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

Thu 29 June 2023, 09:45 - 13:00

Virtually, via Webconference

Agenda

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

06-10
To receive apologies for absence

David Highton

06-11
To declare interests relevant to agenda items

David Highton

06-12
To approve the minutes of the 'Part 1' Trust Board meetings of 25th May 2023 and 22nd June 2023

David Highton

- Board minutes, 25.05.23 (Part 1).pdf (10 pages)
- Extraordinary Board minutes, 22.06.23 (Part 1).pdf (3 pages)

06-13
To note progress with previous actions

David Highton

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

06-14
Report from the Chair of the Trust Board

David Highton

- Report from the Chair of the Trust Board.pdf (1 pages)

06-15
Report from the Chief Executive

Miles Scott

Chief Executive's report June 2023.pdf (3 pages)

Reports from Trust Board sub-committees

06-16
Quality Committee, 14/06/23

Maureen Choong

Summary of Quality C'ttee, 14.06.23.pdf (1 pages)

06-17
Finance and Performance Committee, 27/06/23

David Morgan

Summary of Finance and Performance C'ttee 27.06.23.pdf (2 pages)

06-18
People and Organisational Development Committee, 23/06/23

Richard Finn

Summary of People and Organisational Development Cttee, 23.06.23.pdf (2 pages)

06-19
Patient Experience Committee, 12/06/23 (incl. an update on End of Life Care)

Joanna Webber

Patient Experience Committee, 12.06.23 (incl. an update on End of Life Care).pdf (10 pages)

Integrated Performance Report

06-20
Integrated Performance Report (IPR) for May 2023

Miles Scott and colleagues

Integrated Performance Report (IPR) for May 2023.pdf (32 pages)

Quality Items

06-21
Quarterly mortality data

Peter Maskell

Quarterly mortality data.pdf (11 pages)

Systems and Place

06-22
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) (incl. to approve the Memorandum of Understanding (MoU) with the West Kent HCP)

Rachel Jones

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (77 pages)

Planning and strategy

06-23
To approve the corporate objectives for 2023/24

Rachel Jones

To approve the corporate objectives for 202324.pdf (17 pages)

06-24
Mid-year Nursing and Midwifery staffing review

Jo Haworth

Mid-year Nursing and Midwifery staffing review.pdf (9 pages)

06-25
To approve the Kent and Medway Pathology Network Collaboration Agreement

Rachel Jones

To approve the Kent and Medway Pathology Network Collaboration Agreement.pdf (95 pages)

06-26
To approve the Business Case for Virtual Wards

Sean Briggs

To approve the Business Case for Virtual Wards.pdf (35 pages)

Assurance and policy

06-27
Update from the SIRO (incl. approval of the Data Security and Protection Toolkit submission for 2022/23, and Trust Board annual refresher training on Information Governance)

Rachel Jones

Update from the SIRO.pdf (34 pages)

06-28
To consider any other business

David Highton

06-29
To respond to any questions from members of the public

David Highton

Questions should relate to one of the agenda items above, and be submitted in advance of the Trust Board meeting, to Kevin Rowan, Trust Secretary, via kevinrowan@nhs.net.

Members of the public should also take note that questions regarding an individuals patient's care and treatment are not appropriate for discussion at the Trust Board meeting, and should instead be directed to the Trust's Patient Advice and Liaison Service (PALS) (mtw-tr.palsoffice@nhs.net).

06-30
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 25TH MAY 2023, 9:45 AM, VIRTUALLY, VIA WEBCONFERENCE

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Ainne Dolan	Deputy Chief People Officer, Organisational Development	(AD)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

05-1 To receive apologies for absence

Apologies were received from Neil Griffiths (NG), Non-Executive Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director; Richard Finn (RF), Associate Non-Executive Director; and Sue Steen (SS), Chief People Officer; would not be in attendance, but AD would attend in SS' place.

05-2 To declare interests relevant to agenda items

AY declared that he was a non-Board Associate Non-Executive Director at the Kent and Medway Integrated Care Board (KM ICB), and was a member of the ICB's Performance and Investment Committee (which was relevant for all the ICB-related items on the agenda).

05-3 To approve the minutes of the 'Part 1' Trust Board meeting of 27th April 2023

The minutes of the meeting of the 27th April 2023 were approved as a true and accurate record of the meeting, subject to the following amendment:

- Item 04-11, page 6 of 12: Replace "EPM commented that some investment had been made in the central complaints team so asked if the return on investment had been measured." with "EPM commented that some investment had been made in the patient experience team so asked if the return on investment had been measured.".

Action: Amend the minutes of the 'Part 1' Trust Board meeting of 27th April 2023 to reflect the correction that was approved at the Trust Board meeting on 25th May 2023 (Trust Secretary, May 2023 onwards)

05-4 To note progress with previous actions

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

- **04-11 ("Establish whether the Trust's new Friends and Family Test (FFT) provider had plans to integrate their system with the NHS App").** JH confirmed there was nothing further to report, as the issue was still being explored with the provider. It was therefore confirmed that the action should remain open.

- **04-18 ("Arrange for data on value-weighted elective activity to be included in the Integrated Performance Report (IPR)").** SO reported that it was hoped the requested data would be able to be included in the "Sustainability" section of the IPR from month 2 onwards. It was therefore confirmed that the action should remain open until the data was included.

05-5 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted the following points:
- DH had been very pleased to present the awards at the recent Staff Star Awards ceremony.
- A new clinical oncologist had been appointed and they would start in post on 03/07/23. The Trust had a number of oncologist vacancies, so although the appointment was very welcome, efforts to recruit further oncologists would continue.

05-6 Report from the Chief Executive

MS referred to the submitted report and highlighted the following points:
- MS wanted that month's report to focus specifically on innovation and research and the first issue to highlight was that the Neonatal Unit at Tunbridge Wells Hospital (TWH) had become one of only four in the UK to receive platinum accreditation in the Bliss Baby Charter, which was a significant achievement.
- BBC South East and ITV Meridian TV had featured reports on the LIVing Donor Allograft for Anterior Cruciate Ligament Reconstruction (LivD ACLR) research study, which was a great example of investigator-led research, whereby an individual had an idea, which they then developed and obtained the necessary approvals to proceed.
- The Maternity service was participating in the Calcium Supplementation for Prevention of Pre-eclampsia in High Risk Women (CaPE) research trial, which was a good example of the Trust's clinical services participating in multi-centre research studies.
- All the examples MS had highlighted were an important illustration of how the Trust needed to develop its clinical services. PM was the Executive lead for research and was supported by a Lead Clinician for Research and Innovation and Head of Research and Innovation. The Research and Innovation Team played an important role in the attraction & recruitment of staff.

Reports from Trust Board sub-committees

05-7 Quality Committee, 10/05/23 (incl. the Annual Fire Safety Report, 2022/23; and approval of the revised Terms of Reference (annual review))

MC referred to the submitted report and highlighted the following points:
- Some minor amendments had been made to the Committee's Terms of Reference, which had been submitted for approval.
- The Annual Fire Safety report had been enclosed. MC wanted to thank the Fire Safety team as there had been an improvement in the area of Unwanted Fire Signals.

The revised Terms of Reference were approved as submitted.

DH then pointed out that a wider discussion of the Quality Committee's sub-committees was in progress, and that would likely result in some more substantial changes to the Quality Committee's Terms of Reference in due course.

05-8 Finance and Performance Committee, 23/05/23

DM referred to the submitted report and highlighted the following points:
- The Cost Improvement Programme (CIP) scheme to reduce escalation capacity, which was primarily related to the closure of two escalation wards, Cornwallis Ward and Ward 11, had been discussed in detail. The former ward had been closed, but the latter ward remained open. There were also a range of associated actions, which included Virtual Wards, to aim to reduce the Trust's bed days by circa 14,000, although that was in the context of a total of circa 250,000 bed days across the Trust.

- The CIP target for 2023/24 was £33m and it had been noted that over-performance in clinical income may be a mitigation. There had however been no such over-performance in month 1, so the situation would need to be closely monitored.

DH referred to the latter point and noted that clinical activity in month 1 had been adversely affected by junior doctors' strike; while the British Medical Association had announced a further strike in June 2023, so there would be further adverse implications for activity, for the Trust and the wider NHS. DH continued that the Executive Directors and wider staff should therefore be thanked for their management of the previous strike, while DH hoped that an intervention would occur to prevent the 72-hour strike that had been announced from proceeding, as that would have a significant adverse impact if it went ahead.

05-9 People and Organisational Development Committee, 19/05/23

EPM referred to the submitted report and highlighted that RF had actually chaired the meeting, which was a 'deep dive', and the main item discussed was the plan to extend the Exceptional Leaders programme to all.

Questions were invited. None were received.

