Foundation Trust, a leading acute academic hospital provider in the UK. Neil's other career experience includes helping lead the team and development of the McKinsey Hospital Institute (MHI) in the UK as part of a global initiative for McKinsey & Company to develop analytical tools and performance improvement support for hospitals. Neil is currently Managing Director of TeleTracking Technologies in the UK, a global leader in the provision of services and technology supporting healthcare organisations to improve productivity and patient flow. Neil is also a member of the Audit and Governance and Remuneration and Appointments Committees. Neil has been a local resident for 12 years, is married with two children and lives in Tunbridge Wells.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

David Morgan

Non-Executive Director*

David joined the Trust Board in August 2019. His career has been spent in natural resources, chemicals and technology. He worked for Johnson Matthey plc for twenty years, including ten years as an executive director, and has served on the boards of a number of other companies, both in the UK and internationally. He is currently the chair of a battery development and manufacturing company, AMTE Power plc and deputy chair of Nordgold plc, a gold mining company. He was previously deputy chair of an energy technology company, SFC Energy AG, and the senior independent director at the Royal Mint. David is a chartered accountant, having qualified with KPMG, and chairs the Trust's Audit and Governance and Charitable Funds Committees. Away from work David volunteers as a mentor to staff and students at Imperial College who are looking to start their own businesses; having previously chaired the advisory board of the Department of Chemistry at Imperial. David has lived in Kent for over twenty years and is married with three sons.

Amanjit Jhund

Director of Strategy, Planning and Partnerships∑

Amanjit joined the Board in October 2018. Prior to joining the Trust, Amanjit was Director of Strategy and Transformation at Croydon Health Services NHS Trust, and previously worked as an Expert on Healthcare Systems and Services for McKinsey and Company in London. Amanjit is a doctor by background and first joined the NHS 12 years ago, working in hospitals in both Scotland and England gaining experience in a wide variety of medical specialties. Amanjit holds a professional registration with the General Medical Council and has degrees in both medicine and physiology.

Peter Maskell

Medical Director*∑

Peter joined the Trust Board in February 2017. Peter qualified from The Royal Free Hospital School of Medicine in 1995. He trained in general and elderly medicine at St Thomas' Hospital/Brighton and Sussex University Hospital, where he also studied for an MSc in gerontology and cognitive decline. Peter became a Consultant in General and Geriatric Medicine with an interest in Stroke medicine at the Trust in 2005, and became clinical lead in 2007. Peter was then appointed as Medical Director of Kent Community Health NHS Foundation Trust in 2012 and during his time there, the Trust attained Foundation Trust status and a 'good' rating from the CQC. Clinically, Peter continues to have interests in Stroke, frailty and liaison geriatrics.

Sara Mumford

Director of Infection Prevention and Control

Sara joined the Trust Board in November 2007. She leads the Trust's infection prevention strategy. Sara is also a Consultant Microbiologist, and is the Trust's Deputy Medical Director. Sara joined the Trust in 2007, and has previously worked as Consultant Microbiologist at East Kent Hospitals University NHS Foundation Trust, and as a Consultant in Communicable Disease Control (CCDC) at Kent Health Protection Unit.

Claire O'Brien

Chief Nurse*∑

Claire joined the Trust Board in February 2017 as Interim Chief Nurse and was appointed Chief Nurse (substantive) in March 2018. Claire has worked in the NHS for nearly 40 years, qualifying as a Registered General Nurse at King's College London in the early 1980s. She specialised in Cardiothoracic Nursing and has enjoyed a variety of general management and senior nursing roles within South London NHS acute Trusts, more recently as the Deputy Director of Nursing in Lewisham and Greenwich NHS Trust. Claire joined the Trust as Deputy Chief Nurse in April 2016, bringing a wealth of experience in all areas related to Nursing standards, Nurse Education, recruitment and Nursing professional issues. She has considerable experience working with patient representatives, and has a particular interest in engaging with staff and supporting them in their development, recognising the relationship between staff and patient experience, and feels it is vital that staff are valued and supported to provide the best possible care at all times.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Steve Orpin

Deputy Chief Executive / Chief Finance Officer*Σ

Steve is responsible for providing information and advice to the Trust relating to all financial management issues. Steve joined the Trust Board in April 2014 from Medway NHS Foundation Trust, where he had been Deputy Director of Finance; including a 12-month spell as Director of Finance. Steve has held various positions within the Finance function in a number of NHS organisations across London and the South East in a NHS career spanning over 20 years. Steve is a Fellow of Chartered Association of Certified Accountants and holds an MBA. In addition to his role on the Board, Steve attends several Trust Board sub-committees.

Emma Pettitt-Mitchell

Non-Executive Director*

Emma joined the Trust Board in June 2018 as an Associate Non-Executive Director and was appointed as a substantive Non-Executive Director in August 2019. Emma is a highly experienced senior executive with over 21 years' experience with one of the largest retailers (UK and globally) and FTSE 100 companies, Tesco Stores Ltd. Emma's vast experience includes being the customer 'voice', retail, commercial, insight, human resources, buying and marketing, and also includes a highly successful background in the achievement of profitable business growth; through the creation and execution of strategic business plans. Uniquely Emma has worked extensively as a Director in both the private and public sector. Most recently working for Kent County Council, as the Director of Strategic Business Development and Intelligence, leading a large insight team. For the last 2.5 years Emma has also been a Non-Executive Director for a private limited company, 'Commercial Services', one of the largest suppliers and brokers of products and services in the UK.
Emma lives in Kent with her husband Andrew and 3 children. In addition to her role on the Trust Board, Emma chairs the People and Organisational Development Committee., is Vice Chair of the Patient Experience Committee and is a member of the Audit and Governance Committee and Remuneration and Appointments Committee.

Jo Webber

Associate Non-Executive Director

Jo Webber joined the Trust Board at the end of November 2019. Jo is currently Chair of In Control, a national charity working for an inclusive society supporting people with disabilities to live independently. Jo graduated from Surrey University with a BSc (Hons) in Human Biology, is a Registered General Nurse (RGN) with a specialist District Nursing qualification and has a Masters degree in Primary Health Care. She has held board level operational and clinical management posts in Community Health and Primary Care Trusts in Nottingham. In 2004 Jo moved to the NHS Confederation, working for eight years analysing the impact of new health policy on health and social care and working nationally to influence its development and delivery. She was a Trustee of the Burdett Trust for Nursing for nine years, giving grants to support nursing research and leadership development. She has a keen interest in improving joint working and integration within and between the NHS and local government, both nationally and on a local level, to deliver better co-ordinated and more responsive services for patients and their carers. In addition to her role on the Trust Board, Jo is a member of the Quality Committee.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Simon Hart, Director of Workforce (who left the Trust Board on 13th August 2020) also served on the Trust Board during 2020/21.

Cheryl Lee, Interim Director of Workforce (who joined the Trust Board on 7th September 2020, and left the Trust Board on 1st April 2021) also served on the Trust Board during 2020/21.

Statement regarding Directors' disclosure to auditors

Each Director can confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that they ought to have taken" to make themselves aware of any such information and to establish that the auditors are aware of it.

Attendance at Trust Board meetings

There were 11 formal and 2 extraordinary Trust Board meetings in 2020/21. Attendance at each meeting is shown below:

Trust Board Member	16th April 2020	30th April 2020	May 2020	18th June 2020	25th June 2020	July 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sean Briggs, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Maureen Choong, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Cox, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Finn, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	✓	✓	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amanjit Jhund, Director of Strategy, Planning and Partnerships	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cheryl Lee, Interim Director of Workforce	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	Apologies	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
David Morgan, Non-Executive Director	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma Pettitt-Mitchell, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Webber, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appointment and evaluation of Trust Board Members' performance

The Chair of the Trust Board and its Non-Executive Directors are independently appointed by NHS Improvement (NHSI) (operating at the NHS Trust Development Authority legal entity). The Chief Executive and other Executive posts serving on the Trust Board are appointed by the Trust in liaison with NHSI. All members of the Trust Board are subject to a performance framework through which:

- The Chair of the Trust Board is appraised via a national framework operated by NHSI;
- Non-Executive Directors and the Chief Executive are appraised by the Chair of the Trust Board; and

- Members of the Executive Team are appraised by the Chief Executive.

Trust Board Members are also subject to an annual self-assessment in accordance with the fit and proper persons requirements (FPPR[7]) for Directors. No concerns have been raised in relation to this in 2020/21.

Directors' interests

The Trust Board and other committees routinely ask that any interests relevant to agenda items be declared at each meeting. In addition, a Register of Directors' interests is maintained. The interests recorded on the Register at the end of 2020/21 for those on the Board at the end of that year were as follows:

Trust Board Member	Details of notifiable interest
David Highton, Chair of the Trust Board	▪ Strategic Health Industry Adviser for Servita Group Ltd (Reg co. no. 10497423) ▪ Chairman, Demelza House Children's Hospice (charity Number: 1039651) ▪ Owner and Director, Hyperium Ltd (Reg co. no.: 04684013) ▪ Director of ACG Lettings Limited (Reg co. no.: 03031999) a property lettings business bequeathed to Demelza by legacy
Miles Scott, Chief Executive	None
Sean Briggs, Chief Operating Officer	None
Maureen Choong, Non-Executive Director	Special Advisor: Care Quality Commission (CQC)
Karen Cox, Associate Non-Executive Director	▪ Vice Chancellor and President, University of Kent ▪ Board Member and Chair, Nursing and Midwifery Council ▪ Royal College of Nursing Member ▪ UPP Foundation Advisory Board member ▪ Member Universities UK membership Committee ▪ Applied Research Collaboration Kent, Surrey, Sussex - Board member - 2019 ▪ Director of South East Local Partnership ▪ Member of University of Kent Academy Trust
Sarah Dunnett, Non-Executive Director	▪ Director of CATALYST (london) Ltd (Reg co. no 10121754 ▪ Interim Non-Executive Director, East Kent Hospitals University Foundation Trust
Richard Finn, Associate Non-Executive Director	▪ Director of Richard Finn Ltd ▪ Director of Goring Place ▪ Director of Detling Community Interest Company
Neil Griffiths, Non-Executive Director	▪ Managing Director of TeleTracking Technologies ▪ Advisory Council Member, Staff College
Amanjit Jhund, Director of Strategy, Planning and Partnerships	▪ Member of UK Labour Party
Cheryl Lee, Interim Director of Workforce	▪ Director of Cheryl Lee Associates Ltd ▪ Director of AZT Developments Ltd
Peter Maskell, Medical Director	None
David Morgan, Non-Executive Director	▪ Deputy Chairman and Non-Executive Director of Nord gold PLC ▪ Chairman and Non-Executive Director of AMTE Power PLC ▪ Chairman, Piazza Barnaloft Management Limited ▪ Son works for Grant Thornton UK LLP
Sara Mumford, Director of Infection Prevention & Control	None
Claire O'Brien, Chief Nurse	None
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	Non-Executive Director of NHS Innovations South East (Reg. Co. No: 05210174)
Emma Pettitt-Mitchell, Non-Executive Director	Non-Executive Director of ELM Business Consultancy Ltd (Reg Co. No. 11326434)
Jo Webber, Associate Non-Executive Director	▪ Chair of "In Control Partnerships" Charity ▪ Daughter in Law is Non-Executive Director of East Sussex Hospitals Trust ▪ Daughter In Law is Non-Executive Director of 2-gether Support Solutions

N.B. Some Directors' notifiable interests changed during the year. Further details can be obtained from the Trust Secretary, who can be contacted via Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ (or see www.mtw.nhs.uk/about-the-trust/trust-board.asp). The interests of Trust Board Members who left the Board during 2020/21 can also be obtained from the Trust Secretary.

[7] As introduced by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Pension Liabilities

Details of how the Trust treats Pension Liabilities are outlined in the Principal Financial Statements (within Note 9).

Trust Board sub-committees

The Trust Board has a number of sub-committees, to assist it in meeting its role and duties. Further details are provided in the "Annual Governance Statement for 2020/21" section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of corporate and clinical Divisions. The former includes Corporate Nursing, Emergency Planning, Communications, Estates and Facilities, IT, Finance, Human Resources, and Trust Management. The latter comprise 22 Clinical Directorates, as follows:

Division	Directorate
Medicine and Emergency Care	▶ Emergency Medicine
	▶ Acute Medicine and Geriatrics
	▶ Medical Specialities
Women's, Children's and Sexual Health	▶ Children's Services
	▶ Women's Services
	▶ Sexual Health
Cancer Services	▶ Clinical Haematology
	▶ Oncology
	▶ Cancer and Performance
	▶ Outpatients
Diagnostics and Clinical Support	▶ Pathology
	▶ Pharmacy
	▶ Imaging
	▶ Therapies
	▶ COVID Swabbing and Testing Services
Surgery	▶ General Surgery
	▶ Surgical Specialities
	▶ Theatres and Critical Care
	▶ Orthopaedics
	▶ Head and Neck
	▶ Private Patient Unit
Patient Flow	▶ Flow

Each Division and Directorate is overseen by a clinical management team (triumvirate). The triumvirate is led by a Chief of Service with overall responsibility for the leadership & management of their area. Chiefs of Service are supported by a Divisional Director of Operations (DDO) & Divisional Director of Nursing and

Quality (DDNQ), or equivalent. There is a Clinical Director (CD) for each Directorate and Directorate management teams follow the same triumvirate format as Divisions with Clinical Directors, General Managers, Lead Matrons and Other Professional Leads. All work together to agree annual & strategic plans for their services, are responsible for clinical & operational performance, resource and, communicating and engaging with staff.

Complaints: Ready to listen, ready to learn

The Trust strives to deliver the highest standards of care and treatment for all our patients, but despite the best efforts of staff, we do not always get things right. In order to learn and improve our services, we encourage patients and relatives to tell a member of staff as soon as they can, to allow us to put things right as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process. In 2020/21, the Trust received 389 formal complaints (in 2019/20, this was 556), and 71.3% of complaints received were responded to within the agreed timescale (in 2019/20, this was 64.2%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (which is due for publication in summer 2021) (www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/) provides further detail on: the number of complaints received; the number of complaints which were well founded (upheld); the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO); the subject matter of the complaints received; any matters of general importance arising from those complaints or the way in which the complaints were handled; any matters where action has been or is to be taken to improve services as a consequence of those complaints..

'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the PHSO as part of its Policy and Procedure for Management of Concerns and Complaints. Under the Trust's Policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed between the Complaints and PALS Manager and senior Directorate management team, with input from Legal Services as required. During 2020/21, the Trust offered financial remedy in two cases, totalling £162.58 (one of £12.58 for medication costs and one of £150.00 for injustice caused by the loss of the patient's healthcare records, which prevented the Trust from fully investigating the family's complaint). This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Disclosure of personal data-related incidents

The Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO) (i.e. a 'Level 2' severity incident) as follows.