05-10 Audit and Governance Committee, 16/05/23

DM referred to the submitted report and highlighted the following points:
- The main feature was the review of red-rated risks, which was undertaken at each of the Committee's meetings. The discussion was relevant to item 05-15 and DM was keen to liaise with JH to avoid duplication between the Committee's role and that of the Trust Board.
- The Committee also held a 'deep dive' into an individual risk at each meeting, and the risk relating to the "Age of the Imaging Equipment in Radiology at MTW" had been subject to the latest 'deep dive'. Despite valiant efforts to mitigate the impact of the risk, the position was worsening. It was therefore recognised that there would be a further strain on the Trust's finances but it was clear that the Executive Directors would need to consider the issue further.
- The emergence of Artificial Intelligence (AI) had been referenced, particularly in relation to the implications for cyber security.
- The standard reports were received from the internal audit and counter fraud functions.

DH stated that he understood the Executive Team Meeting (ETM) had considered the radiology equipment risk on 23/05/23. SO confirmed that was the case and reported that more work was required, as alternative funding approaches, such as revenue options, or spreading the available capital funds differently would need to be explored, given the constrained capital funding position. SO also explained that the risk was related to the fact that all of the new equipment that had been purchased for TWH was reaching 'end of life' at the same time. DH welcomed the progress that had been made. MS then acknowledged that the risk had been on the Trust's risk register for a while, but stressed that the Trust Board needed to be clear that a financial plan was in place for wider equipment renewals, and the Trust could not apply one-off solutions for particular areas. MS continued that it was therefore important to properly plan for the ongoing renewal of the Trust's assets, and that would be incorporated into the consideration of the specific issue. The point was acknowledged.

AY asked whether a lease option was feasible. SO clarified that that was what he meant when he had referred to a revenue option being explored, although under International Financial Reporting Standards (IFRS) 16 (Leases), leases would be capitalised, so the option was not straightforward.

DM then referred back to MS' comments and confirmed that he believed the issue had demonstrated that the Trust's risk management system was working effectively. DM also welcomed the development of a plan that would decrease the radiology equipment risk but highlighted that there would always be an element of risk associated with such equipment.

DH then acknowledged the link between the radiology equipment risk with staff morale, as having modern equipment would help attract staff to the department. DM agreed and noted that the

radiology team had embraced the opportunity they had been given to raise the issues to the Audit and Governance Committee.

Integrated Performance Report

05-11 Integrated Performance Report (IPR) for April 2023

AD referred to the "People" Strategic Theme highlighted the following points:
- The vacancy rate position was self-explanatory. The target had been met, but the profiling of additional roles, as part of the Trust's operational planning, had seen the rate increase slightly, although it was still below the target.
- The retention Key Performance Indicator (KPI) was more difficult to change, particularly as it was a 12-month rolling average. There was however a focus on retention within certain groups, including Administrative & Clerical staff and certain professions within the Divisions.
- There would be a focus on the equality, diversity and inclusion (EDI) strategy, so some additional KPIs had been included in relation to protected characteristics, and the progression rate to senior roles. The KPI was however still draft as it was being refined at present.

DH referred to new roles being added to the budget from 01/04/23, which meant that vacancies were measured against a new establishment, and asked whether the relevant departments were able to use temporary staff to recruit to the vacancy, or whether the new posts should have been introduced in a phased manner across the first two quarters of the year, to prevent a major increase in the vacancy rate. SO explained that the Trust had introduced some service developments during 2021/22 with temporary staffing, which had not been added to the budget, so the posts were now being added to the budget to 'tidy up' the position and try and recruit substantive staff, to reduce the reliance on temporary staff. SO also stated that there was an agreed workforce plan with each Division which was related to the expectations regarding recruitment, turnover and any service developments, and one example of the latter was for the Kent & Medway Orthopaedic Centre, which had a phased recruitment plan.

AY referred to the EDI statistics and asked whether these related to overall workforce data or specific roles. AD explained that there was a focus on senior positions i.e. Agenda for Change bands 8a, 8b and 8c, but there was also a focus on retention.

WW then referred to the data on appraisal completeness, which were listed as "0.0%" for the "Latest" and "Trust Target", and "1.3%" for the "Most recent position", and asked for an explanation. AD explained that the figures reflected the fact that the new appraisal 'window' had just opened. WW asked why the target would be "0.0%". AD stated that that must be a mistake, as the target was not "0.0%". MS however confirmed that the "0.0%" target for April 2023 would be correct, as it reflected the fact that the Trust had a three-month appraisal 'window', so the position would be expected to be low in April but increase during the next two months.

WW then asked why the target was 95% and not 100%. AD explained that the 95% target accounted for staff turnover, sickness absence, maternity leave etc. as a 100% target would naturally not be achieved, and it was not unusual to have a slightly lower target rate. WW acknowledged the point but stated that he believed all staff who were available should be appraised, so asked how that would be addressed in the monitoring. AD explained that a different approach to monitoring had been adopted, to try and increase the appraisal rates in specific areas; while there would also be follow-up in relation to the staff that had no appraisal recorded on the appraisal system for the previous year. WW asked how many staff were in the latter group and AD agreed to check and confirm.

Action: Check and confirm how many staff were recorded as not having had an appraisal for the 2022 appraisal round (Deputy Chief People Officer, Organisational Development, May 2023 onwards)

PM then referred to the "Patient Safety & Clinical Effectiveness" Strategic Theme and reported the following points:
- The falls Breakthrough Objective continued to show normal variation and was close to showing special variation around the mean, but there had been no reduction in overall harm, so the

Breakthrough Objective had not achieved the Vision Goal/Target. A meeting had therefore been held with relevant stakeholders to consider whether the Trust should continue to try and reduce the overall number of incidents resulting in harm, or just focus on the 'moderate to severe' harms, and it had been unanimously agreed to try and reduce the more serious harms, given the impact of such incidents. That approach had also been agreed at the ETM on 23/05/23, so the word "serious" would be added to the text of the Vision Goal/Target, which would enable the Breakthrough Objective to be more targeted. Deteriorating patients would be focused on more generally, but Acute Kidney Injury and Sepsis incidents were also being considered, so further work was required to finalise the objective.
- The mortality rates had triggered the need for a verbal Counter Measure Summary, but PM would focus more on mortality at the Trust Board's meeting in June 2023.

SM then referred to the infection control metrics and reported the following points:
- The number of COVID-19 cases continued to decrease, and the number was now in single figures at each main hospital site and close to zero at Maidstone Hospital.
- The number of hospital-acquired COVID-19 cases had reduced dramatically during April 2023.
- The Trust was below the maximum trajectory for *Clostridiodes difficile* cases as there had only been four cases in April.

PM then apologised for an error in the reported "Number of New SIs in month" within the IPR as there had been 11 Serious Incidents (SIs) in April, not 0. The point was acknowledged.

DM then referred to the "Safe Staffing Levels" metric and commended the improved position. JH stated that the latest performance was the culmination of the work done over the last two years to reduce vacancy rates, which had improved markedly, and the focus would now shift to staff retention. MS added that the situation was an example where doing the right thing in one area had a benefit in other areas, such as temporary staffing expenditure and patient safety.

JW referred to the deterioration in the "Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days" indicator and asked why the position had worsened, or whether there were more changes that could be made to improve the position. PM explained that the metric required many things to be done concurrently, as 50% of falls were due to vacancy rates, so it was pleasing to hear that the number of vacancies had reduced. PM also reported that the Deputy Chief Nurse - Quality and Experience would continue to work with the clinical teams, and the next aim was to ensure ward staff received specific training. PM continued that the method of management the position had been reorganised and the concept of earned autonomy had been introduced, so Ward Managers now had to demonstrate that they were leading the work required to reduce falls in their areas. PM also highlighted that the overall trend showed a reduction, so although that trend had not yet reached the criteria for an "Improving special cause", PM did not consider any further action was required.

DH noted that NHS England had now stood down COVID-19 from being an NHS level 3 incident, and reduced the associated reporting that NHS organisations had to do. MS agreed that it was an important sign that COVID-19 now needed to be managed as 'business as usual', as was the case with other infections. SM commented that the change was very welcome, as the Infection Prevention and Control team had spent a lot of time on burdensome data collection, while COVID-19 outbreaks no longer needed to be reported nationally, although the Trust would continue to collect such data for local use. SM also reported that the COVID-19 testing arrangements had changed, and testing was now only required on symptomatic patients when they arrived at the Trust's sites, while staff no longer had to stay off work if they had COVID-19, nor had to test for COVID-19, unless they were caring for immunocompromised patients. SM however confirmed that any staff, patient or visitor who wished to wear a face mask could continue to do so, and masks had been made available at the entrances to the Trust's hospitals and on the wards.

SB then referred to the "Patient Access" Strategic Theme and reported the following points:
- SB would like to thank the Business Intelligence team for correcting the errors in the original version of the IPR that had been issued.
- The Emergency Department (ED) 4-hour waiting time target performance continued to be strong, and it was hoped to make some further improvements to enable 90% performance to be

achieved regularly, which would be important for many aspects of the Trust's functioning. It should also be noted that the current performance had been achieved while Cornwallis Ward had been closed.

- The cancer access targets had been achieved again, and these were also expected to be delivered over the next two months. The position in urology was however a concern, so work was taking place with the urology team and with RJ.
- Clinical activity levels had been good for April, despite the pressures faced during that month. Activity had been discussed at the ETM 'Time Out' session on 24/05/23, and the challenges in keeping staff motivated and energised had been acknowledged. The 40-week waiting position had increased over the last two months, because of the aforementioned junior doctors' strike, so the patients waiting beyond that period would be the focus of future efforts.
- There had been some improvement within outpatients, which was good to see, given that the latest transformation plan had only recently been enacted.

JW referred to the recent national announcements regarding patient choice and asked what impact that would have on the Trust's waiting times. SB explained that patient choice was already in place for elective activity, so he understood that the new announcement related to raising the awareness of the options patients had. SB continued that the Trust had supported other local NHS Trusts with their waiting lists, so it was important to consider how the announcements would affect the referrals to the Trust, which would continue to be monitored closely. SB however also pointed out that if the Trust was able to deliver increased activity, it would be able to obtain additional income, which would have wider benefits.

WW commended SB for maintaining the levels of performance, but asked what was needed to improve the performance on "Outpatient Calls answered <1 minute". SB noted that the performance had been stable but it had been acknowledged that outpatients had not been a main priority in the recent past so SB had made a commitment that that would not be the case for the coming year. SB continued that a report on the outpatient programme had been submitted to the Finance and Performance Committee in April 2023, and that had described the actions that would be taken and set out the programme of improvement that was planned. SB also noted that there were now a far higher number of telephone calls than before the COVID-19 pandemic so the team had introduced a triage system with a central call centre, while there would also be improved transfer of teams to areas of need. SB added that there had been a good debate at the Finance and Performance Committee meeting and there had been an improvement since the plan had started to be implemented three weeks ago, so SB was optimistic that the data would show an improvement in three or four months.

DM referred to the outpatient item at the Finance and Performance Committee, and noted that the Committee had acknowledged that the "Outpatient Calls answered <1 minute" metric was crude, but the average response time data showed a far better position, while the number of abandoned calls was very low, and in some departments, at zero. SB acknowledged the point but confirmed that he believed the "Outpatient Calls answered <1 minute" metric best reflected the position when taken in isolation.

JH then referred to the "Patient Experience" Strategic Theme and reported the following points:

- There had been an improved position against the complaints targets and a reduced number of overdue complaints. The rate of complaints had also reduced slightly as had the number of complaints received.
- However, May had been an unusual month, as a large number of complaints had been received. That, plus the Bank Holidays within the months, would adversely affect performance, so work was underway to try and ensure that that did not derail the plans to achieve the 75% response time target by September 2023.

EPM acknowledged the increase in complaints during May and asked if that was related to a particular area. JH confirmed that was not the case but some additional analysis would be undertaken at the end of the month to understand the situation further and establish whether there were any new emerging themes i.e. beyond the main theme of communication.

JH then referred to the Friends and Family Test (FFT) performance and reported the following points:

- There had been a range of engagement from clinical, administrative and other teams, and there had been improvement across all the domains, which had been achieved through the adoption of a multi-platform approach, which included use of volunteers, text messaging, iPads etc.
- It was now important to focus on what patients were telling the Trust through the surveys, and the ED in particular were undertaking some work on that aspect.
- There was however also a need to continue to improve the FFT response rate, particularly in outpatients.

RJ then referred to the "Systems" Strategic Theme and reported the following points:

- Performance on the "Discharge before Noon" metric had not improved, and was still at circa 22% which was below the 33% target. One of the main areas of focus was the late completion of Electronic Discharge Notifications (eDNs), although that had now gone 'live' on the orthopaedic wards.
- It had also been recognised that it was not helpful to allow staff to record the reason for delayed discharges as "NULL", so it was intended to prevent staff from being able to select that option.

SO then referred to the "Sustainability" Strategic Theme and reported the following points:

- The Trust was £300k adverse to its overall financial plan in month 1, as it had incurred a £400k deficit, mainly as a result of the aforementioned junior doctors' industrial action. The overall of cost of that action had been £400k to £450k, so the Trust would have performed slightly favourable to its overall plan without that cost.
- Overall, the level of clinical income was broadly in accordance with the plan.
- There had been reduction in the expenditure on premium staffing agencies. April had involved the lowest level of expenditure since June 2021, apart from one month, and the position was expected to reduce again in May and June. The largest impact had been on medical agency staffing but there had been a small increase in nurse staffing agency expenditure in April, although that had reduced during May, so an improvement was expected in the future.
- There had however been an increase in Bank staffing expenditure. The majority of that increase had been driven by cover for the aforementioned junior doctors' strike, but April was also a five-week month. However, the position was also expected to improve in the future.
- There had been some one-off beneficial non-pay items in the month.
- The CIP delivery was behind the Trust's plan for month 1 although Cornwallis Ward had been closed ahead of the intended date. Ward 11 was not due to be closed until the end of June 2023 so concerted efforts to do that would be made after the forthcoming Bank Holiday. SO therefore expected a significant improvement in CIP delivery between months 1 and 2 i.e. once the Trust moved from the planning phase to the delivery phase.

WW thanked SO for the latest performance but asked whether SO was comfortable that the CIP delivery would be able to be recovered. SO replied that he was confident that some of the schemes would start to deliver, but he was not comfortable with the overall delivery, which needed to be accelerated, while additional schemes needed to be identified. SO continued that the Trust's CIP plan was 'hockey stick' shaped i.e. with delivery weighted towards the end of the year, although the year-end delivery for 2023/24 was not as extreme as in previous years, so it was important to deliver the planned position month on month. SO also noted that there were additional opportunities for clinical income, so it was possible that there would be a slower delivery against the CIP but a higher delivery against the clinical income plan. WW asked whether the position would be clearer by September 2023. SO replied that he would expect to have a clearer position by the time of the Finance and Performance Committee and Trust Board meetings in July 2023.

Systems and Place

05-12 <u>Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)</u>

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

- The Trust's final operational plan for 2023/24 had been discussed at the Finance and Performance Committee and had been submitted to the ICB. The Trust had not received any comments thus far, but the Trust did not expect to have to make a further submission.
- The Kent and Medway Pathology Network had successfully appointed a Medical Director and Managing Director.
- The Trust had now been awarded the central capital funding to enable it to progress with the Community Diagnostic Centre, which had been on hold until such funding had been confirmed.
- The ICB was currently engaging with its circa 600 staff about the 30% reduction it was required to make.
- The West Kent HCP had issued an advertisement for the Primary Care Medical Director role and interviews would take place soon.
- The HCP had received confirmation that £6.39m of the discharge allocation funding had been allocated, although £1.62m of that related to the Virtual Wards initiative.

Planning and strategy

05-13 Update on the corporate objectives for 2023/24

RJ reported the following points:
- The objectives had been approved at the Trust Board in September 2022, following a delay because of the COVID-19 pandemic, for an 18-month period. A mid-point review was therefore being undertaken.
- Further discussion would be held at the Trust Board 'Away Day' on 07/06/23, and RJ expected to submit a formal report to the Trust Board meeting on 29/06/23.

[Post-meeting note: The Trust Board actually approved the corporate objectives for 2022/23 at its meeting in June 2022, not September 2022]

05-14 Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital

SB referred to the submitted report and highlighted the following points:
- The Trust continued to work with Maggie's, particularly in relation to the design of the new Centre and there was good engagement with the Trust's Director of Estates and Capital Development and Director of Emergency Planning & Response.
- SB was hopeful that the next update submitted to the Trust Board would be able to report more progress.

Assurance and policy

05-15 Six-monthly review of the Trust's red-rated risks

JH referred to the submitted report and highlighted the following points:
- This was the first report that had been considered at a 'Part 1' Trust Board meeting, although a variation of the report had been considered at the Audit and Governance Committee on 16/05/23. As had been noted earlier, further work was required between JH and DM to ensure the approach to risk management was aligned.
- As of 15/05/23 there were 153 risks on the Trust risk register, 21 of which were red-rated.
- There had been an increased focus on the review date of risks, with support from the Risk and Compliance Manager. The number of risks over one year old had also started to be reviewed more closely, while the report also included some content on "Risk exposure / appetite".
- The majority of red-rated risks were under one year old, although one risk, "Delays in transport following outpatient appointments", had been on the risk register since March 2019. That risk had however only recently been upgraded to a red rating.
- The submitted report had used information from the Datix risk management IT system, and the highest number of risks related to staffing, followed by compliance-related issues, competence, and infrastructure, all of which had been discussed by the Trust Board in the past. A new risk management IT system called InPhase would soon however replace Datix, and that system would enable all risks to be aligned to the Trust's Strategic Themes.

- Comments on the format and content of the submitted report were welcome, to inform the aforementioned discussion between JH and DM.

DM highlighted the need to identify target dates for the actions being taken to reduce the risks, and also stated that the next area to consider would be how risks were captured, as the effectiveness of any risk management system was dependent on risks being appropriately identified. The point was acknowledged.