Date of incident (month)	Nature of incident	Number affected	How patients were informed	Lessons learned
July 2020	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who considered the case and concluded that whilst it is possible a disclosure of personal data occurred, there was no evidence of this. The Trust provided evidence of its internal investigation and of a police investigation. Consequently, the ICO was satisfied that appropriate measures were taken in this instance and that the Trust have suitable processes in place.
November 2020	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who considered the case and concluded that sensitive personal data was involved and that there was potential for the incident to cause distress/detriment and that citizen's rights had been breached. The Trust provided a package of care, support and mediation in consultation and agreement with the affected data subject. The Trust have taken actions to prevent a recurrence of this incident by provision of addition training to staff members. Consequently, the ICO was satisfied that appropriate measures were taken in this instance.
December 2020	Non-secure disposal - Paperwork	One thousand and twenty-seven	529 of the affected individuals are deceased. A decision was taken not to notify the remining individuals	The Trust notified this breach to the ICO who considered the case and concluded that the incident related to one rogue employee acting without authority. The data in question has been returned to the Trust and made secure. The Trust provided evidence of disciplinary steps taken. The ICO concluded that appropriate measures were taken in this instance and that the incident be considered to be contained.
March 2021	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who have acknowledged the personal data breach. The Trust are currently awaiting further contact from the ICO. The Trust have instigated its disciplinary procedures in this case and an investigation is ongoing.

The Trust also had the following severity 'Level 1'data-related incidents in the year:

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	93
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	20
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	10
K	Other	0

Policy on setting charges

The Trust has complied with HM Treasury's guidance on setting charges for information, as set out in Chapter 6 of HM Treasury's "Managing Public Money" guidance.

Emergency planning, response and recovery

As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition the Trust has other obligations as required by contracts and performance standards set by NHS England. The following section describes the key areas of focus during 2020/21.

European Union (EU) Exit

Extensive work was carried out in preparations for the UK's exit from the EU. There was a huge additional workload with both internal and external multi agency planning including transport disruption, supplies & procurement, accommodation, staffing and business continuity however the Trust remained in a strong position for EU transition due to work undertaken prior to the pandemic.

Incident Co-ordination Centre (ICC)

The Incident Co-ordination Centre (ICC) was developed in response to the command and control requirements of the COVID-19 pandemic to ensure rapid decision making and it is intended that the ICC be continued into "business as usual". The ICC instituted a number of staff welfare initiatives which included breakout spaces in both academic centres with food and drink provided, a daily newsletter called 'the PULSE' to update staff on key actions and a daily Common Operating Picture distributed to managers .

Swabbing Pods and Swabulance

The Emergency Planning & Response team supported the South East Coast Ambulance service to organise a daily "swabulance" for home testing, aided in the establishment of Coronavirus Assessment Pods to isolate, test and assess potentially infected members of the public and were instrumental in setting up the first swabbing site for staff and elective patients at the Hop Farm in Paddock Wood.

Nightingale Hospital

As the operational pressures of the pandemic increased the government requested that Nightingale Hospitals be developed to help care for COVID-19 patients in large, central, locations. The Emergency Planning & Response team were involved in the development of plans to create a Nightingale Hospital at the Kent Country Showground in Detling by utilising inter-agency working. Although the site was not needed it proved the ability of the Trust to quickly response to the situation at hand.

Personal Protective Equipment (PPE)

PPE was a major challenge during the COVID-19 pandemic due to supply chain disruption. The Emergency Planning & Response team worked tirelessly with procurement, corporate nursing and the Trust's five Clinical Divisions every week to ensure there were sufficient supplies and that appropriate fit testing capacity was available to meet demands, thereby ensuring staff safety.

Oxygen Supply to Clinical Areas

The Emergency Planning & Response team worked with the Estates and Facilities Directorate to undertaking testing of the Trust's capacity in relation to the maximum litres per minute of Oxygen that could be delivered to each Clinical area. The testing enabled on-call managers to manage the Trust's Oxygen capacity.

Exercises and training

The training and exercise programme had to either be cancelled or adapted to maintain social distancing rules which presented additional challenges. E-Learning was developed to reduce face to face training, larger venues were booked, with strict infection prevention control measures undertaken to ensure staff safety for the limited practical sessions.

The Chemical Biological Radiation and Nuclear event (CBRNe) training had to be maintained to ensure the trust maintained the capability to respond to such an event.

Loggist training was considered essential to support the Trust's response to COVID-19 and provide a Loggist seven days a week, twelve hours a day in the Incident Co-ordination Centre. The training had to be delivered face to face so more sessions with fewer staff in larger rooms were implemented.

Adverse Weather and Winter Preparedness

The 2020 annual winter exercise was converted into a seminar event, business continuity plans were reviewed and appropriate contingencies such as snow clearing and 4X4 transport to get isolated critical staff into the Trust were reaffirmed.

Assurance

NHS England carry out an annual assurance process and this year the Trust was once again rated fully compliant. A number of areas of good practice were highlighted.

Safety Advisory Groups (SAGs)

The Trust continued to offer advice and guidance to any events that came under Sevenoaks District Council, Tonbridge & Malling Borough Council, Maidstone Borough Council and Tunbridge Wells Borough Council. The focus of the guidance was directed at adequate medical cover, provisions for inclement weather, infection prevention and control measures and social distancing.

COVID-19 Vaccination Centre

The Trust's mass vaccination plan, which was developed and exercise tested during the 2012 Olympics was effectively deployed and the Vaccination Centre established at Maidstone Hospital. The mass vaccination plan enabled over 15,000 vaccination doses to be administered in 2020/21 and received commendation from the Secretary of State for Health & Social Care.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and;
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Insert Signature

Miles Scott,

Chief Executive

Insert date

Statement of Directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and;
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Trust Board

Insert signature *Insert signature*

Miles Scott, Chief Executive Steve Orpin, Chief Finance Officer

Insert Date *Insert Date*

Annual Governance Statement for 2020/21

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2021 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

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

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

- The Chief Nurse is the Senior Information Risk Owner (SIRO)
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- The Chief Executive is the Board Level Director (with fire safety responsibility) and the Security Management Director[8]
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[9]

[8] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[9] Required by The Health and Social Care Act 2012

- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and Resuscitation[10], and they have also been allocated the EPRR portfolio[11]
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention , and also the Non-Executive lead on mortality and learning from deaths[12]

The Trust has a Risk Register and Board Assurance Framework (BAF) and in place, the operation of which are informed by accepted best practice . The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. The objectives within the BAF are devolved for oversight by one or more Trust Board sub-committees, and reports on the objectives are submitted to such sub-committees. 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).

As is the case every year, the BAF and Risk Register are subject to review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2020/21, gave an overall assessment of "Reasonable Assurance".

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

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

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian or their Deputy (who was appointed during 2020/21); being aware of their responsibility to report

[10] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[11] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"
[12] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"

and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

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

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

The risk and control framework

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

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

The key elements of the quality governance arrangements (including how the quality of

performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are overseen via the Quality Committee, which receives a report from each Divisional clinical governance committee whenever it meets in its 'main' form[13] . The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (as well as oversee quality within the clinical divisions)..

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

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

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, regular engagement events have taken place with the CQC during 2020/21. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been covered by these events.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda, and overseen by a Quality Improvement Committee, which is accountable to the Executive Team Meeting (ETM) via the Chief Nurse. The ETM and 'main' Quality Committee receive regular reports on progress with the Trust's ambition to achieve an "Outstanding" rating by the CQC.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust made a "Standards Met" Toolkit submission for the 2019/20 year on 29th September 2020 (the submission deadline for the Toolkit was extended because of the COVID-19 pandemic). The Trust is required to make its submission for the 2020/21 Toolkit by the end of June 2021 (as the deadline was again extended because of the pandemic).

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

The objectives for 2020/21, which were approved by the Trust Board on 23rd July 2020 , are 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.

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

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.

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement in November 2020 and March 2021. In-year reports BAF reports on specific objectives were also considered by several Trust Board sub-committees. A year-end BAF report regarding the achievement of the objectives was then received by the Trust Board in April 2021.

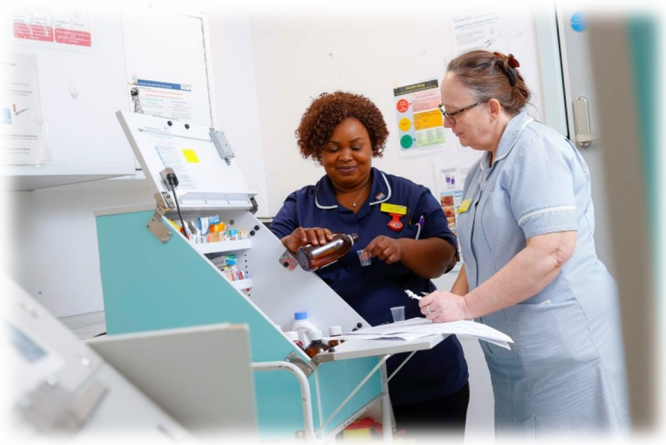
In addition, a number of risks were rated as 'red' in 2020/21. Red-rated risks are reviewed and validated at the ETM (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2020/21, and include the cost pressures associated with the use of temporary staff; risk associated with failing to learn from incidents; the inability to fulfil the national standard of 35% of women being cared for by Continuity of Carer teams within the Maternity service; the risk of harm from delays in psychiatric assessment and implementing the required actions following assessment; the risk of insufficient capacity in certain specialties (glaucoma, ENT, Head and Neck, Critical Care); staffing absences in certain specialties; the ability to undertake timely mortality reviews; statutory legionella management control; the number of policies that had exceeded their review date; and the effect of COVID-19 (coronavirus) outbreak on the Trust's ability to carry out its functions. Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

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

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2021/22.

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

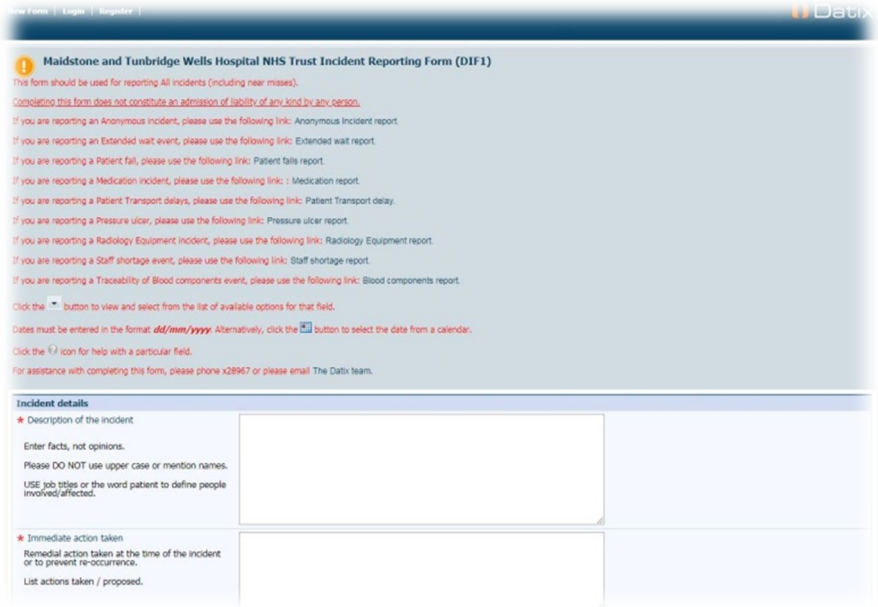
In May 2020, the Trust Board completed the required self-certification (for 2019/20) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2019/20. The Trust Board will be asked to undertake the required self-certification for 2020/21 at its meeting in May 2021, and it will again be proposed that full compliance be confirmed.



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

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

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department).
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning and Cost Improvement Programme



(CIP) arrangements, via the Quality Impact Assessment (QIA) process.

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

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

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[14] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHS England/Improvement (NHSE/I) along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission
- The ETM received regular updates during 2020/21 on progress against the Trust's recruitment plan
- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse
- The Trust Board reviews workforce metrics on a monthly basis as part of its Integrated Performance Report (IPR), to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.

- The Trust's People and Organisational Development Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every two months. The Committee's purpose (as stated it its Terms of Reference) is to provide assurance to the Board in the areas of people development, planning, performance and employee engagement. The Committee also works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the CQC.

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHS England "Managing Conflicts of Interest in the NHS" guidance and has not

[14] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. The Trust's Audit and Governance Committee (which receives reports of declarations made under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2021/22.

NHS Pension scheme

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

Obligations under equality, diversity and human rights legislation

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

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. This is primarily driven by the implementation of the Trust's Sustainable Development Management Plan (SDMP), which is approved by the Trust Board each year (this was approved in May 2020, and is scheduled to be approved next in May 2021).

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

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2020/21. The Trust's annual Internal Audit plan for 2020/21 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay Expenditure", and "Critical Financial Assurance – Payroll", which achieved overall assessment of "Reasonable Assurance".

Information governance incidents

The Trust had four serious incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO), as described within NHS Digital's Data Security and Protection Toolkit, during 2020/21. Three of the incidents related to unauthorised disclosure, while the other related to the non-secure disposal of paperwork. All four were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for three of the incidents, while for the fourth, which was notified to the ICO in March 2021, the Trust is currently awaiting further contact from the ICO..

Data quality and governance

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

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

- The Trust has a "Patient access to elective care policy" (which was revised and ratified in September 2020), which covers the management of waiting lists at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those relating to data quality.
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality
- There is a validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data.
- The Trust has a Data Quality Steering Group, chaired by the Deputy Chief Executive/Chief Finance Officer, and the Group has, during 2020/21, overseen the creation of a Data Quality Strategy and workplan. This is linked to NHS Digital's Provider Data Quality Assurance Framework, against which a baseline assessment was undertaken, and the workplan has been developed to improving the Trust's position against that assessment. A Task and Finish group, chaired by the Associate Director of Business Intelligence, has been established to deliver the workplan.

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. The "Data Quality of Key Performance Indicators" that was undertaken as part of the 2019/20 Internal Audit plan (and which was issued in September 2020 because of the delays arising from the COVID-19 pandemic) covered the Stroke Best Practice Tariff and 18 Weeks Referral to Treatment (RTT) incomplete pathway indicators, and gave an overall assessment of "Reasonable Assurance".

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

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised

on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Governance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2020/21 states that "My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.". The last sentence of the Opinion reflects the fact that some reviews undertaken by Internal Audit during 2020/21 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2020/21 resulted in an overall 'Reasonable assurance' assessment, four led to an assessment of 'Limited assurance'. These related to the processes for the management of post, the effective use of the Electronic Staff Record (ESR), the Oncology ICT Healthcheck, and the Roche Managed Service Contract, and actions to address the issues identified in these reviews will be taken during 2021/22.

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

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All Trust Board meetings in 2020/21 were held 'virtually', as a result of the COVID-19 pandemic, and from June 2020, the requirement to meet in public was met via the Trust Board's meetings being broadcast live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website.

The agenda for Trust Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from sub-committees. A separate

('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key part of the information the Board receives at each meeting in public is an IPR, which contains up-to-date details of performance across a range of indicators.

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

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

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the BAF); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and meets three times per year.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a Non-Executive Director, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The People and Organisational Development Committee. This provides assurance to the Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a Non-Executive Director and meets monthly.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the

Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.

- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Team; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met several times during 2020/21).

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

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

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

The impact of the COVID-19 pandemic during 2020/21

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2020, but was more significantly felt within 2020/21, particularly during the 'second wave', which was experienced during the winter of 2020/21. However, despite the unprecedented scale of the impact, the Trust's structure of

governance allowed a prompt response to the significant change in circumstances. The Incident Command Centre that was established in March 2020, with the Chief Operating Officer as the Strategic Commander, led and coordinated the Trust's response to the pandemic, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision-making authority over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response.

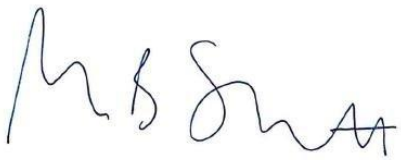
Significant internal control issues

The following significant internal control issue[15] has been identified in 2019/20:

1. Two "Never Events" were declared at the Trust in 2020/21. One related to a misplaced naso-gastric (NG) tube and one involved a retained swab following a delivery. The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.
2. In November 2020, HM Coroner issued the Trust with a Regulation 28 ("Report to Prevent Future Deaths") report, following the Inquest into the death (in August 2019) of one of the Trust's patients, who sustained a severe head injury following a fall from a trolley in the Clinical Decision Unit. The Trust wrote to HM Coroner in January 2021 to explain the actions that had been taken, and would be taken in the future, to learn from the incident, and prevent it from recurring.

Conclusion

The Trust has maintained a sound system of internal control during 2020/21, and has identified only two significant internal control issues during the year. These are described above, in the body of the Annual Governance Statement.



Miles Scott, Chief Executive

24th June 2021

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

Accountability Report for 2020-2021:
Remuneration and staff report

Our staff

NHS national staff survey

Our aim is to provide high quality compassionate care for our patients that is underpinned by providing high quality compassionate care for our staff. The NHS National Staff Survey, our culture work and our climate surveys are important methods for us to hear the views of our staff. The thoughts, experiences and opinions of everyone across the organisation are vital in gauging how well we are providing the care and support needed to our staff to progress us on our journey to becoming the best place to work.

Our 2020 NHS National Staff Survey response rate saw an increase of 1% compared to 2019 with 3199 staff completing the survey, representing 52% of our workforce. With the national average response rate for acute Trusts being 45% and against the backdrop of a global pandemic, we are delighted to report statistically significant improvements in Health and Wellbeing, Morale, Quality of Care, Safety and Staff Engagement.

Around 92% of respondents felt their role is making a difference to patients/service users, 83% feel satisfied with the quality of care they give to patients/service users and 82% are happy with the standard of care provided by the organisation should a friend or relative need treatment. We have seen a 10% increase in the number of staff feeling that the Trust takes positive action on health and wellbeing since 2019 and 75% of staff would recommend the Trust as a place to work.

We plan to continue the work we started prior to and during the Covid-19 pandemic with a focus on Civility, Dignity and Respect by supporting staff to be confident in speaking up about the issues affecting them; developing a robust and inclusive recruitment practice using Equality, Diversity and Inclusion (EDI) Recruitment Champions; and supporting staff to develop their careers here at the Trust.

The full staff survey results are available at: http://www.nhsstaffsurveyresults.com/

Employee benefits

The details within this section relating to staff benefits, analysed by staff grouping, are included in accordance with section 411 of the Companies Act 2006.

Staff numbers and costs (subject to audit)

Average[16] staff numbers	Permanently employed (WTE)[17]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	863	43	95,282	6,972
Ambulance staff	4	0	267	0
Administration and estates	1,178	67	43,733	3,532
Healthcare assistants and other support staff	1,641	1	47,303	53
Nursing, midwifery and health visiting staff	1,753	75	85,571	5,367
Nursing, midwifery and health visiting learners	0	0	10	0
Scientific, therapeutic and technical staff	541	35	27,303	2,552
Social Care Staff	0	0	0	0
Healthcare Science Staff	200	0	10,775	11
Other	0	0	0	0
Apprenticeship levy	0	0	1,277	0
Employers Pension Contribution 6.3%	0	0	12,824	0
Total	6,180[18]	221	324,345	18,487
Staff engaged on capital projects (excluded from above)	16	6	1,308	1,002

[16] The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.
[17] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)
[18] Readers will note that this figure is different to the WTE figure reported in the "Organisation" table within the "Sustainability Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers and costs" table is an average over the year and is based on when staff are paid (therefore any staff on unpaid leave i.e. maternity leave, long term sickness absence etc. do not feature)

The permantantly employed staff costs are further analysed into their component elements in the table below:

The analysis of staff costs by main elements of costs:

Analysis of staff costs	2019/20 Permanently employed (£000s)	2020/21 Permanently employed (£000s)
Salaries and wages	219,594	255,636
Social security costs	23,565	26,419
Apprenticeship levy	1,157	1,277
Pension cost - employer contributions to NHS pension scheme	26,180	29,422
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	11,381	12,824
Pension cost - other*	21	76
Total	281,898	325,654

Exit packages (subject to audit)

The figures disclosed below relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts.

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	None	N/A	0	0	None	0	None	0
£10,000 - £25,000	None	N/A	0	0	None	0	None	0
£25,001 - £50,000	None	N/A	0	0	None	0	None	0
£50,001 - £100,000	1	67	0	0	1	67	None	0
£100,001 - £150,000	1	123	0	0	1	123	None	0
£150,001 - £200,000	None	N/A	0	0	None	0	None	0
>£200,000	None	N/A	0	0	None	0	None	0
Total	None	N/A	0	0	None	0	None	0

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements 2020/21	Total Value of agreements (£000s)	Number of exit package agreements 2019/20	Total Value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	0	0	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Note * this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

Staff engagement and consultation (understanding and learning from the views of staff)

The Trust meets formally on a regular basis with local Trade Union representatives, via the Joint Consultative Forum (JCF) and Joint Medical Consultative Committee (JMCC), to discuss key issues and agree relevant employment policies and procedures. Staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes.

Information is cascaded to all staff through a monthly "Team Brief" meeting which is led by the Chief Executive and is undertaken virtually. A weekly Chief Executive's update and "MTW News" newsletter are also issued to all staff via email, enabling messaging on matters of note. In addition, key news items are communicated daily via the Pulse – an electronic communication sent to each staff member via email.

The Trust's Freedom to Speak Up Guardian (FTSUG) submitted reports to the Trust Board each quarter during 2020/21. The FTSUG aims to ensure that patients are cared for in a safe way and that staff are able to raise concerns that they feel are not being heard or are unable to raise with management. It is also the Guardian's role to listen in confidence, note concerns and raise issues through the appropriate channels.

A Deputy FTSUG has been recruited on a 0.8 Whole Time Equivalent (WTE) substantive contract who provides a focus on supporting our staff from minority backgrounds.

During 2019/20 as part of the first phase of the culture and leadership programme, Exceptional People Outstanding Care, a culture Change Team was launched. A number of staff around the organisation received training from the NHS Leadership Academy enabling them to undertake surveys, run workshops and carry out interviews and questionnaires with staff to find out about the way things are done at the Trust and what can be done to make positive change in the future.

Towards the end of 2020, the Divisional Voices Leads network was formed. The purpose of the group is to act as a conduit for sharing updates on staff welfare initiatives both from the corporate team and divisions. The Divisional Leads have been able to work with their areas of work to identify trust wide improvement ideas, share engagement and deployment plans and share best practice and good news stories.

Exceptional People, Outstanding Care programme

The Trust recognises the importance of culture and leadership in an organisation's success. In this regard, the Trust embarked on an Exceptional People Outstanding Care cultural and leadership programme during 2019/20. The programme involved three phases: "discovery", "design" (i.e. to develop an Organisational Development strategy), and "delivery" (i.e. implementation of that Strategy).

While the COVID-19 pandemic has clearly had an impact in 2020/21, this has also highlighted the importance of the programme and in addition incorporated an additional emphasis for Staff Welfare, which was successful and well received by our people.

Although the COVID-19 pandemic meant that the timescales planned to proceed with the second "design" phase had to be adjusted, in Autumn 2020 , the programme moved on to the design phase and will complete shortly with a report being taken to Board in Summer 2020. A 'change team' was also maintained and increased, to lead the work, which involved nearly 100 staff from all areas of the Trust – clinical and non-clinical.

This delay has however enabled consideration of the learning from the COVID-19 pandemic, which will be incorporated into the delivery phase. It is expected that significant progress will be made during 2021/22 with the delivery phase. The programme will has also informed and supported the roll out of strategic programmes in 2021/21.

Education and Development

The Trust takes the ongoing development of its staff very seriously. Each hospital site has an Education / Academic Centre, giving dedicated staff teaching space, and a library. Staff have an annual appraisal with a plan of personal development and access to education teams to support them with advice and guidance about development needs. In-house learning activities & funding for staff to access external training are available.

Education and training for its next generation of clinical leaders is critical to the Trust's success. The Trust has a vibrant apprenticeship programme, with apprentices working across its hospitals in a range of roles. Having a strong education ethos that supports younger medical students through to high specialty trainees is equally important and the Trust's Medical Education team has worked hard to develop high quality training programmes as well as creating a friendly, supportive environment where trainees can grow and thrive. The team trains and develops medical trainees as well as provides professional development for all doctors in the Trust.

Fostering strong team working and putting education & development at the core of the organisation is an integral part of the Trust's journey to being more clinically led. Trusts that engage in education & development are safer and have better clinical outcomes. Critically, evidence of a strong learning ethos, in a supportive environment, with good team spirt, will also encourage others to want to work for the Trust.

Covid-19 has presented an extraordinary challenge in 2020/21 however, the hard work and dedication of the teams involved has allowed for significant changes to be made to continue to support staff education and

development. For example, increased access to, and availability of e-learning programmes and bitesize packages, the launch of the leadership dashboard with a clear aim of supporting staff to learn new skills in response to the changes in the operational context within the Trust and a strong focus on supporting staff health and wellbeing and encouraging meaningful conversations and positive interactions between staff.

Equal opportunities

We are committed to providing services and employment to a community with a diversity of backgrounds. To do this effectively it is essential that we promote equality, embrace diversity and treat all of our patients, relatives, staff and service users with civility, dignity and respect. This is not about treating everyone the same but ensuring that access to opportunities are available to all by taking account of people's differing needs and capabilities. We continue to put diversity and inclusion at the heart of everything we do because we are dedicated to diversity.

Celebrating the diversity of our workforce ensures that we have a representative, supported and well-led organisation where staff perform to their best ability within an environment that promotes civility, dignity and respect.

Black, Asian and Minority Ethnic (BAME) employees

The last year has highlighted the enormity of the impact of Covid-19 and death of George Floyd on our BAME staff. The Cultural and Ethnic Minorities Network were swift to respond to the needs of our BAME community and increased the support they provide by scheduling weekly evening online events. The events were not only supportive to BAME staff but powerful and emotional, enabling white allies to understand more of the lived experiences and fears of their BAME colleagues. Over the year, these meetings have developed into learning events for the whole organisation, bringing in guest speakers from other areas within MTW, the wider NHS and our local MP.

We have embarked upon a Reverse Mentoring programme which includes the Trust Board learning from the lived experiences of staff trained in mentoring skills and plan to roll out a White Ally programme in the coming months. We are also in the early planning stages of a Kent and Medway ICS BAME mentoring programme to support the career development of BAME staff.

In the coming year we plan to support our BAME staff further by:

- Setting KPIs and targets to increase the number of BAME representation at all levels within the Trust
- Organise talent panels to identify staff eligible for promotion and create development opportunities including stretch and acting up assignments
- Introducing values based recruitment practices
- Adapt resources, guides and tools to help leaders have productive conversations about race

LGBT+ employees

As a vibrant network, this group of staff have been disappointed not to have participated in the usual activities that they would normally such as Pride events and our annual LGBT+ conference. They have continued to support each other, continued to recruit allies wishing to display the NHS Rainbow Badge and are excited to launch Pronouns on staff name badges in the coming weeks. There has been a great deal of work taking place with Divisions supporting them to make changes to documents to make the language used gender neutral and, therefore, more inclusive.

With lockdown measures lifting, the group are excited to start planning our third annual LGBT+ conference and other celebration and educational activities during the course of the year.

Disabled employees

This year has seen a re-launch of the Disability Network with more members than before. The group is deciding how it will run and are planning support events for disabled staff and leaders within the organisation to help with productive conversations about disability and support.

The network are keen to drive the implementation of a disability leave policy and health passport to support the needs of disabled people within the workplace.

We have recently submitted our application for Level 3 – Disability Confident Leader status which will demonstrate our commitment and leadership skills in:

- Actively attracting and recruiting disabled people
- Promoting a culture of being disability confident

Fair and inclusive recruitment

We are embarking upon a journey at the Trust that will see changes to way we recruit to roles including Consultant grades by introducing EDI Recruitment Champions. These staff have been provided with the skills to identify bias within shortlisting and interview processes and given the confidence to challenge in a supportive manner to ensure that fairness and equity occurs within our recruitment processes.

Gender	Staff [head count]		Trust Board Members	
Male	1568 (1463)	23.9% (23.6%)	9 (10)	52.9% (58.8%)
Female	4983 (4735)	76.1% (76.4%)	8 (7)	47.1% (41.2%)
Grand total	6551 (6198)	-	17 (17)	-

Age	Staff [head count]		Trust Board Members	
Less than or equal to 20 years	55 (46)	0.8% (0.7%)	0 (0)	0% (0%)
21 to 25	472 (419)	7.2% (6.8%)	0 (0)	0% (0%)
26 to 30	810 (791)	12.4% (12.8%)	0 (0)	0% (0%)
31 to 35	852 (781)	13.0% (12.6%)	1 (1)	5.9% (5.9%)
36 to 40	668 (659)	10.2% (10.6%)	1 (1)	5.9% (5.9%)
41 to 45	851 (825)	13.0% (13.3%)	2 (1)	11.8% (5.9%)
46 to 50	882 (840)	13.5% (13.6%)	2 (5)	11.8% (29.4%)
51 to 55	832 (795)	12.7% (12.8%)	3 (1)	17.6% (5.9%)
56 to 50	672 (617)	10.3% (10.0%)	2 (2)	11.8% (11.8%)
61 to 65	355 (335)	5.4% (5.4%)	3 (4)	17.6% (23.5%)
66 to 70	75 (60)	1.1% (1.0%)	2 (2)	11.8% (11.8%)
71 years or over	27 (30)	0.4% (0.5%)	1 (0)	5.9% (0%)

Please note that the data for Trust Board Members is not included within the "Staff [head count]" data, to avoid double counting, even though 8 of the 17 Trust Board members are substantive members of staff.