EPM noted that the submitted report had included a reporting timescale from 28/02/23 to 27/04/23 and asked why that period had been chosen. JH replied that the position had been slightly affected by the transition to the aforementioned InPhase system but confirmed that future analysis would be cover the more routine quarterly periods.

MC commended the work, but referred to the "Red risks by month opened" chart on page 7 of 12, which showed that no red-rated risks had been opened between June 2019 and December 2021, and asked whether that reflected the absence of the relevant data. JH explained that there were no red-rated risks added to the risk register during those months, while the risk that had been added in March 2019 had not been red-rated when it had been added, but it had now been upgraded to a red-rated risk, so there was an argument to consider that risk as a new risk. DM agreed that it may be more helpful to focus on the date a risk became red-rated rather than the date it had originally been added to the register. JH agreed.

DH referred to the "Staffing-related" risks theme and stated that he presumed the risks would be focused on specific roles as the overall vacancy rate reduced. JH confirmed that would be the case but clarified that the "Staffing-related" theme included issues such as training, and was not solely focused on staffing levels.

AY asked how "Risk exposure / appetite" how was measured. JH explained that the risk exposure was the current risk score while risk appetite was the target risk score. AY asked what the chart on page 5 of 12 intended to show. JH replied that the chart showed the level of risk currently being carried and the overall target that the Trust wanted to achieve. DM added that the chart was a composite of all the recorded risks, which were assessed on a five by five matrix, so it was interesting that the mean risk exposure had recently reduced while the risk appetite had also reduced, as there was no reason to expect a reduction in risk appetite. AY queried whether that pattern therefore indicated that the Trust was not sufficiently sensitive to risk. DM stated that he believed the chart showed that the Trust was actually becoming more sensitive to risk, as the target for risk mitigation has higher than it had been previously so the Trust was seeking more mitigation of risk than it had in the past.

DH asked for confirmation that risk appetite was based on an individual target risk score. DM confirmed that was correct. DH stated that he therefore believed it would be important for the Trust Board to consider risk appetite more generally, and proposed that that be discussed at the Trust Board 'Away Day' in December 2023. DM agreed that would be sensible. MS however stated that the Trust would soon commence an external governance review, which would be discussed at the Trust Board 'Away Day' on 07/06/23, so proposed that he discussed that aspect with JH and arrange for a discussion on risk appetite to be included in that 'Away Day'. This was agreed.

Action: Arrange for the Trust Board 'Away Day' in June 2023 to have a discussion regarding 'risk appetite' from a more general perspective (i.e. beyond the definition of risk appetite as the target risk score for individual risks), as part of the external governance review item (Chief Executive, Chief Nurse and Trust Secretary, June 2023)

05-16 <u>NHS provider licence: Self-certification for 2022/23</u>

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

- An NHS provider licence had been in place for several years, and although it technically did not apply to NHS Trusts, NHS Improvement had required NHS Trusts to undertake a self-certification against certain licence conditions, starting with 2016/17. NHS Trusts were also required to publish that self-certification on their website.

- The Trust had therefore undertaken a self-certification each year since then, and the latest self-certification, for 2022/23, was enclosed, for approval. The primary evidence to support the self-certification was the draft Annual Governance Statement for 2022/23, but that should be considered to be a summary of the wider range of evidence that Trust Board members had seen during the year, at Trust Board and sub-committee meetings.
- This would be the last year that a self-certification would be required, as a new NHS provider licence regime took effect from April 2023. The licence had now been formally extended to NHS Trusts, and the Trust was issued with its first licence on 01/04/23. The Standard Conditions of the new licence had been enclosed in Appendix 2, for the Trust Board's information.

The provider licence self-certification for 2022/23 was approved as submitted.

DH then asked whether a light-touch review of compliance with the new licence could be undertaken. KR explained the limitations of such a review with regards to external regulators, but DH confirmed it would be beneficial for internal purposes. KR therefore agreed to liaise with the Executive Directors to undertake the requested review.

Action: Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions (Trust Secretary, May 2023 onwards)

05-17 Ratification of Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)

KR referred to the submitted report and highlighted the following points:
- The Trust had committed to reviewing its Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation each year, and the last such review had been conducted in March 2022. DM had however agreed, in January 2023, to a short deferral request, to enable the review to be undertaken in May 2023.
- The three documents had therefore been reviewed and updated, in conjunction with the Deputy Director of Finance (Governance), and some proposed changes had been made. The revised documents had been circulated widely for consultation in April 2023 and the circulation had included all Trust Board members. The revised documents had then been "approved" by the Audit and Governance Committee on 16/05/23.
- The Trust Board was therefore now asked to "ratify" the documents, to enable them to be published via the Trust's intranet.
- The main changes to the documents were described in the submitted report, but the full documents, with the proposed changes shown as 'tracked', had been made available to Trust Board members as supplements within the Admincontrol portal.

The revised Standing Orders, Standing Financial Instructions, and Reservation of Powers and Scheme of Delegation were ratified as submitted.

Other matters

05-18 To consider any other business

KR highlighted that an extraordinary Trust Board meeting had been scheduled for 22/06/23, to approve the Trust's Annual Report and Accounts for 2022/23.

05-19 To respond to questions from members of the public

KR confirmed that no questions had been received.

05-20 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 22ND JUNE 2023, 10:30 A.M, VIA WEBCONFERENCE

FOR APPROVAL

Present:	Neil Griffiths	Non-Executive Director (Chair)	(NG)
	Sean Briggs	Chief Operating Officer (from item 06-4)	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive (joined during item 06-4 – refer to the relevant minute for the specific details)	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Helen Callaghan	Director of Quality Governance	(HC)
	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	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)
	The meeting was livestreamed on the Trust's YouTube channel.		

06-1 To receive apologies for absence

Apologies were received from Jo Haworth (JH), Chief Nurse; David Highton (DH), Chair of the Trust Board; and Peter Maskell (PM), Medical Director. It was however noted that HC was attending in JH's place. It was also noted that Alex Yew (AY), Non-Executive Director, would not be in attendance.

06-2 To declare interests relevant to agenda items

NG declared that he was the Managing Director of TeleTracking Technologies UK, which had been listed as a "related party" within the Trust's annual accounts for 2022/23.

DM declared that his son worked for Grant Thornton LLP, the Trust's external auditors, but the individual was not connected to the Trust's external audit.

WW declared that his businesses provided mentoring support to other businesses within the healthcare sector, and he had two business interests in the US that related to healthcare, pharmacy and medical devices.

Reports from Trust Board sub-committees

06-3 Audit and Governance Committee, 22/06/23 (incl. the Committee's 2022/23 Annual Report)

DM referred to the submitted report and highlighted the following points:
- There had been some minor amendments since the report had been approved by the Audit and Governance Committee at its meeting in May 2023. Those amendments were primarily related to updating the outcome of the Internal Audit reviews that had been completed since the Committee's previous meeting.
- The report recognised the Committee's new responsibility for security.
- The Committee had noted the unmodified external audit opinion that had been given for the Trust's annual accounts for 2021/22, and the "reasonable assurance" rating that had been given in the Head of Internal Audit Opinion.
- Nothing worthy of reporting had emerged from the Committee's work on counter fraud.

- The Committee had reviewed and approved the Trust's Annual Governance Statement.

Questions were invited. None were received.

Annual Report and Accounts

06-4 <u>To approve the Trust's Annual Report, 2022/23 (incl. Annual Governance Statement)</u>

DM firstly explained that it would be more efficient to consider items 06-4, 06-5 and 06-6 together. DM then referred to the reports submitted for all three items and highlighted the following points:
- The Audit and Governance Committee had met earlier that day and reviewed the annual report and annual accounts for 2022/23 with the Trust's external auditors.
- The external audit had gone very well, and no issues of note had emerged. Both the external auditors and the relevant Trust staff had confirmed that the audit had involved an efficient process, so credit should be given to Grant Thornton LLP and the relevant Trust staff for ensuring a 'clean' and thorough process.
- The audit work was substantially complete, and just required the completion of some process steps, such as the signing of the Management Representation Letter, the draft of which had been submitted to the Trust Board meeting. The accounts were therefore expected to be signed by the relevant representatives from the Trust and external auditors within the next day or so.
- An unmodified opinion was expected from the auditors, which was the best rating that could be obtained.
- Several changes to the accounts had been identified by the auditors, but most of these related to ensuring that the disclosures that were now required under International Financial Reporting Standards (IFRS) 16 (Leases) were absolutely correct.
- The largest item that had not been adjusted was the estimated useful life of the Trust's assets, which was related to the assets that were still being used beyond their originally expected useful life. From an accounting perspective that meant that the Trust had depreciated the assets too quickly, although this was just an estimate and a matter of opinion rather than fact. The external auditors had therefore not proposed any adjustment and were content with how the Trust had reflected the issue in the accounts.
- The auditors' 'Value for Money' work had been completed, and the associated report had been sent to the Trust's management for factual accuracy checking. Once a response had been received the report would be formally issued and discussed at the Audit and Governance Committee meeting in July 2023.
- The Management Representation Letter contained standard text that was required as part of the audit process, and there was only one point within the letter that was specific to the Trust. That related to leases, as the Trust had several, so the auditors wanted specific assurance from the Trust's management that these had been considered.