Ethnic group	Staff [head count]		Trust Board Members	
A White - British	3928 (3794)	60.0% (61.2%)	15 (14)	88.2% (82.4%)
B White - Irish	55 (57)	0.8% (0.9%)	1 (1)	5.9% (5.9%)
C White - Any other White background	476 (442)	7.3% (7.1%)	0 (0)	0% (0%)
C2 White Northern Irish	2 (3)	> 0.1% (>0.1%)	0 (0)	0% (0%)
C3 White Unspecified	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CA White English	0 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CF White Greek	3 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CG White Greek Cypriot	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
CK White Italian	1 (2)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CP White Polish	8 (8)	0.1% (0.1%)	0 (0)	0% (0%)
CU White Croatian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CY White Other European	16 (22)	0.2% (0.4%)	0 (0)	0% (0%)
D Mixed - White & Black Caribbean	15 (10)	0.2% (0.2%)	0 (0)	0% (0%)
E Mixed - White & Black African	15 (12)	0.2% (0.2%)	0 (0)	0% (0%)
F Mixed - White & Asian	32 (30)	0.5% (0.5%)	0 (0)	0% (0%)
G Mixed - Any other mixed background	31 (25)	0.5% (0.4%)	0 (0)	0% (0%)
GA Mixed - Black & Asian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GC Mixed - Black & White	1 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
GD Mixed - Chinese & White	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
GE Mixed - Asian & Chinese	1 (2)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GF Mixed - Other/Unspecified	1 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
H Asian or Asian British - Indian	594 (566)	9.1% (9.1%)	1 (1)	5.9% (5.9%)
J Asian or Asian British - Pakistani	67 (70)	1.0% (1.1%)	0 (0)	0% (0%)
K Asian or Asian British - Bangladeshi	22 (17)	0.3% (0.3%)	0 (0)	0% (0%)
L Asian or Asian British - Any other Asian background	328 (311)	5.0% (5.0%)	0 (0)	0% (0%)
LA Asian Mixed	5 (6)	0.1% (0.1%)	0 (0)	0% (0%)
LB Asian Punjabi	1 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LF Asian Tamil	2 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LH Asian British	3 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
LJ Asian Caribbean	1 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LK Asian Unspecified	3 (3)	> 0.1% (>0.1%)	0 (0)	0% (0%)
M Black or Black British - Caribbean	25 (22)	0.4% (0.4%)	0 (0)	0% (0%)
N Black or Black British - African	197 (182)	3.0% (2.9%)	0 (0)	0% (0%)
P Black or Black British - Any other Black background	14 (13)	0.2% (0.2%)	0 (0)	0% (0%)
PB Black Mixed	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
PC Black Nigerian	9 (11)	0.1% (0.2%)	0 (0)	0% (0%)
PD Black British	4 (4)	0.1% (>0.1%)	0 (0)	0% (0%)
PE Black Unspecified	1 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
R Chinese	31 (35)	0.5% (0.6%)	0 (0)	0% (0%)
S Any Other Ethnic Group	149 (144)	2.3% (2.3%)	0 (0)	0% (0%)
SA Vietnamese	1 (0)	>0.1% (0)	0 (0)	0% (0%)
SB Japanese	4 (4)	0.1% (0.1%)	0 (0)	0% (0%)
SC Filipino	18 (19)	0.3% (0.3%)	0 (0)	0% (0%)
SD Malaysian	2 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
SE Other Specified	4 (8)	0.1% (0.1%)	0 (0)	0% (0%)
Z Not Stated / Undeclared	476 (350)	7.3% (5.6%)	0 (1)	0% (5.9%)
Grand Total	6551 (6198)	-	17 (17)	-

Please note that the data for Trust Board Members is not included within the "Staff [head count]" data, to avoid double counting, even though 8 of the 17 Trust Board members are substantive members of staff.

Staff sickness absence

Sickness absence data can be accessed via the NHS Digital publication series on NHS sickness absence rates (see https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates).

Health and Safety at Work

The Trust is committed to ensuring the health and safety of its employees, patients, visitors, volunteers, contractors and others affected by its activities. It aims to provide safe and healthy working conditions and seeks the support of staff in achieving this. The use of risk assessment to identify, assess and manage risk is key to health and safety management within the Trust. During the year:.

- The Risk Management Policy and Procedure was updated to reflect the current risk grading matrix and committee structure.
- To support the increased number of shielding and non-front line staff working from home the Display Screen Equipment Policy was revised and ratified, with guidance provided to staff.
- The Noise at Work Policy and Procedure was rewritten to incorporate the risks from vibration at work and ratified.
- Risk assessment templates, guidance and support has been provided for managers to support them in assessing the workplace for COVID-19 risks.
- The reduced number of staff and members of public on site during the COVID-19 pandemic did lead to a decrease in the number of non-patient safety incidents. There were 2089 in 2020/21 compared with 2342 in 2019/20, a reduction of around 10%. While it remains the largest health and safety-related incident category, there was a decrease in incidents of violence and harassment against staff. The incidents are largely attributable to patients diagnosed with dementia or those suffering from a mental health crisis. Work is ongoing to mitigate the risk.

- At the end of March 2021, there was a reduction in the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 – 22 in 2020/21 compared with 25 in 2019/20. This does not include COVID-19-related occupational disease RIDDOR reports.
- The Trust followed Health and Safety Executive (HSE) guidance in reporting cases under RIDDOR where there was reasonable evidence that staff contracted COVID-19 as a result of workplace exposure. This led to a high number of reports which reflected the extent of the pandemic, requiring vigilence and dedication from those assessing and submitting reports to the HSE.
- A number of temporary structures have been erected on both sites to support social distancing and protect those queueing during the COVID-19 pandemic. These have needed to be assessed to ensure staff and public safety.
- An interim Health and Safety Advisor has been appointed to support the wider health and safety team, bringing a wealth and experience in incident management and investigation.
- The health and safety audit tool has been upgraded and a new electronic inpsection process will be trialled in 2021/22 with the aim of reducing incidents further during the course of the year.

"Senior Managers" remuneration

In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies, this report includes details regarding "senior managers" remuneration. In the context of the NHS, this is defined as: "Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments".

It is usually considered that the regular attendees of the entity's Board meetings are its "Senior Managers", and the Chief Executive has confirmed that the definition of "Senior Managers" only applies to Trust Board Members (refer to the 'Directors' Report' for further details). With the exception of the Non-Executive Directors (whose remuneration is set by NHSI) all "Senior Managers" are on "Very Senior Manager" (VSM) contracts and salaries are agreed with each individual.

The Trust Board has established a Remuneration and Appointments Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts (refer to the Annual Governance Statement for 2020/21 for further details of the Remuneration and Appointments Committee).

The Chief Executive and Directors' remuneration is reviewed annually and decisions are based on market rates, national pay awards and performance. Reward is primarily through salary adjustment, although non-recurrent awards can be used to recognise exceptional achievements. Pay rates for Non-Executive Directors of the Trust are determined in accordance with national guidelines, as set by NHSI. Remuneration for the Chair of the Trust Board is also set by NHSI.

The Directors are normally on permanent contracts and subject to a minimum of 6 months' notice period; the Chief Executive's notice period is six months. Contract, interim and seconded staff will all have termination clauses built into their letters of engagement, which will be broadly in line with the above. All Director contracts contain a 'Fit and Proper Person' clause stating that the post holder will be unable to continue as a Trust Board Member should they meet any of the criteria for being "unfit" within The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Termination arrangements are applied in accordance with statutory regulations as modified by Trust or National NHS conditions of service agreements, and the NHS pension scheme. The Remuneration and Appointments Committee will agree any severance arrangements following appropriate approval from NHSI and HM Treasury as appropriate. The figures included in the tables below show details of salaries, allowances, pension entitlements and any other remuneration of the Trust's 'Senior Managers' i.e. non-recurrent awards etc.

There are no staff sharing arrangements in place for any of the Trust's senior managers.

Salaries and allowances for the year ending 31st March 2021 (subject to audit)

Comparatives for the year ending 31st March 2020 are shown in brackets below the figure for 2020/21.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2020/21 year unless otherwise disclosed	(a) Salary (bands of £5,000) £000	(b) Taxable expense payments and other benefits in kind, to the nearest £100 £ Λ	(c) Annual performance-related pay and bonuses (bands of £5,000) £000	(d) Long-term performance-related pay and bonuses (bands of £5,000) £000	(f) All pension-related benefits (bands of £2,500) £000	(g) TOTAL (columns a - f) (bands of £5.000) £000	(h) Payments or compensation for loss of office £000
Sean Briggs, Chief Operating Officer	135-140 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	30-32.5 (65.0-67.5)	165-170 (195-200)	N/A (N/A)
Maureen Choong, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Karen Cox, Associate Non-Executive Director ±	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0 (0)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Richard Finn, Associate Non-Executive Director	10-15 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)
Neil Griffiths, Associate Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Simon Hart, Director of Workforce (until 13/08/20)	85-90 (130-135)	0 (0)	N/A (N/A)	N/A (N/A)	32.5-35.0 (25-27.5)	120-125 (155-160)	N/A (N/A)
David Highton, Chair of the Trust Board	35-40 (40-45)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	35-40 (40-45)	N/A (N/A)
Amanjit Jhund, Director of Strategy, Planning & Partnerships	115-120 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	27.5-30.0 (27.5-30.0)	145-150 (155-160)	N/A (N/A)
Cheryl Lee, Interim Director of Workforce (from 07/09/20)	100-105 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	100-105 (0)	N/A (N/A)
Peter Maskell, Medical Director Ψ	205-210 (200-205)	0 (0)	N/A (N/A)	N/A (N/A)	20.0-22.5 (7.5-10)	225-230 (205-210)	N/A (N/A)
David Morgan, Non-Executive Director	10-15 (0-5)[19]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	195-200 (175-180)	0 (0)	N/A (N/A)	N/A (N/A)	75.0-77.5 (70-72.5)	270-275 (245-250)	N/A (N/A)
Claire O'Brien, Chief Nurse	130-135 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	12.5-15.0 (7.5-10)	145-150 (130-135)	N/A (N/A)
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	155-160 (145-150)	0 (0)	N/A (N/A)	N/A (N/A)	32.5-35.0 (35-37.5)	190-195 (180-185)	N/A (N/A)
Emma Pettitt-Mitchell, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Miles Scott, Chief Executive	225-230 (225-230)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	225-230 (225-230)	N/A (N/A)
Jo Webber, Associate Non-Executive Director	10-15 (0-5)[20]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). All other columns are in £ thousands
Ψ Drs Maskell and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers
± Karen Cox does not receive renumeration from the Trust

[19] David Morgan started in August 2019, therefore the comparator value represents a part year renumeration
[20] Jo Webberjoined the Trust in November 2019, therefore the comparator value represents a part year renumeration

Pension benefits for the year ending 31st March 2021[21] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2020/21 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31st March 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2021 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1st April 2021	(f) Real increase in Cash Equivalent Transfer Value Σ	(g) Cash Equivalent Transfer Value Λ at 31st March 2021	(h) Employee's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer	0-2.5	0	20-25	0	191	6	219	0
Simon Hart, Director of Workforce (until 13/08/20)	0-2.5	0	50-55	105-110	816	32	876	0
Amanjit Jhund, Director of Strategy, Planning & Partnerships	0-2.5	0	5-10.0	0	56	6	79	0
Cheryl Lee, Interim Director of Workforce¥ (from 07/09/20)	0	0	0	0	0	0	0	0
Peter Maskell, Medical Director	0-2.5	0	30-35	60-65	547	19	589	0
Sara Mumford, Director of Infection Prevention and Control	2.5-5.0	2.5-5.0	65-70	85-90	993	75	1108	0
Claire O'Brien, Chief Nurse	0-2.5	2.5-5.0	55-60	165-170	1292	46	1378	0
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	2.5-5.0	0	60-65	130-135	958	32	1028	0
Miles Scott, Chief Executive¥	0	0	0	0	0	0	0	0

Ψ As Non-Executive Directors (and Associate Non-Executive Directors) do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors

Λ A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008. Please however note that the CETV values at 31/03/20 and 31/03/21 may have been calculated using different methodologies, and this may have impacted the "Real increase in Cash Equivalent Transfer Value" figure in the table

Σ Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period

¥ Miles Scott and Cheryl Lee did not make any contributions into the NHS Pension Scheme in 2020/21

Please also note that the benefits and related CETVs do not allow for a potential adjustment arising from the McCloud judgement (a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design).

Fair pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This is calculated at the reporting date i.e. 31st March 2021 by "annualising" the March pay information taking into account temporary staff and adjusting for the full-time effect of part-time staff.

The banded remuneration of the highest paid director in the financial year 2020/21 was £227,500 (2019/20 £227,500). This was 7.4 times (2019/20 7.5) the median remuneration of the workforce, which was £30,615 (2019/20 £30,401). The highest paid Director in the financial year 2020/21 was the Chief Executive (in 2019/20 this was the Chief Executive).

[21] The Trust only makes contributions into the NHS pension scheme and the National Employment Savings Trust (NEST) scheme

In 2020/21 no employees (2019/20 no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £12,569 to £227,209 (2019/20 £12,477 to £224,963).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Reporting relating to the review of tax arrangements of public sector appointees

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, the Trust in common with all public bodies, is required to publish information in relation to the number of 'off-payroll' arrangements meeting the specific criteria set by the Treasury. Individuals that are 'on-payroll' are subject to Pay As You Earn (PAYE), with income tax and employee National Insurance Contributions (NICs) deducted by the Trust at source. Individuals engaged to provide services to the Trust but who do not have PAYE and NICs deducted at source are 'off-payroll'.

All off-payroll engagements as of 31st March 2021, for more than £245 per day and lasting for longer than six months

	Number
Number of existing engagements as of 31st March 2021	8
Of which, the number that have existed…	
for less than one year at the time of reporting =	4
for between one and two years at the time of reporting =	1
for between two and three years at the time of reporting =	1
for between three and four years at the time of reporting =	2
for four or more years at the time of reporting =	0

All existing off-payroll engagements have at some point been subject to a risk based assessment, as to whether assurance was required that the individual is paying the right amount of tax. Where necessary, that assurance has been sought.

New off-payroll engagements between 1st April 2020 and 31st March 2021, for more than £245 per day that last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2020 and 31st March 2021	4
Of which…	
Number assessed as caught by IR35	4
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	18

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2020/21 was £3,855k, an increase of £3,284k from previous financial year (£571k in 2019/20). This increase related to IT development projects including Electronic Patient Records implementation.

Declaration

I confirm adherence to the reporting framework in respect of the Accountability Report.