DM then invited questions or comments. KR referred to the sickness absence data, on page 84 of 99 of the Annual Report, and noted that it had been identified in the Audit and Governance Committee meeting held earlier that day that there had been an error in the reporting of the data. KR elaborated that the "Average Sick Days per FTE" had been erroneously reported as "107,600", when the "107,600" figure represented the "FTE-Days recorded Sickness Absence"; while the "Average Sick Days per FTE" was the "10.5" figure that had been reported in the "FTE Days Available" column. KR therefore confirmed that the errors would be corrected prior to the Annual Report being submitted and published. The point was acknowledged.

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

DM then confirmed that the Audit and Governance Committee had recommended that the Annual Report for 2022/23; Annual Accounts 2022/23; and Management Representation Letter, 2022/23 be approved by the Trust Board.

The Annual Report for 2022/23; Annual Accounts 2022/23; and Management Representation Letter, 2022/23 were duly approved by the Trust Board, subject to the correction of the error in the reported sickness absence data within the Annual Report.

KR then proposed that should any non-material amendments be required before the external auditors fully concluded their work, such amendments would be agreed with DM, as Chair of the Audit and Governance Committee, and NG as the Chair of that day's Trust Board meeting, or DH, as the Chair of the Trust Board, should the process continue into w/c 26/06/23. This was agreed.

06-5 <u>To approve the Trust's Annual Accounts 2022/23</u>

The discussion of this item took place under item 06-4.

06-6 <u>To approve the Management Representation Letter, 2022/23</u>

The discussion of this item took place under item 06-4.

Quality items

06-7 <u>To approve the Trust's Quality Accounts, 2022/23</u>

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

- The report described the improvements that had been made against the priorities for 2022/23, which included, but was not limited to, a reduction in adverse sepsis- and falls-related incidents across the Trust; improvements in training funding within maternity services; the production of a new incident response plan in accordance with the national Patient Safety Incident Response Framework (PSIRF); improved care for patients who required nasogastric tube feeding; the launch of an Electronic Prescribing and Medicines Administration system; and the procurement and launch of a new digital safety reporting and monitoring system.
- The Quality Accounts also listed the corporate improvement projects and Strategic Themes, and concerted efforts had been made to ensure that the quality priorities aligned with the high-level strategic objectives, as well as the evolving digital and patient experience strategies.
- It had been agreed that any objectives that had only been partially achieved, or not achieved, during 2022/23 should be to carried forward into 2023/24.
- The Quality Accounts were required to be published by 30/06/23.

Questions were invited. None were received.

The Quality Accounts for 2022/23 were approved as submitted.

06-8 <u>To consider any other business</u>

NG thanked, on behalf of the Trust Board, the Executive Directors for their work and achievements during 2022/23, which had been a very strong year for the Trust, in spite of difficult circumstances. NG also extended his thanks to all the Trust's staff, who had demonstrated hard work, persistence and loyalty throughout the year.

06-9 <u>To respond to questions from members of the public</u>

KR confirmed that no questions had been received.

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]
04-11	Establish whether the Trust's new Friends and Family Test (FFT) provider had plans to integrate their system with the NHS App.	Chief Nurse	April 2023 onwards	This functionality is still being explored.
04-18	Arrange for data on value-weighted elective activity to be included in the Integrated Performance Report (IPR).	Deputy Chief Executive / Chief Finance Officer	April 2023 onwards	Discussions have been held regarding the data and it has been agreed to submit a report to the Finance and Performance Committee meeting on 27/06/23 to explain the options involved and agree an approach, with the intention of then introducing the data into the June IPR (which will be reported to the Trust Board in July).
05-16	Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions.	Trust Secretary	May 2023 onwards	A review will be undertaken during the summer and scheduled for consideration at the Trust Board in September 2023 (having been reviewed at the Executive Team Meeting (ETM) beforehand).

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-3	Amend the minutes of the 'Part 1' Trust Board meeting of 27th April 2023 to reflect the correction that was approved at the Trust Board meeting on 25th May 2023.	Trust Secretary	May 2023	The minutes were amended.
05-11	Check and confirm how many staff were recorded as not having had an appraisal for the 2022 appraisal round.	Deputy Chief People Officer, Organisational Development	June 2023	The 2022 appraisal window saw the Trust reach 90% compliance with appraisal completions. During this window, 561 staff were recorded as not having an appraisal vs 4,806 staff who did. The 561 staff who did not

[1]

Not started	On track	Issue / delay	Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				have an appraisal were fairly evenly distributed amongst directorates with no clear outlying areas. The number of non-compliant staff may also include staff who had a conversation with their manager which was not recorded on the system and/or some instances where the recording process started but was not completed. The true number of staff not having an appraisal is therefore anticipated to be slightly lower than 561. The 2023 appraisal window is now open until 31/007/23 and support for managers and staff to encourage completion of a meaningful conversation which is then recorded in the MTW Learning system is ongoing. There is an online resource hub, weekly reporting, virtual weekly workshops and FAQ sessions and multiple communications streams are being used to raise awareness.
05-15	Arrange for the Trust Board 'Away Day' in June 2023 to have a discussion regarding 'risk appetite' from a more general perspective (i.e. beyond the definition of risk appetite as the target risk score for individual risks), as part of the external governance review item.	Chief Executive, Chief Nurse and Trust Secretary	June 2023	The subject was covered at the Trust Board 'Away Day' held on 07/06/23.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A N/A

Trust Board meeting – 29th June 2023

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. 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/s	Surname	Department	Potential / Actual Start date	New or replacement post?
13/06/23	Consultant, Intensive Care	Agnieszka	Walecka	Anaesthetics	October 2023	Replacement post

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

Trust Board meeting – 29th June 2023

Report from the Chief Executive **Chief Executive**

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

- Industrial Action by junior doctors this month impacted our services between 14-17 June. Ahead of the action, plans had been put in place across the Trust to ensure staff rosters were filled to minimise the impact on our patients. We also coordinated greater senior management and tactical commander presence on-site and implemented additional services, including phlebotomy and pharmacy, which helped us to reduce any delays. While we maintained elective and new patient activity where possible, a number of appointments did unfortunately need to be postponed. Patients impacted were contacted prior to their appointment and rescheduled to the nearest possible date. We know this has been a challenging time for our teams and thank colleagues for their dedication in continuing to provide the best possible care during this time. The British Medical Association are currently balloting their consultant members and if the threshold for action is reached, they will take industrial action on 20 and 21 July. The ballot ends on 27 June and we will continue to monitor developments to ensure our sites are prepared ahead of any possible action next month.

- MTW continues to perform well against key quality standards including the four-hour ED standard and 62-day cancer standard and we are currently ranked fourth out of 120 Trusts in the Telegraph's NHS data tracker. We are continuing to use additional services and technology to help improve patient access. Recent developments include:

  - Our tier 4 bariatric service team have set up a multi-disciplinary way of working and have an integrated pathway for the surgical management of obesity. They have already received over 80 referrals, meaning patients can have their treatment closer to home.
  - Work to roll-out our new patient portal delivered by Patients Know Best (PKB) is moving towards a launch date of September. Patient portals support patients to play an active role in their care enabling them to 'self-manage' areas of their care pathway.

- Good patient flow through our hospitals is key to supporting performance and patient care. The introduction of virtual wards (VWs) at our Trust at the end of last year is playing a growing role in this and we have received positive feedback from patients who have benefited from this innovative new way of providing care. Our use of virtual wards and the virtual ward team is growing and now includes:

  - Specialist doctors/consultants and nursing staff monitoring 24hrs a day
  - Multi-disciplinary team working including specialist stroke nurses, respiratory nurses, therapists, site managers and pharmacy colleagues
  - Collaborative working between acute and community services
  - Dedicated technology and IT systems, and the introduction of IV treatments and blood tests at home

- We have now introduced three new pathways in General Medicine, Haematology and Stroke, with the first stroke patient going onto the VW at the end of May. Work is now underway with other specialties to develop pathways in Surgery, Trauma & Orthopaedics and Oncology. By the end of the year, our aim is to manage up to 60 patients at any one time in the VWs.

- There have been a number of IT issues over recent weeks and I want to thank our staff and IT teams for their support and hard work in helping us resolve these. As part of this work the Trust will be installing new servers in early July.

- Diabetes patients at Maidstone Hospital are benefiting from two newly-converted spaces, allowing specialist teams to see more patients and offer an increased level of support to people

with the condition. The new facilities were officially opened by Gary Fagg MBE, Chairman of the Trustees at the Paula Carr Diabetes Trust, which generously supported the project. Our specialist diabetes service cares for a population of around 27,000 across west Kent. The Paula Carr Diabetes Trust supports people living with the condition across Kent and Medway and has played a pivotal role in the development of our diabetes service over the years. This has included funding the initial building and creation of the Diabetes Centre at Maidstone Hospital, as well as supporting a specialist diabetes nurse training programme at a time when there is a shortage of diabetes nurse specialists nationwide.

- A new state-of-the-art patient record system called OpenEyes has been rolled out for cataract patients across the Trust's hospitals as well as Medway. The aim of OpenEyes is to connect eye services across hospital trusts and community services, giving healthcare professionals access to up-to-date information at every stage of the patient's ophthalmology journey. The project was supported by the Maidstone Hospital League of Friends, who generously donated £30,000 - our thanks to the Maidstone Hospital League of Friends for their continued support.

- A new Breastfeeding Café has recently opened at Crowborough Birthing Centre. The Birthing Centre, which is part of our Trust, has provided antenatal and postnatal maternity care to around 700 women and babies over the past year. The Breastfeeding Café was set up as a community-based resource which provides a friendly, welcoming space for new parents to meet, socialise and receive emotional support as well as expert advice on feeding. Held every Thursday morning in the Day Centre at Crowborough War Memorial Hospital, the Breastfeeding Café is run by a variety of health specialists, including staff from the Birthing Centre and specially trained breastfeeding peer supporters. We are grateful to the Friends of Crowborough Hospital who have generously supported the use of the Day Centre.

- Our Maternity teams have recently won two awards at the South East Midwifery Regional Team's 'Celebrating Perinatal Excellence' event. They were awarded 'Midwifery Team of the Year' for the incredible support they provided to a terminally-ill patient and her partner. The team also won the 'Excellence in Perinatal Education, Learning and Research' award in recognition of their outstanding contribution to clinical research for maternity services.

- Andy Cairns, System Manager for Central Operations, has become the first certified Teletracking System Administrator in the UK and Europe. Andy's award highlights his expertise in patient flow and his knowledge of the Teletracking bed management system which the Trust has been using in our Care Coordination Centre since 2021. Andy now plans to create a UK-based TeleTracking System Managers forum to build further partnerships and share best practices, as well as promote the use of the system among other healthcare providers.

- The new Mayor of Tunbridge Wells, Councillor Hugh Patterson, has nominated our own dedicated MTW Hospitals Charity as one of the two local causes he will fundraise for during his term of office. The Mayor said: ""Maidstone and Tunbridge Wells NHS Trust Charity exists to enhance the standard of care, services and facilities provided to patients, relatives, visitors and staff ... I thought this was particularly appropriate this year, the 75th anniversary of the NHS, and would help raise awareness of the work that has been done by our hospital staff over that time. It is also a way of expressing my gratitude for the quality of care and speedy and successful treatment I received following my prostate cancer diagnosis last year." Our brilliant Charity team are looking forward to working with the Mayor over the next year, raising vital funds to make a difference to our staff and patients.

- The NHS will celebrate its 75th birthday on 5 July and we are working with a number of partner organisations to mark the occasion. Events planned include:
  - 4 July: we will be celebrating the opening of an exhibition into the history of healthcare at Maidstone Museum, in collaboration with Maidstone Borough Council. Entry will be free and the exhibition will run throughout the summer.
  - 5 July: Lady Colgrain, His Majesty's Lord-Lieutenant of Kent, will visit Tunbridge Wells Hospital to meet staff, plant a tree and present some special awards. Two of our staff will also raise the NHS flag on top of the town hall.

- This will be followed by a civic reception at the Amelia Centre where Tunbridge Wells Borough Council will make a presentation to the Trust.

At all three events we will be recognising our longest serving staff who have completed over 40 years' service – this adds up to an incredible 500 years of service to the NHS.

- Congratulations to the winner of the Trust's Employee of the Month award for May, Senior Inpatient Booker, Emily Sturrock. Emily works tirelessly within Trust guidelines to ensure that targets are met and patients are seen in a timely manner. Her can do attitude to work means that she has the respect of all her colleagues. Porter Andrew Luxton-Brown also received the Highly Commended award for always going the extra mile to help everyone on his shift.

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

Summary report from Quality Committee, 14/06/23 **Committee Chair (Non-Exec. Director)**

The Quality Committee met (virtually) on 14th June 2023 (a 'deep dive' meeting).

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

- The **actions from previous meetings** were noted.
- The Lead Nurse and Stroke Clinical Lead, Stroke Consultant and lead Clinician and Senior Physiotherapist and Clinical Lead, Stroke Services presented a comprehensive **review of Stroke Services** which covered all aspects of the service. The Committee was particularly interested in the work being undertaken on patient involvement, the challenges in relation to staffing and recruitment (given the multidisciplinary nature of the team), and the relationships with external stakeholders, including the community stroke rehabilitation service.
- The Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation presented a **review of the Trust's medicine management and optimisation.** The presentation was again very comprehensive and cover all aspects of the subject, including the financial savings arising from the use of generic medicines when the patents for branded medications had expired. The Committee also heard that a Business Case was being developed for a dispensing robot at Tunbridge Wells Hospital, although the constrained financial position, particularly for capital funding, was recognised.
- The Senior Nursing Information Officer (SNIO) and Programme Director for EPR (Sunrise) and Digital Transformation attended for a **further review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record** which acknowledged the significant achievement in delivering the step-change that had occurred with the implementation. The issue of remote patient monitoring was also raised and the SNIO acknowledged the need to develop an approach, so agreed to undertake some research into the matter.
- It was agreed that the **items to be scheduled for scrutiny at future Quality Committee 'deep dive' meetings** would be confirmed outside of the meeting, following liaison between the Chair, Vice Chair, Chief Nurse, Medical Director and Director of Quality Governance.
- The Committee conducted an **evaluation of the meeting** which acknowledged that the meeting had been adversely affected by time constraints, so it was suggested that it may be helpful if a maximum of two presentations were scheduled at future 'deep dive' meetings, to allow more time for each presentation. It was also agreed that future 'deep dive' meetings should be held face-to-face/in-person (it had previously been agreed that all the 'deep dive' meetings would be held in-person, but the format of this meeting had been changed the day before the meeting to a virtual meeting because of the junior doctors' strike that was taking place at the time). It was also agreed that those invited to present to the Quality Committee 'deep dive' meetings should be provided with a more specific steer on what to include in their presentations, so the Chair, Vice Chair, Chief Nurse, Medical Director and Director of Quality Governance would consider how that should be done.

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

Trust Board Meeting – 29th June 2023

Summary report from the Finance and Performance Committee, 27/06/23	**Committee Chair (Non-Exec. Director)**

The Committee met on 27th June 2023, via a webconference.

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

- The **actions from previous meetings** were reviewed, which included an update on the request that the Chief People Officer explore if staff members' Annual Leave year could be based on the date they started at the Trust, instead of a generic financial year (as was currently the case).
- The Deputy Chief Operating Officer attended for a 'deep dive' into the **delivery of the Trust's elective, day case, and new outpatient activity plans**, which confirmed that the Trust was slightly behind its plan but would have been on track were it not for the adverse impact of the last junior doctors' strike. It was therefore noted that the forthcoming further junior doctors' strike in July would pose a further challenge.
- The **Patient Access strategic theme metrics for May** were reviewed, and the continued good performance in relation to the Emergency Department 4-hour waiting time target and cancer access targets was noted, as was the improvement in outpatient performance. It was agreed that the Integrated Performance Report (IPR) should include data on the percentage of cancer waiting list patients that had waited longer than 62 days for treatment; and that the "Update on the outpatients transformation programme" 'deep dive' item at the Committee's meeting in July should distinguish between the improvements in outpatient clinic utilisation that were related to data cleansing and those that were related to 'real' improvements in utilisation. It was further agreed that an update on the options being pursued to manage risk ID2992 ("Age of the Imaging Equipment in Radiology at MTW") should be given to the Committee's meeting in September.
- **Options to include data on value-weighted elective activity within the IPR** were considered and it was agreed to add two metrics to the IPR: "Delivery of the variable Elective Recovery Fund (ERF) plan - % of £ plan" and "Delivery of the variable non-ERF plan - % of £ plan".
- The review of **financial performance for May** confirmed that the Trust had delivered to plan for May, but the adverse position from April had not been recovered, so the Trust was £300k behind its plan for the year-to-date. It was also reported that the delivery of the Cost Improvement Programme (CIP) was behind the plan by £0.7m for the year-to-date.
- The latest **quarterly update on the Facilities response to the external Estates and Facilities review** was considered and it was agreed to change the frequency of the updates to six-monthly, subject to the approval of the Committee's substantive Chair. It was however also agreed to schedule an "Update on recruitment within Facilities" item at a future meeting.
- The Director of Estates and Capital Development attended for the latest **quarterly update on the Estates response to the external Estates and Facilities review**, which emphasised the need to address the significant issues that had arisen from an Independent Statutory Compliance Review for Maidstone Hospital (MH). it was also agreed that the Director should liaise with the Associate Director of Procurement to explore the application of Radio Frequency Identification (RFID) to the Trust's Estates assets, and ensure that the use of RFID was included in the options appraisal for the development of the Estates asset register.
- The Committee undertook its **annual review of the Trust's Green Plan**, and supported the content of the Plan, which will be submitted to the Trust Board in July, for approval. The Committee also confirmed that it was content to just receive an annual update on the issues and that any variance from the Plan should be considered by exception.
- The Assoc. Dir. of Procurement attended for the **Annual review of the Procurement Strategy**.
- The Director of Strategy, Planning and Partnerships attended to present the **Kent and Medway Pathology Network Collaboration Agreement**, which was supported. The Agreement has been submitted to the Trust Board, for approval, under a separate item.
- The Committee considered a **proposal to extend, and expand the scope of, the Trust's contract with TeleTracking Technologies, Inc.**, and some actions were agreed ahead of the Trust Board's consideration of the proposals in the 'Part 2' Board meeting on 29/06/23.
- A **Business Case for Virtual Wards** was reviewed and it was agreed to recommend that the Trust Board approve the Case (which has been submitted under a separate item).