Insert signature

Miles Scott, Chief Executive

Insert date

Accountability and audit report for 2020-2021:
Independent auditor's report to the directors of Maidstone and Tunbridge Wells NHS Trust

Independent auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

Report on the Audit of the Financial Statements

To be supplied by External Audit

Insert signature

Darren Wells

Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor Crawley

24th June 2021

Glossary of NHS terms

Term	Definition/explanation
Accident and Emergency (A&E)	Also referred to as Emergency Department (ED)
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a new suspected stroke
Care Quality Commission (CQC)	A body that regulates all health & social care services in England. The CQC ensures the quality 7 safety of care in hospitals, dentists, ambulances, & care homes, and the care given in people's own homes. It is an executive non-dep-artmental public body, sponsored by the Department of Health & Social Care
Clinical Commissioning Group (CCG)	CCGs are clinically-led statutory NHS bodies, created following the Health and Social Care Act 2012, responsible for the planning and commissioning of health care services for their local area. CCGs are membership bodies, with local GP practices as the members
Clinical Governance	Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish
Commissioning	The process of planning, agreeing and monitoring services, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment
Control total	A figure calculated by NHSI, on a Trust by Trust basis, which represents the minimum level of financial performance, against which the the Trust's Board/ Governing Body and Chief Executives must deliver in 2018/19, and for which they will be held directly accountable
Cost Improvement Programme (CIP)	Sets out the savings that an NHS organisation plans to make to reduce its expenditure/increase efficiency. It is used to close the gap between the income received by the NHS body and expenditure incurred in any one year
Commissioning for Quality and Innovation (CQUIN)	Introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
Datix	The Trust's incident reporting and risk management system
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as

Term	Definition/explanation
	they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients
Elective treatment	Treatment that is not urgent and can be planned
Emergency Department (ED)	Also known as Accident and Emergency (A&E)
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience
Getting It Right First Time (GIRFT)	A national programme, led by frontline clinicians and designed to improve the quality of care within the NHS by reducing unwarranted variations. GIRFT tackles variations in the way services are delivered across the NHS, and shares best practice between trusts, identifying changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings
Hyper Acute Stroke Unit (HASU)	A dedicated Stroke unit bringing experts and equipment under one roof to provide world class treatment 24 hours a day
Integrated Care System (ICS)	ICSs brings together local organisations to redesign care and improve population health, creating shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
Inpatient	A person who stays in hospital for one or more nights
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an inpatient
Marginal Rate Emergency Tariff (MRET)	An adjustment made to the amount a provider of emergency services is reimbursed to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid a percentage of the national price for each patient admitted as an emergency over and above a set threshold.
NHS England (NHSE)	An executive non-departmental public body, sponsored by the Department of Health and Social Care, which leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care
NHS Improvement (NHSI)	The body responsible for overseeing NHS Trusts, and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable
Non-elective treatment	Treatment that is not planned, but requires admission to hospital

Term	Definition/explanation
Outpatient	A person who goes to a hospital for treatment or assessment, but does not stay overnight
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers
Patient experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care
Patient pathway	The route that a patient will take from entry into a hospital or other healthcare seeting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway)
Provider Sustainability Fund (PSF)	A fund held by NHS England and NHS Improvement that is available to providers when they that met their control total.
Referral to Treatment (RTT)	The waiting time calculated from the date the Trust receives a referral, to the date the patient either receives treatment or a decision is made that no treatment is required
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. Stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.

Financial statements:
2020-2021

NHS
Maidstone and Tunbridge Wells
NHS Trust

Thank you for your support

Miles Scott, Chief Executive

David Highton, Chair of the Trust Board

The Trust receives support and well wishes from patients, carers, stakeholders, volunteers, and fundraisers. This support is expressed in a varied number of ways, including compliments sent directly to the Trust; letters sent to the local media; comments posted on social media; participation in the Patient Experience Committee; attendance at Trust Board meetings and the Annual General Meeting and fundraising to buy much needed equipment, to name but a few. This support is highly valued by the Trust's staff and the Board - without this, the Trust's task would be far harder. Thank you all.

taking pride

MTW
exceptional people, outstanding care

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

www.mtw.nhs.uk

mymtwhealthcare

@mtw_nhs_trust

Search for: 'Maidstone and Tunbridge Wells NHS Trust'

@MTWnhs

@MTWnhs

Search for: 'Maidstone and Tunbridge Wells NHS Trust'

taking pride

Patient First – Respect – Innovation – Delivery – Excellence

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve the Annual Accounts, 2020/21	Chair of the Audit and Governance Committee

The Annual Accounts for 2020/21 are enclosed.

The Accounts, along with the External Auditors' findings, will be reviewed in detail at the Audit and Governance Committee on 23rd June 2021.

The Audit and Governance Committee will be asked to recommend that the Trust Board approves the Accounts, and a verbal update on the outcome of the Committee's review will be given at the Trust Board meeting.

Once approved, the Accounts will be signed, and submitted to the External Auditors for their opinion, the Trust will then submit via the NHSI portal and also post the original set to NHSI by noon Tuesday 29th June 2021.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 13/05/21 (pre-audit draft)
- Audit and Governance Committee, 23/06/21

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

To review and approve the Annual Accounts for 2020/21

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

Maidstone and Tunbridge Wells NHS Trust

Annual accounts for the year ended 31 March 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	496,048	457,588
Other operating income	4	68,148	55,468
Operating expenses	6.1	-550,300	-491,848
Operating surplus/(deficit) from continuing operations		**13,896**	**21,208**
Finance income	11	9	309
Finance expenses	12	-14,694	-15,729
PDC dividends payable		-1,285	-633
Net finance costs		**-15,970**	**-16,053**
Other gains / (losses)	13	16	73
Surplus / (deficit) for the year from continuing operations		**-2,058**	**5,228**
Surplus / (deficit) for the year		**-2,058**	**5,228**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-2,778	-1,663
Revaluations	17	1,930	76
Total comprehensive income / (expense) for the period		**-2,906**	**3,641**

Note - Adjusted financial performance (control total basis):

The Trust's deficit for 2020/21 was £2.1m. NHS England and Improvement excludes the impact of certain transactions - impairments, revaluations, capital grants and the net impact of "push stock" received from DHSC bodies - for the purposes of measuring NHS Trusts' financial performance. After adjusting for these transactions, the Trust's adjusted financial performance surplus for the year is £0.3m as shown in the table below. The table does not form part of the Statement of Comprehensive Income and represents a note to the accounts.

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	-2,058	5,228
Remove net impairments not scoring to the Departmental expenditure limit	4,699	2,748
Remove I&E impact of capital grants and donations	-730	-389
Remove 2018/19 post audit PSF reallocation (2019/20 only)	0	-583
Remove net impact of inventories received from DHSC group bodies for COVID response	-1,581	0
Adjusted financial performance surplus / (deficit)	**330**	**7,004**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	10,658	3,957
Property, plant and equipment	15	298,452	291,187
Receivables	19	2,816	2,925
Total non-current assets		**311,926**	**298,069**
Current assets			
Inventories	18	9,988	8,893
Receivables	19	17,314	35,156
Cash and cash equivalents	20	26,221	3,355
Total current assets		**53,523**	**47,404**
Current liabilities			
Trade and other payables	21	-49,436	-38,944
Borrowings	23	-6,830	-33,560
Provisions	24	-3,226	-1,726
Other liabilities	22	-2,454	-3,172
Total current liabilities		**-61,946**	**-77,402**
Total assets less current liabilities		**303,503**	**268,071**
Non-current liabilities			
Borrowings	23	-183,152	-189,879
Provisions	24	-1,800	-1,675
Total non-current liabilities		**-184,952**	**-191,554**
Total assets employed		**118,551**	**76,517**
Financed by			
Public dividend capital		261,345	216,405
Revaluation reserve		29,170	30,139
Income and expenditure reserve		-171,964	-170,027
Total taxpayers' equity		**118,551**	**76,517**

The notes on pages 6 to 49 form part of these accounts.

Name

Position Chief Executive Officer

Date 24th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**216,405**	**30,139**	**-170,027**	**76,517**
Impairments	0	-2,778	0	**-2,778**
Revaluations	0	1,930	0	**1,930**
Transfer to retained earnings on disposal of assets	0	-121	121	**0**
Public dividend capital received	44,940	0	0	**44,940**
Taxpayers' and others' equity at 31 March 2021	**261,345**	**29,170**	**-171,964**	**118,551**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**211,790**	**31,782**	**-175,311**	**68,261**
Taxpayers' and others' equity at 1 April 2019 - restated	**211,790**	**31,782**	**-175,311**	**68,261**
Impairments	0	-1,663	0	**-1,663**
Revaluations	0	76	0	**76**
Transfer to retained earnings on disposal of assets	0	-56	56	**0**
Public dividend capital received	4,615	0	0	**4,615**
Taxpayers' and others' equity at 31 March 2020	**216,405**	**30,139**	**-170,027**	**76,517**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,896	21,208
Non-cash income and expense:			
Depreciation and amortisation	6.1	13,828	13,022
Net impairments	7	4,699	2,748
Income recognised in respect of capital donations	4	-1,392	-890
(Increase) / decrease in receivables and other assets		18,784	-1,737
(Increase) / decrease in inventories		-1,095	-1,073
Increase / (decrease) in payables and other liabilities		7,710	9,218
Increase / (decrease) in provisions		1,624	944
Net cash flows from / (used in) operating activities		**58,054**	**43,440**
Cash flows from investing activities			
Interest received		9	309
Purchase of intangible assets		-3,160	-1,536
Purchase of PPE and investment property		-27,636	-13,199
Sales of PPE and investment property		16	73
Receipt of cash donations to purchase assets		251	890
Net cash flows from / (used in) investing activities		**-30,520**	**-13,463**
Cash flows from financing activities			
Public dividend capital received		44,940	4,615
Movement on loans from DHSC		-27,696	-19,082
Movement on other loans		-351	-372
Capital element of PFI, LIFT and other service concession payments		-5,349	-5,426
Interest on loans		-342	-1,387
Other interest		-5	-4
Interest paid on PFI, LIFT and other service concession obligations		-14,407	-14,370
PDC dividend (paid) / refunded		-1,458	-1,002
Net cash flows from / (used in) financing activities		**-4,668**	**-37,028**
Increase / (decrease) in cash and cash equivalents		**22,866**	**-7,051**
Cash and cash equivalents at 1 April - brought forward		**3,355**	**10,406**
Cash and cash equivalents at 1 April - restated		**3,355**	**10,406**
Cash and cash equivalents at 31 March	20	**26,221**	**3,355**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2.1 Going concern

The NHS Trust's annual report and accounts have been prepared on a going concern basis.

The DHSC GAM requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts stating:

"for non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and has prepared the 2020/21 accounts on a "going concern" basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

- The funding regime that has existed for 2020/21 is expected to continue for the first half of 2021/22. NHS organisations will submit a formal plan in May.

- The Trust has agreed its 2021/22 capital plans with the Kent and Medway STP which now manages the overall resource level within the patch. The Trust has submitted its five year capital plans to NHSI/E in April 2021.

- The Trust continues to fully participate in the STP planning and assurance process. The STP has developed its role as local system lead in ensuring that the patch organisations work collaboratively in delivering income and expenditure and capital control totals. The Trust is a key player in ICP and STP/ICS work on reconfiguring services in the patch for the future e.g. it is one of the selected sites for Hyper Acute Stroke Unit as part of the STP-wide Stroke services consultation.

- The Trust will have contracts in place for provision of healthcare services for 2020/21 albeit at this stage they will be at least in part block contract arrangements nationally determined in response to the C-19 pandemic. The Trust's main commissioner is NHS Kent & Medway CCG with other main sources of income from NHSE Specialist Commissioners, NHS East Sussex CCG, NHS West Sussex CCG, NHS Brighton and Hove CCG and NHS Surrey Heartlands CCG. The current financial regime provides certainty for income and cash flows in 2021-22 for at least the first half of the financial year.

- Following the conversion of the working capital loan to PDC in 2020/21 the Trust has no working capital loans and has not required any support during 2020/21 and not anticipating requiring support in 2021/22.

- The Trust does not consider that there are any material uncertainties to the going concern basis.

For these reasons, the Trust will prepare its Accounts using the going concern basis in line with the GAM guidance.

Note 1.2.2 Interests in other entities

The Trust does not have interests in subsidiaries, associates, joint ventures or joint operations and the Trust does not consolidate its charitable funds on the basis that the value is not material.

Note 1.3 Interests in other entities

The Trust does not have interests in subsidiaries, associates, joint ventures or joint operations and the Trust does not consolidate its charitable funds on the basis that the value is not material.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

PFI support income will be recognised as revenue when all, or substantially all, of the promised funding has been received by the Trust.

In 2020 to 2021 NHS providers have received reimbursement and top-up income in addition to amounts included in block contracts and system evelopes. This income is earned based on either incurring costs or other aspects of financial performance. In line with IFRS 15, such income should be accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Education Income

The Trust receives income from Health Education England (HEE) for education and training of medical and non-medical trainees as well as other associated training support costs. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligations are undertaken within the financial year and is as agree and invoiced to HEE, see note 4.

Non-Patient care services to other bodies

The Trust supplies a range of staff and goods to a range of customers, and also rents out facilities. For these services, revenue is recognised as and when performance obligations are satisfied during the period covered by the recharge

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2020/21. The rate remains at 3% from April 2021.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8.1 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives. In respect of buildings, the Trust has determined that it is appropriate to depreciate the component blocks of the two hospital sites separately, as this takes into consideration the age and condition of the asset components and their differing depreciation profile and follows the external valuation schedules. The individual elements (e.g. walls, floors, lifts, heating etc.) within these blocks are not deemed to be significant in relation to the block assets.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

The financial year 2020/21 is the first year following the five year cyclical valuation period. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desk top valuation at 31st March 2021. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in property plant and equipment notes 15 and 17.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust periodically reviews annually high value plant and machinery assets (net book value over £100k) to ensure these are held at the correct values and remaining useful lives. IT devices (PC's, Laptops and IPads) assets are also subject to annual review to update their current value in exisiting use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income. Any residual balance in the revaluation reserve in respect to an individual asset is transferred to the retained earnings reserve on disposal of the asset.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.

The sale must be highly probable ie:
- Management are committed to a plan to sell the asset
- An active programme has begun to find a buyer and complete the sale
- The asset is being actively marketed at a reasonable price
- The sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- The actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.8.2 Private Finance Initative (PFI)

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Services received

The fair value of services received in the year is recorded under the relevant expenditure within 'operating expenses' in the Statement of Comprehensive Income.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	60
Plant & machinery	2	15
Transport equipment	5	20
Information technology	3	10
Furniture & fittings	10	20

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

• the Trust intends to complete the asset and sell or use it;

• the Trust has the ability to sell or use the asset;

• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and

• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	2	7
Software licences	3	5

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust does not have any embedded derivatives that have different risks and characteristics to the host contracts; therefore the Trust does not have any financial assets/liabilities at fair value through profit and loss

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust has used historic data for the last two years to assess the expected credit loss rates that should be applied to trade debtor categories, taking into account the materiality of debtor classes. For 2020/21 the Trust has reassessed the ageing debt classes for the main categories of trade debtor and assessed their expected credit loss characteristics in the light of the current economic situation due to the C-19 pandemic. The Trust has revised its assessment to provide for all main trade classes with debt balances over 60 days (2019-20 over 180 days). The exception to this are Direct Debits where debtors are repaying in accordance to a repayment plan and therefore this is a zero credit loss assessment; overseas visitors and any companies in liquidation are provided in full as soon as the debt is recognised. For 2021/22 the Trust will continue to assess these categories and will amend as necessary.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	-0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) Donated and grant funded assets;
(ii) Average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility;
(iii) Approved expenditure on COVID-19 capital assets;
(iv) Assets under construction for nationally directed schemes and
(v) Any PDC dividend balance receivable or payable.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

The CRC Energy Efficiency Scheme (formally known as the "Carbon Reduction Commitment") was closed on the 31st March 2019. It has been replaced by the Climate Change Levy (CCL).

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases - The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity is from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 regarding estimated increases in capital additions commencing in 2022/23. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation based on existing information.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	49,553
Additional lease obligations recognised for existing operating leases	-48,282
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2022	**1,271**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	-4,802
Additional finance costs on lease liabilities	-588
Lease rentals no longer charged to operating expenditure	5,086
Other impact on income / expenditure	31
Estimated impact on surplus / deficit in 2022/23	**-273**
Estimated increase in capital additions for new leases commencing in 2022/23	**0**

Note 1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements, these exclude accounting estimations. For 2020/21 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes:

The financial statements have been prepared on a going concern basis as set out in note 1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future contractual income and cost improvements.

Assets relating to land and buildings were subject to a desktop valuation as at 31st March 2021, completed on an "modern equivalent asset" basis. An existing use value alternative was used which assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service provision as the existing asset. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area than the existing assets which reflects the challenges healthcare providers face when utilising NHS Estate). under the Trust's alternative modern equivalent asset valuation, the modern alternative hospitals are of the same service potential and in the same locations but on a smaller physical footprint to serve the catchment area of population.

The Trust's PFI contract was judged at inception as meeting the IFRIC 12 principles as a service concession arrangement so that the Trust immediately recognised an infrastructure asset and a corresponding finance lease liability, under IAS 17. No change to the underlying contract has subsequently occurred to alter that judgement and the concession continues to be recognised on-SoFP.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Material areas including estimates within the 2020/21 accounts are as follows:

Property, Plant and Equipment valuation including PFI infrastructure assets; estimation of the valuation of Property and Land is based upon professional valuer methodologies for applying modern equivalent asset concepts to the estimation of depreciated replacement cost. This methodology assumes a modern asset equivalent (MEA) approach to valuation of Trust's specialised assets, with replacement buildings being of the same service potential. Inherent within the MEA valuation approach, using the depreciated replacement cost, is the Build Cost Information Service Indices (BCIS) input. The carrying value of assets valued under DRC approach was £240m (part of the £253m land and buildings disclosed in note 15). The valuer uses the latest BCIS information closest to the date of valuation in valuing the Trust's specialised assets. Significant changes in the BCIS indices used valuations would result in a significantly lower or higher carrying value of building assets held by the Trust. For example a 10% +- percentage change in the building assets would result in a decrease or increase in asset values by £8.5m over the next financial year with an estimated decrease/increase to depreciation of £0.2m.

Note 2 Operating Segments

Maidstone and Tunbridge Wells NHS Trust reports under a single segment of Healthcare. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that the overall financial and operational performance of the Trust is measured.

The Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare Income, but this does not reflect current Trust Board reporting practice which reports on both the aggregate Trust position and by Directorate. Each of the significant directorates are deemed to have similar economic characteristics under the Healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS 8.

The Trusts income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups and NHS England. This accounts for 86% of the Trust total income. Disclosure of all material transactions with related parties is included within note 33 to these financial statements. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	Restated 2019/20 £000
Acute services		
Block contract / system envelope income	465,001	388,543 *
High cost drugs income from commissioners (excluding pass-through costs)	2,575	44,432
Other NHS clinical income	4,207	5,267
All services		
Private patient income	677	1,322
Additional pension contribution central funding	12,824	11,381
Other clinical income	10,764	6,643
Total income from activities	**496,048**	**457,588**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. The £388.5m value has been restated from 2019/20 where this was previously separated by income stream e.g: elective/non-elective income.

In line with NHSE/I reporting guidance, all High Cost Drugs' (HCD's) not subject to pass-through arrangement have been reported within the Block Contract/System Envelope income for 2020/21, the remaining HCD's that are charged on a cost and volume basis during the second half of the year have continued to be reported within the High Cost Drugs income from Commissioners' line, these cover some Specialised Commissioned Drugs, Cancer Drugs Fund and HEp C Drugs. Therefore the majority of the HCD income in 2020/21 is reported within the block contract line whereas it was reported under High Cost Drugs in 2019/20.

The employer pension contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding of £12.8m have been recognised in these accounts.

The increased movement in 'other clinical income' is in line with national reporting guidance and relates to additional funding to cover the Trusts annual leave accrual £4.7m.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	104,378	96,528
Clinical commissioning groups	382,002	349,459
Other NHS providers	3,442	3,636
NHS other	1	0
Local authorities	4,177	4,563
Non-NHS: private patients	677	1,322
Non-NHS: overseas patients (chargeable to patient)	189	378
Injury cost recovery scheme	326	930
Non NHS: other	856	772
Total income from activities	**496,048**	**457,588**
Of which:		
Related to continuing operations	496,048	457,588

The income movement in Clinical Commissioning Groups (CCG) income is a result of the increased funding given to the Trust to support the covid-19 pandemic response and is to cover growth, inflationary pressures and additional top-up funds to cover the increased costs during the pandemic.

The reduction in Income from Private Patients between years is a result of Covid-19 and reducing the Trusts ability to treat private patients.

NHS injury cost recovery income is subject to a provision for impairment of receivables, previously the Trust has calculated this estimate using historical information for each main site. For 2020/21 the Trust has re-evaluated this process and for all prior years debt this has been provided for in full and debt relating to 2020/21 the Trust has reverted back to using the DHSC given rate of 22.43%.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	£000
Income recognised this year	189	378
Cash payments received in-year	138	182
Amounts added to provision for impairment of receivables	217	57
Amounts written off in-year	11	0

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,347	0	**1,347**	1,459	0	**1,459**
Education and training	11,634	513	**12,147**	10,420	268	**10,688**
Non-patient care services to other bodies	14,189	0	**14,189**	15,042	0	**15,042**
Provider sustainability fund (2019/20 only)	0	0	**0**	8,234	0	**8,234**
Marginal rate emergency tariff funding (2019/20 only)	0	0	**0**	6,199	0	**6,199**
Reimbursement and top up funding	29,038	0	**29,038**	0	0	**0**
Receipt of capital grants and donations	0	1,392	**1,392**	0	890	**890**
Charitable and other contributions to expenditure	0	7,743	**7,743**	0	0	**0**
Rental revenue from operating leases	0	107	**107**	0	187	**187**
Other income	2,185	0	**2,185**	12,769	0	**12,769**
Total other operating income	**58,393**	**9,755**	**68,148**	**54,123**	**1,345**	**55,468**
Of which:						
Related to continuing operations			68,148			55,468

Provider Sustainability and Transformation Funding (PSF) and Marginal rate emergency tariff (MRET) ceased at the end of 2019-20.

Included within the receipt of government grants and donations of £1.39m are £1.1m donated equipment from DHSC relating to the covid pandemic. This includes £0.5m on ventilators and monitors, £0.4m on testing equipment and £0.3m on imaging equipment.

Included within charitable and other contributions to expenditure is £7.7m relating to the consumables (inventory) additions from DHSC group bodies donated to the Trust.

Further analysis of "other income"

	2020/21	2019/20
	£000	£000
PFI support income	**0**	8,000
Car Parking income	**350**	2,456
Catering Income	**320**	952
Other	**1,515**	1,361
	2,185	12,769

PFI Support - Due to Covid-19 the financial funding regime in 2020/21 changed, the Trust received funding based on block payments which were calculated based on expenditure. The £8m PFI support income was not received but the shortfall was covered by the block funding which the Trust received, this block payment is reported within patient care income in note 3.2

Car parking - During the pandemic national guidance stated that staff car parking should be free, this reduction and the reduction is the number of patients and visitors attending the hospital resulted in a reduction of c£2.1m in income.

Catering income - the number of patients and visitors who attended the hospital sites in 2020/21 was reduced impacting on the footfall within the restaurants. This reduction and the implementation of various staff wellbeing support packages during the pandemic resulted in a £0.6m reduction in catering income.

Other - the Trust increased the provision held for clinical pensions by £0.2m in 2020/21. This increase was due to a change in discount rate, national guidance confirmed this increase would be offset by additional income

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	0	2,580

Due to the finance regime for 2020-21 where NHS providers and Commissioners transact via block contract arrangement, the provider's entitlement to income does not vary based on the treatment of individual patients. The prior year value of £2.6m relates to Maternity Pathway, however due to the block arrangements NHSE guidance results in Trusts returning this income back to the Commissioners.

Note 5.2 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2020/21	2019/20
	£000	£000
Income	669	3,325
Full cost	-2,334	-2,888
Surplus / (deficit)	**-1,665**	**437**

Majority of this income is through Car Parking and Catering, however due to the pandemic the Trust did not allow visitors in the hospital therefore the income for both car parking and catering reduced compared to the previous year. The Trust under national guidance gave free car parking to all staff across the hospital sites. The Trust was unable to avoid the majority of the costs as they are fixed in nature.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,302	6,923
Purchase of healthcare from non-NHS and non-DHSC bodies	6,381	15,798
Staff and executive directors costs	342,645	299,931
Remuneration of non-executive directors	126	94
Supplies and services - clinical (excluding drugs costs)	45,234	37,005
Supplies and services - general	7,206	5,238
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,880	55,034
Inventories written down	673	0
Consultancy costs	3,855	625
Establishment	2,465	1,657
Premises	20,556	17,820
Transport (including patient travel)	1,994	2,522
Depreciation on property, plant and equipment	12,409	11,813
Amortisation on intangible assets	1,419	1,209
Net impairments	4,699	2,748
Movement in credit loss allowance: contract receivables / contract assets	757	471
Change in provisions discount rate(s)	184	35
Audit fees payable to the external auditor		
audit services- statutory audit	99	84
other auditor remuneration (external auditor only)	0	9
Internal audit costs	104	147
Clinical negligence	19,070	17,558
Legal fees	272	330
Insurance	539	453
Education and training	3,466	1,884
Rentals under operating leases	4,804	3,372
Redundancy	189	0
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	5,417	5,199
Car parking & security	2,131	1,075
Hospitality	0	9
Losses, ex gratia & special payments	585	17
Other services, eg external payroll	350	308
Other	3,489	2,480
Total	**550,300**	**491,848**
Of which:		
Related to continuing operations	550,300	491,848

Purchase of healthcare from Non-NHS and Non DHSC bodies relates to the Trusts role as Prime Provider including related Independent outsourcing costs. However for 2020/21 this went under the National Contract therefore not paid by the Trust.

Included within supplies and services - clinical are £5.4m (2019-20 £nil) of consumables donated from DHSC group bodies for Covid response

The inventories written down value of £0.7m (2019-20 £nil) relates to consumables donated from DHSC group bodies for Covid response. The £0.7m relates to the difference of the lower of the market values held at the financial year end and the unit prices held for each personal protective equipment item. All the pricing information was provided by the DHSC.

The audit fees included within Note 6.1 above are reported as the gross position, the value excluding VAT for 2020/21 is £82.1k (2019/20 £70k).

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
8. Other non-audit services not falling within items 2 to 7 above	0	9
Total	**0**	**9**

The £9k reported in 2019/20 note 6.2 relates to the audit of the Trusts quality accounts. For 2020/21 there is no requirement to audit the quality accounts. As the Trust does not consolidate its charitable funds (see note 1.3) the fee for the independent examination of the charitable fund accounts is charged directly to those funds. The total charitable funds income and costs are reported in note 33 as a related party.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,699	2,748
Total net impairments charged to operating surplus / deficit	**4,699**	**2,748**
Impairments charged to the revaluation reserve	2,778	1,663
Total net impairments	**7,477**	**4,411**

The Trust commissioned its independent professional valuers to undertake a desktop valuation as at the 31st March 2021 to support its assessment of year end property valuations. The result of the valuation has been a net decrease in property values leading to a net impairment of £3.4m charged to the Income and Expenditure account. In addition an assessment of the current value in exisitng use has been undertaken for IT devices (PCs, Laptops and IPads) has been carried out based on the valuation model used by the Trust, this is in accordance with the Trust's policy 1.9. For 2020/21 the assessment totalled £1.3m (2019-20 £0.565m). These two impairments make up the change in market price figure in note 7.

The net impairments charged to the revaluation reserve is an in-year impairment against the business reserve of £4.3m less reversal of previous balance sheet impairment (£1.6m).

Both the gross impairments and the reversals are disclosed in note 15.3.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	255,636	219,594
Social security costs	26,419	23,565
Apprenticeship levy	1,277	1,157
Employer's contributions to NHS pensions*	42,246	37,561
Pension cost - other	76	21
Temporary staff (including agency)	19,490	20,109
Total gross staff costs	**345,144**	**302,007**
Recoveries in respect of seconded staff	0	0
Total staff costs	**345,144**	**302,007**
Of which		
Costs capitalised as part of assets	2,310	2,076

Further information on staff benefits by category of staff, exit packages and staff sickness absence is reported in the remuneration and staff section of the Trust's annual report.

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% totalling £12.8m (2019-20 £11.4m excluding administration charge) from 1 April 2020. For 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on provider's behalf. The full cost and related funding have been recognised in these accounts.

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £12k (0k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Included within the employee benefits note are employer contributions to NHS Pension scheme £42.2m (£37.6m 2019/20) and other pensions schemes which are NEST and 247 time NEST totalling £76k (£21k 2019/20).

The Trust participates in the National Employees Savings trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate of 3% for 2020/21 and remains at 3% for 2021/22. Trust contributions under the NEST scheme for the 2020/21 financial year totalled £23k (£21k 2019/20).

Note 10 Operating leases

Note 10.1 Maidstone and Tunbridge Wells NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Maidstone And Tunbridge Wells NHS Trust is the lessor.

The Trust leases an element of land on the Maidstone Hospital site to a day nursery contractor and also receives income from various shops in the reception area of Maidstone Hospital.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	107	187
Total	**107**	**187**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	188	187
- later than one year and not later than five years;	751	748
- later than five years.	891	1,001
Total	**1,830**	**1,936**

Note 10.2 Maidstone and Tunbridge Wells NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Maidstone and Tunbridge Wells NHS Trust is the Lessee.

The top five material leases are given in detail below:

Apogee - Lease of photocopiers and printers under a managed service arrangement, £657k (£707k 2019-20). The contract is expected to complete in March 2024.

MGIF - lease of Springwood Road staff accommodation. The Trust entered into an operating lease arrangement on the 29th March 2019 with MGIF including an initial leaseback of the existing staff residences whilst planning permission is sought by the landlord to redevelop the site, including the provision of new staff accommodation. The overarching lease is structured in different tiers, with the initial period phasing into a 40 year primary term lease on the new accommodation, structured into two interlinked lease periods, with an ultimate option for the Trust to acquire the property for fair value at the end of the arrangement. The current rent is £550.8k per annum; the rent for the new accommodation will be £960k per annum, subject to RPI uplifts annually, with a cap and collar arrangement. The Trust manages the tenancies with staff and receives the sublease rentals.

WGIF - lease of 32 High Street, Pembury for staff residences, rental of £240k per annum, subject to 5 yearly RPI reviews. The Trust entered into a 25 year operating lease on the 21st February 2019 expiring in February 2044, with a landlord only break clause in February 2033. The Trust manages the tenancies with staff and receives the sublease rentals.

MCH Ltd - operating lease of a modular Acute Medical Unit at Maidstone Hospital for an 8 year term that commenced on the 20th February 2020. The annual rental is a fixed at £993k.