- The latest **update on the implementation of the Electronic Patient Record (EPR)** was given, which noted that June 2023 marked the second anniversary of the introduction of the EPR. It was agreed to schedule a "Digital and Data update" item to replace the current EPR item, to broaden the scope of the report.
- The latest **recent findings from relevant Internal Audit reviews** report was received.
- The content of the **summary report from the People and Organisational Development Committee** meeting in May 2023, **report submitted to the People and Organisational Development Committee in relation to the "Reduce the amount of money the Trust spends on premium workforce spend" Breakthrough Objective**, and report of the **latest uses of the Trust Seal** was all noted.

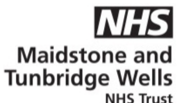
2. **In addition to the agreements referred to above, the Committee agreed that:** N/A

3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Committee supported the Kent and Medway Pathology Network Collaboration Agreement which has been submitted to the Trust Board, for approval, under a separate item.
   - The Committee considered a proposal to extend, and expand the scope of, the Trust's contract with TeleTracking Technologies, Inc., and some actions were agreed ahead of the Trust Board's consideration of the proposals in the 'Part 2' Board meeting on 29/06/23.
   - The Committee recommend that the Trust Board approve the Business Case for Virtual Wards, which has been submitted to the Trust Board, for approval, under a separate item.

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

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

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



Summary report from the People and Organisational Development Committee, 23/06/23 | **Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (face-to-face / in-person at Maidstone Hospital) on 23rd June 2023 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were reviewed.
- The Deputy Chief Executive / Chief Finance Officer and Programme Director, Premium Staffing Spend provided the latest **Update on the progress with the Sustainability Strategic Theme four key themes (which included a 'roadmap' and associated timelines for the delivery of the four key themes),** which included the Corporate Projects which had been developed to support the reduction in temporary staffing expenditure and a comprehensive overview of the initiatives which had been implemented. The Committee emphasised the importance of ensuring the management of agency staff was incorporated into one of the Corporate Projects and it was agreed that the Chief People Officer should develop a communication plan to inform Bank Staff of the rationale for their ineligibility for the non-consolidated national NHS pay award for 2022/23; ensuring such a communication plan utilised of face-to-face discussions and personalised letters. It was also agreed that the Programme Director, Premium Staffing Spend should ensure that future "Update on the progress with the Sustainability Strategic Theme four key themes…" reports incorporated the feedback received at the June 2023 'main' People and Organisational Development Committee meeting (i.e. financial forecasts related to the impact of the work to reduce premium workforce expenditure; the key risks to the programme of work; and details of where the future accountability resided).
- The Committee reviewed the **Nursing and Midwifery five-year workforce plan**, which included details of the enhanced focus on career development and talent management, the importance of a robust apprenticeship programme, and the continued focus on improving the opportunities for Internationally Educated Nurses / Midwives. It was agreed that the Chief People Officer and Deputy Chief Nurse, Workforce and Education should check, and confirm to Committee members, whether the Trust intended to develop an Allied Health Professional (AHP) / Advanced Clinical Practitioner (ACP) five-year workforce plan and, if so, provide Committee members with the plan and details of the associated governance arrangements and timelines.
- The Committee reviewed the **Medical Workforce five-year plan**, wherein the Committee outlined its support for the five goals contained therein; the Committee emphasised the importance of creating and promoting the Trust's Employee Value Proposition (EVP) to increase the retention of Doctors and Consultants.
- The Deputy Chief People Officer, Organisational Development and Head of Organisational Development presented an **update on the latest 'MTW Climate survey', national NHS staff survey 2022, and findings from the 'Moving On' survey and Exit Interviews (incl. discussion of the Trust's future survey strategy and an update on Divisional Development Plans)** which included a comprehensive overview of the feedback which had been received from Trust staff; the benefits associated with the 'VoiceBox' pilot and the reduction in the response rate to staff surveys due to survey fatigue. The following actions were agreed:
  - The Vice Chair of the People and Organisational Development Committee should liaise with the Chair of the People and Organisational Development Committee to consider what, if any, further mechanism could be implemented to ensure staff were aware that their voices were heard by Senior Leaders at the Trust, including the Trust Board;
  - The Deputy Chief People Officer, Organisational Development, and Head of Organisational Development should engage with Trust staff to investigate what, if any, mechanisms should be implemented to provide assurance that their voices were heard by Senior Leaders at the Trust, including the Trust Board; and,

- The Chief People Officer and Deputy Chief People Officer, Organisational Development should liaise with Trust staff to develop a programme of co-designed engagement initiatives, to ensure that Trust staff were supportive of such engagement initiatives

- The **Director of Medical Education** presented the latest **six-monthly update** wherein the Committee received an in-depth overview of the Trust's undergraduate and postgraduate training programmes and a discussion was held regarding the importance of ensuring that staff and trainees were empowered to address and raise any instances of incivility, bullying or harassment.
- The Committee noted the latest **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**.
- The **annual report on the outcome of the Trust's internal compliance checks regarding the DBS checking process** was noted and Committee members emphasised the importance of ensuring DBS compliance for all relevant Trust staff.
- The Committee's **forward programme** was noted and Committee members conducted a brief **evaluation of the meeting**.

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

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

Trust Board meeting – 29th June 2023

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 12/06/23	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 12th June 2023, face-to-face at Maidstone Hospital,

The key matters considered at the meeting were as follows:

- The Chief Nurse provided a **review of the revised Patient Experience Strategic Theme** and explained how data from patient and staff feedback was used to identify the key focus themes.
- The Deputy Chief Nurse for Quality and Experience then provided a brief **update on the NHSE Patient Experience Framework 2023 and pilot** in which it was agreed that the Chief Nurse, Deputy Chief Nurse, Quality and Experience, and Director of Strategy, Planning and Partnerships would provide the Patient Experience Strategy action plan for circulation to the Committee members.
- The Head of Patient Concerns attend to provide an **update on Complaints and Patient Advice and Liaison Services (PALS)** and it was agreed that the Head of Patient Concerns would amend the "Performance by Division and Trust by Month" table within the "Update on Complaints and the Patient Advice Liaison Service (PALS)" report to provide further narrative regarding the process by which the Trust's overall complaints performance was calculated. It was also agreed that the Head of Patient Concerns would liaise with the Lead Nurse for Palliative and End of Life Care to discuss the complaints performance for the Cancer Services division; and finally that the Director of Quality Governance would confirm the scheduling of an "Update on the current complaints policy and procedure" item at a future Committee meeting, which would include the expected use of volunteers to develop the policy.
- The Deputy Chief Nurse for Quality and Experience provided an **update on the Friends and Family Test (FFT)** and it was agreed that an "Update on the improvement plan for car parking at the Trust's sites" item would be scheduled at the Committee's meeting in September 2023 and the General Manager for Facilities Management would be invited to attend.
- As the Interim Head of Midwifery was unable to attend the meeting it was agreed that the **Trust's response to the findings from the Care Quality Commission Maternity Survey** and the **Divisional report from Women's, Children's and Sexual Health** would be re-scheduled at the Committee's meeting in September 2023.
- The Lead Nurse for Palliative and End of Life Care provided the **annual update on End of Life Care** which would also be submitted to the June 2023 'Part 1' Trust Board meeting so it was agreed that the Chief Nurse would liaise with the Lead Nurse for Palliative and End of Life Care to consider what, if any, amendments were required to the report prior to submission.
- The Learning Disability Liaison Nurse attended to provide a **Learning Disability update** in which it was agreed that a link to the report appendix "NHSE - Learning Disabilities Year 4 - IS104" be circulated to Committee members and the Director of Quality Governance should liaise with the Learning Disability Liaison Nurse to investigate whether the case examples for the complex patient admission pathway could be used for the next "patient story" item at a future 'Part 1' Trust Board meeting.
- The Patient Experience Lead provided the Committee with an **update on Voluntary Services** which included progress updates on volunteer projects such as the SWAN initiative, Emerge charity, and PAT dogs.
- The Research Governance Officer provided an **update from the National Institute for Health Research (NIHR)** which included a request for a member of the NIHR to join the membership of the Committee.
- The representative from **Healthwatch Kent** provided an update and agreed to investigate the ways in which the Trust work with Healthwatch in regards to patient concerns.