MCH Ltd - two individual operating leases for single storey modular car parks, one at Maidstone Hospital and one at Tunbridge Wells Hospital. The arrangement for each lease is for seven years and commenced on the 31st March 2020. The annual rent for the Maidstone car park is £379k and for Tunbridge Wells is £313k. Both rental levels are fixed for the period.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	5,325	3,998
Less sublease payments received	-521	-626
Total	**4,804**	**3,372**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,630	5,013
- later than one year and not later than five years;	16,082	16,945
- later than five years.	47,577	47,234
Total	**69,289**	**69,192**
Future minimum sublease payments to be received	-44,027	-44,715

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	9	309
Total finance income	**9**	**309**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	281	1,354
Interest on late payment of commercial debt	5	4
Main finance costs on PFI and LIFT schemes obligations	9,816	10,110
Contingent finance costs on PFI and LIFT scheme obligations	4,591	4,260
Total interest expense	**14,693**	**15,728**
Unwinding of discount on provisions	1	1
Other finance costs	0	0
Total finance costs	**14,694**	**15,729**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	5	4

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	16	73
Total gains / (losses) on disposal of assets	**16**	**73**
Total other gains / (losses)	**16**	**73**

All gains on disposals of assets relates to disposals of Plant Property and Equipment, primarily on medical equipment and vehicles

Note 14.1 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**2,208**	**9,743**	**0**	**11,951**
Additions	0	254	2,906	**3,160**
Reclassifications/ transfers from Assets Under Construction	49	608	4,303	**4,960**
Disposals / derecognition	0	-38	0	**-38**
Valuation / gross cost at 31 March 2021	**2,257**	**10,567**	**7,209**	**20,033**
Amortisation at 1 April 2020 - brought forward	**612**	**7,382**	**0**	**7,994**
Provided during the year	276	1,143	0	**1,419**
Disposals / derecognition	0	-38	0	**-38**
Amortisation at 31 March 2021	**888**	**8,487**	**0**	**9,375**
Net book value at 31 March 2021	**1,369**	**2,080**	**7,209**	**10,658**
Net book value at 1 April 2020	**1,596**	**2,361**	**0**	**3,957**

The debit value of £4.960m on reclassifications/transfers from assets under construction relates to items transferred from Tangible assets, see note 15.1

Note 14.2 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**718**	**9,412**	**0**	**10,130**
Valuation / gross cost at 1 April 2019 - restated	**718**	**9,412**	**0**	**10,130**
Additions	1,205	331	0	**1,536**
Reclassifications	285	0	0	**285**
Valuation / gross cost at 31 March 2020	**2,208**	**9,743**	**0**	**11,951**
Amortisation at 1 April 2019 - as previously stated	**527**	**6,258**	**0**	**6,785**
Amortisation at 1 April 2019 - restated	**527**	**6,258**	**0**	**6,785**
Provided during the year	85	1,124	0	**1,209**
Amortisation at 31 March 2020	**612**	**7,382**	**0**	**7,994**
Net book value at 31 March 2020	**1,596**	**2,361**	**0**	**3,957**
Net book value at 1 April 2019	**191**	**3,154**	**0**	**3,345**

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**12,414**	**245,957**	**0**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Additions	0	4,721	0	8,260	8,594	236	8,370	0	**30,181**
Impairments charged to operating expenses	0	-4,046	0	0	0	0	-1,262	0	**-5,308**
Impairments charged to the revaluation reserve	0	-4,336	0	0	0	0	0	0	**-4,336**
Reversal of impairments credited to operating expenses	0	609	0	0	0	0	0	0	**609**
Reversal of impairments credited to the revaluation reserve	35	1,523	0	0	0	0	0	0	**1,558**
Revaluations	5	-4,080	0	0	0	0	0	0	**-4,075**
Reclassifications/ transfers from Assets Under Construction	0	461	0	-7,925	2,078	0	426	0	**-4,960**
Disposals / derecognition	0	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Valuation/gross cost at 31 March 2021	**12,454**	**240,809**	**0**	**9,132**	**91,252**	**610**	**20,130**	**2,797**	**377,184**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**110**	**0**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Provided during the year	0	6,060	0	0	4,865	0	1,232	252	**12,409**
Revaluations	0	-6,005	0	0	0	0	0	0	**-6,005**
Disposals / derecognition	0	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Accumulated depreciation at 31 March 2021	**0**	**165**	**0**	**0**	**64,161**	**374**	**11,406**	**2,626**	**78,732**
Net book value at 31 March 2021	**12,454**	**240,644**	**0**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**
Net book value at 1 April 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

note - the adjustments within the disposal/derecognition line relates to housekeeping exercise clearing zero Net Book Value assets for previously disposed PPE. For further analysis on Assets under Construction can be found in Note 15.3.

The credit value of £4.960m on reclassifications/transfers from assets under construction relates to items on Intangible assets, see note 14

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Valuation / gross cost at 1 April 2019 - restated	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Additions	0	2,391	0	8,652	3,293	0	1,019	0	**15,355**
Impairments	0	-6,391	0	0	0	0	-565	0	**-6,956**
Reversals of impairments	300	2,245	0	0	0	0	0	0	**2,545**
Revaluations	0	-19,940	0	0	0	0	0	0	**-19,940**
Reclassifications	0	0	0	-5,727	4,601	0	841	0	**-285**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Valuation/gross cost at 31 March 2020	**12,414**	**245,957**	**0**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Accumulated depreciation at 1 April 2019 - as previously stated	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Accumulated depreciation at 1 April 2019 - restated	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Provided during the year	0	6,074	0	0	4,384	4	1,095	256	**11,813**
Revaluations	0	-20,016	0	0	0	0	0	0	**-20,016**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Accumulated depreciation at 31 March 2020	**0**	**110**	**0**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Net book value at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**
Net book value at 1 April 2019	**12,114**	**253,600**	**0**	**5,872**	**17,774**	**4**	**2,222**	**679**	**292,265**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	12,454	88,379	0	9,132	24,643	236	8,646	171	**143,661**
On-SoFP PFI contracts and other service concession arrangements	0	152,202	0	0	0	0	0	0	**152,202**
Owned - donated/granted	0	63	0	0	2,448	0	78	0	**2,589**
NBV total at 31 March 2021	**12,454**	**240,644**	**0**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	12,414	90,054	0	8,797	19,587	0	2,331	423	**133,606**
On-SoFP PFI contracts and other service concession arrangements	0	155,458	0	0	0	0	0	0	**155,458**
Owned - donated/granted	0	335	0	0	1,697	0	91	0	**2,123**
NBV total at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

Assets under construction (AUC) in year additions of £11.1m relates to Plant & Machinery £6m, IT £2.4m, Intangible of £2.9m and Transport £0.2m. These are assets at 31.3.21 are classed as "work in progress" and were not available for use at the end of 2020-21.

The main AUC projects are: 1) Electronic Patient Records System - £6.9m; 2) Linear Accelerator Machine £2.5m; 3) MRI £1.3m; 4) IT network infrastructure £1.3m; 5) Interventinal radiology £0.7m; 6) Ophthalmology Services £0.7m; 7) Breast Screening Equipment £0.7m and 8) CT Simulator for Radiotherapy £0.6m,

The Trust spent £31.7m on tangible assets and £0.2m on intangible assets from its capital resource in 2020-21. The main items were as follows: Covid-19 IT & equipment (e.g. ventilators), £3m; Electronic Patient Record project £2.9m; ICT Devices replacement project £5.5m plus £0.7m for reset and recovery; Network infrastructure £2.7m; Kent Care record and Think 111 projects £1.1m; expenditure of £2.8m in Urgent & Emergency Care improvements; £2.9m of estates backlog, renewal and PFI Lifecycle. Medical equipment included: £2.3m on a replacement Linear Accelerator machine for radiotherapy at Canterbury; £1.8m on endoscopy equipment; £1.1m replacing major breast screening equipment; £0.9m updating and expanding critical care capacity and testing equipment (supporting C-19 treatment); £0.7m renewing the Interventional Radiology equipment at Maidstone; £0.6m for a new CT simulator for cancer patients; £0.7m for ophthalmology equipment supporting the service transferred from Moorfields Hospital; and £2.0m of general Trust wide equipment replacement. In addition £1.4m of donated capital was recognised in the year which is described in note 16.

Note 16 Donations of property, plant and equipment

In the financial year 2020-21 the Trust recognised donated assets of £1.4m including Trust purchased and centrally procured loan equipment. The Trust acquired three assets from charitable funds and grants totalling £0.3m; of which the most significant was a prone biopsy table for £0.2m. The remaining balance relates to assets loaned to the Trust from DHSC to support clinical teams with Covid-19. These assets will be transferred formally to the Trust in 2021-22 (assuming the Trust wishes to retain them) and all Trusts were instructed to account for these assets within 2020-21 as donated assets.

The most significant of these loan equipment's are 9 ventilators £0.3m, testing equipment £0.4m, mobile x-rays £0.3m.

Note 17 Revaluations of property, plant and equipment

The Trust's depreciation on tangible assets (including donated) in the year was £12.4m and amortisation for intangible assets £1.4m.

The Trust has carried out housekeeping exercise on its zero valued assets held in its asset register. Throughout 2020-21 the Trust reviewed these assets and de-recognised any zero valued assets (excluding Build and Land) that the Trust confirmed as having been disposed. Going forward the Trust will continue to review any zero valued assets held.

The previous financial year a full valuation was undertaken in accordance with the five year cyclical valuation period. in keeping with the Trust previous practice a desktop valuation was commissioned from independent professional valuers, Montagu Evans LLP. This was undertaken on the Trust's Land and Building assets as at 31st March 2021. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS.

Specialist properties (main hospitals) have been valued on Depreciation Replacement Cost (DRC) using the modern Equivalent Assets (MEA) valuation concept and taking into account the Trust's previous approach to the application of MEA e.g. the PFI property valued excluding recoverable VAT. Non specialised buildings and land have been valued on an Existing Use Value (EUV) basis in line with RICS guidelines.

The 31st March 2021 valuation resulted in an overall decrease in the carrying value of the Trust's Land and Property assets as at the 31st March of £4.3m, of which (£4m) is an in year charge to I&E impairments and £0.6m reversed previous I&E impairments: both of these are reflected in operating expenses. (£4.3m) relates to an in year impairment charge to the revaluation reserve and £1.6m reversed previous impairments taken to the revaluation reserve. The downward valuations are driven by an overall reduction in the BCIS indices reflecting the market. However, for some component assets driven by specific BCIS elements there was an increase of £1.9m with no previous reversal to the revaluation reserve. The valuer considered the remaining useful economic lives of the assets taking into account backlog and capital work undertaken between valuations, and the age and condition of the properties.

The valuer has reported that at the valuation date property markets are functioning sufficiently to provide an adequate quantum of market evidence on which to base the opinions of value. Therefore, the valuation is not reported as being subject to a "material valuation uncertainty" as it was in 2019-20.The valuer has continued to exercise professional judgement in providing the valuation; the Trust has reviewed and challenged the valuation in detail and is satisfied that this remains the best information to the Trust.

Fixtures and Fittings are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has reviewed its plant and machinery assets to ensure that both the value and the remaining lives are held at the correct values. An assessment of current value in exisiting use of IT devices (PCs, Laptops and IPads) assets has been carried out based on a valuation model as advised by Trust experts, this is in accordance with the Trust's policy 1.9

Note 18 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	3,209	3,332
Consumables	1,089	975
Consumables donated from DHSC group	1,581	0
Energy	108	108
Other	4,001	4,478
Total inventories	**9,988**	**8,893**

Inventories recognised in expenses for the year were £56,932k (2019/20: £57,154k). Write-down of inventories recognised as expenses for the year were £673k (2019/20: £0k).

The inventories written down value of £0.7m (2019-20 £nil) relates to consumables donated from DHSC group bodies for Covid response. The £0.7m relates to the difference of the lower of the market values held at the financial year end and the unit prices held for each personal protective equipment item. All the pricing information was provided by the DHSC.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,690k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables**	7,239	27,526
Capital receivables	0	107
Allowance for impaired contract receivables / assets*	-1,358	-1,556
Prepayments (non-PFI)	5,708	4,299
PDC dividend receivable	1,136	963
VAT receivable	3,702	2,424
Other receivables	887	1,393
Total current receivables	**17,314**	**35,156**
Non-current		
Contract receivables	1,474	1,471
Allowance for impaired contract receivables / assets*	-924	0
PFI lifecycle prepayments (Revenue variations)	202	205
PFI lifecycle prepayments (Capital)	999	339
Other receivables - Clinician Pension	1,065	910
Total non-current receivables	**2,816**	**2,925**
Of which receivable from NHS and DHSC group bodies:		
Current	5,769	24,678
Non-current	1,065	910

The majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The calculation for the allowance of other impaired receivables has been amended to reflect the change in IFRS 9 accounting standards for provision of expected credit losses. Please see note 19.2 for further information.

* For 2020/21 the allowance for impaired contract receivables has been split between non-current and current in respect to RTA CRU receivables. This was not required for 2019/20. For further details on allowance for impaired receivables please see note 19.2.

** The variance between years for contract receivables is due to the new finance regime implemented during Covid 19. To ensure the flow of funds throughout NHS organisations; NHSE Guidelines recommended fixed charges between provider to providers therefore resulting in a reduction of aged debtor balances.

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,556**	**0**	**1,398**	**0**
Allowances as at 1 April - restated	**1,556**	**0**	**1,398**	**0**
New allowances arising	1,403	0	904	0
Reversals of allowances	-646	0	-433	0
Utilisation of allowances (write offs)	-31	0	-313	0
Allowances as at 31 Mar 2021	**2,282**	**0**	**1,556**	**0**

Following the implementation of IFRS 9 in 2018-19 the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised. This is assessed by looking at classes of debtor with common credit characteristics.

The expected credit loss is only applied to trade debtors. NHS organisation are excluded from the calculation as NHS debt is considered to be part of "intra-company" transactions. It does also apply to Local Authorities.

Under IFRS 9 the Trust attributed the trade debtors into six categories grouped by similar characteristics with assessment based on prior year debt write off levels. Due to Covid 19 and the heightened risk to the economy the Trust has taken a prudent view and for all trade debt categories these are now fully provided for over 60 days

Injury Cost recovery – the Trust decided to adopt its own methodology over 5 years ago and moved away from the DHSC given bad debt provision rate to calculate its own rate. The calculation was based looking at historic data for both the Maidstone and Tunbridge Wells site and comparing the amount of write offs to the initial claim. Given the heightened risk to the economy, for 2021 the Trust has provided in full for all prior year debt, and for 2020/21 the Trust will has reverted back to using the DHSC given rate of 22.43%.

Note 19.3 Exposure to credit risk

The Trust adheres to best practice in credit control activities which includes referral to an external debt collection agency and formal litigation procedures if required to trace debtors and seek to recover overdue debt. In addition the majority of the Trust's revenue comes from contracts with other public sector bodies which in turn are supported by underlying contractual agreements and specific payment terms. As a result, it is deemed that the Trust has a low exposure to credit risk.

Expected credit losses for contract and other receivables are reviewed on a regular basis taking account of historic, current and forecast information to determine a sufficient and appropriate level of allowance for impaired contract and other receivables.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**3,355**	**10,406**
Prior period adjustments		0
At 1 April (restated)	**3,355**	**10,406**
Net change in year	22,866	-7,051
At 31 March	**26,221**	**3,355**
Broken down into:		
Cash at commercial banks and in hand	23	24
Cash with the Government Banking Service	26,198	3,331
Total cash and cash equivalents as in SoFP	**26,221**	**3,355**
Total cash and cash equivalents as in SoCF	**26,221**	**3,355**

The high closing cash balance for 2020/21 relates to £8.6m SLA income adjustment to CCG, £4.8m annual leave funding received to fund the accrual which will be released in 2021/22 and £5.4m to fund capital invoices received in April which relate to 2020/21 capital programme.

Note 21 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	13,595	12,615
Capital payables	6,110	4,046
Accruals	26,648	15,194
Social security costs	5	1,520
Other taxes payable	0	2,919
Other payables	3,078	2,650
Total current trade and other payables	**49,436**	**38,944**
Of which payables from NHS and DHSC group bodies:		
Current	11,291	7,659

Included within Accruals value above is an estimate for annual leave untaken of £4.7m.

Note 22 Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	2,454	3,172
Total other current liabilities	**2,454**	**3,172**

Note 23.1 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from DHSC	985	27,768
Other loans	443	443
Obligations under PFI, LIFT or other service concession contracts	5,402	5,349
Total current borrowings	**6,830**	**33,560**
Non-current		
Loans from DHSC	5,432	6,406
Other loans	949	1,300
Obligations under PFI, LIFT or other service concession contracts	176,771	182,173
Total non-current borrowings	**183,152**	**189,879**

Within 2020/21 the Trust received £26.1m Public Dividend Capital to repay the working capital loans from DHSC.

The Trust also has Salix loans total value of £1.4m which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. These loans are repayable over 5 years and is interest free. Salix Finance Ltd provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills.

Under IFRS 9 the loan values also include their associated interest charges.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**34,174**	**1,743**	**0**	**187,522**	**223,439**
Cash movements:					
Financing cash flows - payments and receipts of principal	-27,696	-351	0	-5,349	**-33,396**
Financing cash flows - payments of interest	-342	0	0	-9,816	**-10,158**
Non-cash movements:					
Application of effective interest rate	281	0	0	9,816	**10,097**
Carrying value at 31 March 2021	**6,417**	**1,392**	**0**	**182,173**	**189,982**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**53,289**	**2,115**	**0**	**192,948**	**248,352**
Prior period adjustment	0	0	0	0	**0**
Carrying value at 1 April 2018 - restated	**53,289**	**2,115**	**0**	**192,948**	**248,352**
Cash movements:					
Financing cash flows - payments and receipts of principal	-19,082	-372	0	-5,426	**-24,880**
Financing cash flows - payments of interest	-1,387	0	0	-10,110	**-11,497**
Non-cash movements:					
Application of effective interest rate	1,354	0	0	10,110	**11,464**
Carrying value at 31 March 2020	**34,174**	**1,743**	**0**	**187,522**	**223,439**

Note 24 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	2019/20 clinicians' pension reimbursement	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**464**	**391**	**930**	**1,616**	**3,401**
Change in the discount rate	22	0	162	0	**184**
Arising during the year	32	771	0	718	**1,521**
Utilised during the year	-24	-11	0	0	**-35**
Reversed unused	0	-46	0	0	**-46**
Unwinding of discount	1	0	0	0	**1**
At 31 March 2021	**495**	**1,105**	**1,092**	**2,334**	**5,026**
Expected timing of cash flows:					
- not later than one year;	25	1,105	27	2,069	**3,226**
- later than one year and not later than five years;	99	0	59	86	**244**
- later than five years.	371	0	1,006	179	**1,556**
Total	**495**	**1,105**	**1,092**	**2,334**	**5,026**

Pension Injury Benefit costs relates to two ill health injury benefits calculated by current payment made by NHS Pensions Agency adjusted for average life expectancy using tables published by the National Statistics Office. Legal claims include estimates notified by NHS Resolution.

Legal claims are notified at year end to the Trust from NHS Resolution and other solicitors that the Trust engages with.

"Other" includes the provision for dilapidations of leased properties of £0.7m and equipment of £1.5m.

The Clinicians' Pension Scheme relates to clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the previous tax year (2019-20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme. The NHSE have used the information provided by Government Actuary's Department (GAD) and Business Services Authority (BSA) and calculated a national 'average discounted value per nomination'. The Trust has followed the guidance and based its provision on this estimated value and applied it to the Trusts data as reported in the NHS Digital's NHS workforce Statistics - November 2019' consultant headcount data which is the same basis that NHSE have used for the National provision within its accounts.

Note 24.1 Clinical negligence liabilities

At 31 March 2021, £266,300k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone and Tunbridge Wells NHS Trust (31 March 2020: £230,759k).

Note 25 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-43	-22
Net value of contingent liabilities	**-43**	**-22**
Net value of contingent assets	**0**	**0**

Contingent liability for 2020/21 relates to legal claims notified by NHS Resolution of £43k.

Note 26 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	676	1,994
Total	**676**	**1,994**

Note 27 Other financial commitments

The Trust has no commitments to make under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement).

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2020/21 year was 2.46%. The RPI uplift for 2021/22 is 1.37%.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**306,014**	**321,178**
Of which liabilities are due		
- not later than one year;	14,942	15,165
- later than one year and not later than five years;	59,344	59,758
- later than five years.	231,728	246,255
Finance charges allocated to future periods	-123,841	-133,656
Net PFI, LIFT or other service concession arrangement obligation	**182,173**	**187,522**
- not later than one year;	5,402	5,349
- later than one year and not later than five years;	24,229	23,393
- later than five years.	152,542	158,780

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**744,896**	**772,816**
Of which payments are due:		
- not later than one year;	26,567	26,000
- later than one year and not later than five years;	113,114	110,665
- later than five years.	605,215	636,151

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**25,989**	**25,365**
Consisting of:		
- Interest charge	9,816	10,110
- Repayment of balance sheet obligation	5,349	5,426
- Service element and other charges to operating expenditure	5,257	4,975
- Capital lifecycle maintenance	315	434
- Contingent rent	4,591	4,260
- Addition to lifecycle prepayment	661	160
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	160	224
Total amount paid to service concession operator	**26,149**	**25,589**

Note 29 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP schemes.

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its capital resourcing limit as approved by DHSC. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,224	0	0	**8,224**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	26,221	0	0	**26,221**
Total at 31 March 2021	**34,445**	**0**	**0**	**34,445**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	29,703	0	0	**29,703**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	3,355	0	0	**3,355**
Total at 31 March 2020	**33,058**	**0**	**0**	**33,058**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	6,417	0	**6,417**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	182,173	0	**182,173**
Other borrowings	1,392	0	**1,392**
Trade and other payables excluding non financial liabilities	48,473	0	**48,473**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2021	**238,455**	**0**	**238,455**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	34,174	0	**34,174**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	187,522	0	**187,522**
Other borrowings	1,743	0	**1,743**
Trade and other payables excluding non financial liabilities	34,289	0	**34,289**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2020	**257,728**	**0**	**257,728**

Note 30.4 Fair Values of Financial Assets and Liabilities

The Trust uses the book value (carrying value) as a reasonable approximation of fair value.

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	15	18	15	22
Bad debts and claims abandoned	18	16	22	349
Total losses	**33**	**34**	**37**	**371**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	1	1
Ex-gratia payments	27	18	35	12
Total special payments	**27**	**18**	**36**	**13**
Total losses and special payments	**60**	**52**	**73**	**384**
Compensation payments received		0		0

The Trust has no cases exceeding £300k.

In keeping with policy 1.24 this note includes losses and compensations paid and accrued but excludes provisions, which are reported under Note 24.

Note 32 Gifts

There were no gifts made by the Trust in 2020/21.

Note 33 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken and material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year 2020/21 the Trust has received £26.1m Revenue Public Dividend Capital (PDC) and £18.8m Capital funding in the form of PDC. The Trust also has loans with DHSC, interest paid within the year £0.3m, principal repayment of £27.7m. The Trust has repaid all the working capital loans within 2020/21. The Trust has also had a significant number of material transactions with other entities for which the Department is regarded as the parent department eg NHSE/I. Other public sector bodies are recognised as relevant who are not part of the DHSC group eg HMRC. The following entities with material transactions of more than £1m are listed below:

East Sussex CCG
Kent and Medway CCG
South East London CCG
West Sussex CCG
NHS England
Health Education England
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
Dartford and Gravesham NHS Trust
HMRC
NHS Pension Authority
NHS Resolution
NHS Supply Chain
NHS Blood and Transplant
NHS Property Services
Kent County Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy notes 1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	2020-21	2019-20
	£000s	£000s
Total charitable resources expended with the Trust	**217**	1,038
Closing creditor (monies owed to the Trust by the Charity)	**407**	589
Total income received by the Charity in the reporting period	**540**	720
Total Charitable Funds at end of the reporting period	**1,083**	763

Note 34 Prior period adjustments

The Trust has made one prior period adjustment relating to moving an element of RTA CRU allowance for impaired contract receivables from the current receivables to non-current receivables of (£0.3m).

Note 35 Events after the reporting date

The Trust has no events after the reporting date

Note 36 Better Payment Practice code

	2020/21	2020/21	2019/20	2019/20
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	92,876	218,998	109,425	196,467
Total non-NHS trade invoices paid within target	89,409	205,094	90,990	168,173
Percentage of non-NHS trade invoices paid within target	96.3%	93.7%	83.2%	85.6%
NHS Payables				
Total NHS trade invoices paid in the year	3,194	39,080	2,728	38,336
Total NHS trade invoices paid within target	2,099	33,006	1,825	34,024
Percentage of NHS trade invoices paid within target	65.7%	84.5%	66.9%	88.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 37 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2020/21	2019/20
	£000	**£000**
Cash flow financing	-11,322	-13,214
External financing requirement	**-11,322**	**-13,214**
External financing limit (EFL)	-7,032	-12,858
Under / (over) spend against EFL	**4,290**	**356**

The Trust financed its operating and capital investment activities with £4.3m less cash requirement than expected. This was supported by the national funding regime e.g cash backed annual leave accrual.

Note 38 Capital Resource Limit

	2020/21	2019/20
	£000	**£000**
Gross capital expenditure	33,341	16,891
Less: Donated and granted capital additions	-1,392	-890
Charge against Capital Resource Limit	**31,949**	**16,001**
Capital Resource Limit	32,361	16,218
Under / (over) spend against CRL	**412**	**217**

The £412k underspend against capital resource limit reflects the reimbursement in 2020/21 of Covid-19 capital claims relating to 2019/20 capital expenditure. The Trust was reimbursed by means of additional PDC but this was not available to re-utilise in 2020/21.

Note 39 Breakeven duty financial performance

	2020/21
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	330
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**330**

There is no adjustment for the PFI (IFRIC 12) accounting as the on-balance sheet impacts to I&E are currently lower than the equivalent off-balance sheet reporting.

Note 40 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		189	1,710	300	129	-12,374	157
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149
Operating income		311,889	322,176	345,101	367,391	375,714	403,310
Cumulative breakeven position as a percentage of operating income		-0.98%	-0.42%	-0.31%	-0.25%	-3.54%	-3.26%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	-23,413	-10,918	-10,790	20,324	7,587	330
Breakeven duty cumulative position	-36,562	-47,480	-58,270	-37,946	-30,359	-30,029
Operating income	400,930	430,502	440,269	473,169	513,056	564,196
Cumulative breakeven position as a percentage of operating income	-9.12%	-11.03%	-13.24%	-8.02%	-5.92%	-5.32%

The Trust's last formal 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust has achieved in year break even duty surpluses and met its NHSEI control totals in each of the last three financial years. The Trust is not in any formal recovery regime relating to recovering its historic accumulated deficit but is required to achieve the in year break even position agreed as part of the overall Kent & Medway STP system control total. The Trust delivered a surplus of £0.3m in 2020/21 which was slightly better than plan and its system control total requirement.

NHS
Maidstone and Tunbridge Wells NHS Trust

Approval of Management Representation Letter, 2020/21	**Chair of Audit and Governance Committee**

The approval of the Management Representation Letter from the Trust is a formal part of the Annual Accounts process.

The Letter is drafted by the Trust's External Auditors following the completion of their audit of the Annual Accounts.

The enclosed Letter is scheduled to be reviewed and agreed at the Audit and Governance Committee on 23/06/21, with the intention that the Committee recommend that the Trust Board approves the Letter. A verbal update on the outcome of the Audit and Governance Committee's review will be given at the Trust Board meeting on 23/06/21.

If the Audit and Governance Committee agrees, the Trust Board is asked to approve the Letter. If approved, the Letter will then be signed, on behalf of the Trust Board, and submitted to the External Auditors.

Which Committees have reviewed the information prior to Board submission?
- Audit and Governance Committee, 23/06/21

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

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

Maidstone and Tunbridge Wells NHS Trust

Our Ref: SO/jr

Steve Orpin
Deputy Chief Executive / Chief Finance Officer
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

24th June 2021

Dear Sirs

Maidstone & Tunbridge Wells NHS Trust
Financial Statements for the year ended 31 March 2021

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust for the year ended 31 March 2021 for the purpose of expressing an opinion as to whether the Trust financial statements are presented fairly, in all material respects in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2020/21 and applicable law.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities for the preparation of the Trust's financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2020/21 ("the GAM"); in particular the financial statements are fairly presented in accordance therewith.

ii. We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii. The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include […] We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative, methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

vi. In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a. there are no unrecorded liabilities, actual or contingent

b. none of the assets of the Trust has been assigned, pledged or mortgaged

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have only accrued for items received before the year-end.

xii. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The Trust financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xiii. We have considered the unadjusted misstatements schedule included in your Audit Findings Report and attached. We have not adjusted the financial statements for these misstatements brought to our attention as they are immaterial to the results of the Trust and its financial position at the year-end. The financial statements are free of material misstatements, including omissions.

xiv. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xv. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xvi. We have updated our going concern assessment. We continue to believe that the Trust's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

a. the nature of the Trust means that, notwithstanding any intention to cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements

b. the financial reporting framework permits the entry to prepare its financial statements on the basis of the presumption set out under a) above; and

c. the Trust's system of internal control has not identified any events or conditions relevant to going concern.

We believe that no further disclosures relating to the Trust's ability to continue as a going concern need to be made in the financial statements.

Information Provided

xvii. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the Trust's financial statements such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your audit; and

c. access to persons within the Trust via remote arrangements, in compliance with the nationally specified social distancing requirements established by the government in response to the Covid-19 pandemic from whom you determined it necessary to obtain audit evidence.

xviii. We have communicated to you all deficiencies in internal control of which management is aware.

xix. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xx. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xxi. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the financial statements.

xxii. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

xxiii. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiv. We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxv. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Governance Statement

xxvi. We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Annual Report

xxvii. The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the Trust's financial statements.

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on 24th June 2021.

Yours faithfully

Steve Orpin
Deputy Chief Executive / Chief Finance Officer
24th June 2021
Signed on behalf of the Trust Board