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

- That the "To consider the actions required to ensure a positive patient and staff experience in relation to the Kent and Medway Elective Orthopaedic Centre" item be removed from the forward programme.

- That the new Director of Nursing and Quality for Cancer Services be invited to future Committee meetings.

The issues that need to be drawn to the attention of the Board: The Annual update on End of Life Care report had been included in Appendix 1 for the Board's information.

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

Reason for submission to the Board (decision, discussion, information, assurance etc.)[1]
1. Information and assurance
2. To review the Annual update of the End of Life Care report (see Appendix 1)

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

PATIENT EXPERIENCE COMMITTEE – JUNE 2023

REVIEW OF THE END OF LIFE CARE (EOLC) ANNUAL REPORT	**LEAD NURSE FOR PALLIATIVE AND END OF LIFE CARE**

The End of Life Care Annual Report is enclosed for review.

Reason for submission to the Patient Experience Committee
Information and assurance

Mandatory Training	EoLC Mandatory training- 91% of Trust staff completed at end of January 2023.
Educational resources	Development of four in-house EoLC learning resource videos for staff to access on the Trust intranet: • Common questions around EoLC • Ethical dilemmas around EoLC • Am I dying? - Communication demonstration video • Discussion around spirituality and EoLC National e- ELCA EoLC modules can be accessed via MTW learning and development platform. Palliative Care CNS assigned to each ward to be the link for education- greater emphasis on local training needs of the individual wards. EoLC training provided as part of the Preceptorship Programme. E- learning, mandatory EoLC training package on MTW Learning and development platform. Face to face training to resume on return of EoLC CNS. Foundation year doctors (Year 1 & 2) and core medical trainees on both hospital sites receive face to face training from the palliative care consultant and Trust clinical ethicist on ethical challenges at the end of life and end of life care. There is an end of life information hub held each week in the library on Wednesday’s alternate weeks. This is an opportunity for staff to talk to the team about any issues and from us all to learn form each other.
Documentation	All EoLC documentation is scheduled to be uploaded to Sunrise in March, there has been a significant delay, outside the team’s control. This will include the Individualised Care Plan (ICP) for the Dying Patient and the symptom assessment checklist. The ICP, provides clinicians with guidance on areas that should be considered when caring for a dying patient. Though this is available in a hard copy, this has been underutilised. An electronic version will be easily accessible, and completion will hopefully assist in improving patient care and provide valuable data for the national end of life care audit, which benchmarks organisations EoLC across the United Kingdom.
Department Audits	MTW participated in the National End of Life Care Audit (NACEL), during 2021. The results were published in February 2022 and the action plan in response to this was approved by the EoLC committee at the end of 2022. The action plan is particularly focussed on improving the early recognition of dying, the provision of a 7-day palliative care face to face service and the integration of the end of life care documentation into the electronic patient record. In particular this will include the integration of the Individualised Care Plan (ICP) for the dying patient into Sunrise and embed the use of the document in practice across the Trust. We also plan to monitor the use of the ICP through audit.

<table>
<tr><td>Projects</td><td>Enhanced Supportive care (ESC) Project:

Enhanced Supportive Care is a two-year project funded by NHSE- which is due for completion on the 31/3 /2023. The project has two pathways;

Pathway 1- rapid access to ascitic drainage- opened up to all metastatic tumour site groups, to prevent/reduce hospital stay and improve the patient journey.

Pathway 2- ESC Clinic and rapid access to telephone support for patients who have metastatic disease (for identified tumour sites) and who are not yet known to the Hospice.

Appendix 1 – EoLC Steering Committee report</td></tr>
<tr><td>Oustanding Care</td><td>We have a number of priorities to help us deliver outstanding care in MTW.

Appendix 2 – Outstanding Care EoLC Action Plan</td></tr>
<tr><td>SWAN initiative</td><td>The SWAN initiative was introduced into the organisation during the pandemic. A Swan logo 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. The SWAN symbol is also available to be used on the SUNRISE system.

Phase two of the initiative has now been fully implemented. 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. Funding through Charitable Funds has allowed us to also provide:

• A purpose made tote SWAN bag
• Heart in their hand bereavement product
• Condolence card
• Packet of Forget Me Not seeds
• Jewellery pouch
• Note book and pen

The Swan Initiative will be evaluated via the “Bereaved Carers” survey.</td></tr>
<tr><td>EoLC/SWAN Volunteers</td><td>MTW are in the process of introducing EoLC Volunteers in to the organisation in collaboration with the Anne Robson Trust, a Charity that works with NHS Acute Hospitals. The charity provide support to set up and train teams of volunteers who provide support and companionship to dying patients and their loved ones, and support ward initiatives. We have recruited a 1.0 WTE co-ordinator at Band 4, to manage the volunteers and the service. To date we have recruited and trained 18 volunteers. The project will start at Pembury, initially and target key wards. The volunteers will work closely with palliative Care and Chaplaincy.

Both sites have a bereavement box on each ward which contains death paperwork, bereavement leaflets and the Swan bags. The contents of these boxes are currently checked and topped up by the Bereavement team

In addition, each site has a wedding box with items to decorate a room and there is a flow chart on how to arrange a wedding on the intranet.</td></tr>
</table>

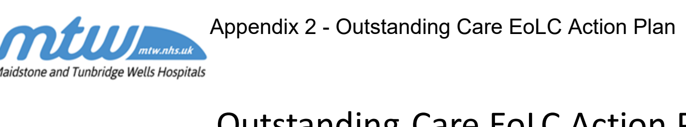
T34 syringe pump	The project to implement ambulatory syringe pumps in to the organisation for EoLC patients across adult wards to promote dignity and comfort is in the final stages. The policy has been ratified. Training on the devices is now underway though a programme for superuser training. 53 nurses across MTW, have undergone superuser training in order to cascade training at a local level on the wards. The training will also be supported by other teams including PDN's, site practitioners and palliative care.
Acquisitions	• A supply of children's books that explore the concepts of dying, death and grief. These can be given to our families that require this support. • Delivery of 30 Portable radios (15 on each site) for patients to access. • Boxes for designated EoLC/SWAN resources to be stored in the clinical areas, for easy access. 2 Glide away beds been acquired, 1 for each site, for relatives to use if staying with an end of life patient.
Dying Matters Week	A well evaluated Dying matters week in May 2022. Events were planned for staff throughout the working week and included: • "Death Café" within a designated area of the Wingman Wellbeing Tents. Prompt cards were used to spark conversations about death and dying with staff. • Staff were asked to express their "Bucket List "wishes before they die, with their reasons/explanations (if prepared to disclose) & were displayed as part of the Death café. • Screening of the film Bucket List. • Staff demonstrated their breadth of talent through submitting art work on the subject of death and dying and their feelings around this, though both art and poetry. This was displayed in the Wingman Tents across the trust. • Libraries on both sites, displayed books and DVD's during the week that staff could borrow relating to death and dying. This year "Dying Matter" week is scheduled for 8th-14th May of May and the topic is "Dying Matter at work".
Future Plans	• Development of nursing staff competencies for EoLC. • Develop more training videos – that are accessible to staff at any time.

Maidstone and Tunbridge Wells NHS Trust

End of Life Care Steering Committee Report
Project: Enhanced Supportive Care project
Month: January 2023

Overview of Project and Aims	MTW is participating in a two year Enhanced Supportive Care project funded by NHSE (February 2021- March 2023). The aim of the service is to provide additional support for patients diagnosed with non-curative malignant disease. The project started with a defined group of patients, including UGI and gynae cancers. It has since expanded to include metastatic breast cancer and it is anticipated that other tumour sites will be included as the project evolves. The project has two pathways; Pathway 1- rapid access to ascitic drainage as a day case - this aims to enhance the patients experience through rapid access to drainage 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 patient's 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.
Progress to date	• The ESC project commenced February 2021. • The Ascitic Drainage and ESC Clinic pathways commenced from 4/6/21. • After an initial slow start both pathways are now being well utilised. Additional Oncology clinic slots for the ESC Clinic pathway were negotiated in April 22- and there is now allocated clinic space available each day. • Ascitic drainage pathways criteria extended to all non-curative cancer patients to where possible reduce LOS and avoid hospital admission May 22. • Patient satisfaction surveys for the ESC clinics commenced May 22. • Service Model for ESC clinic pathways agreed to move towards a Patient initiated follow up (PIF) service to provide resilience and best use of resource • Consideration for ascitic drainage pathway to open up to pleural taps/drains. SOP amended and approved through Radiology Governance October /Nov 22.
Next steps	• Continue to review on a monthly basis for consideration of other tumour groups. • Business Case for ESC Service • MTW Representation on the UKASCC ESC Steering Group and workstreams.
Issues/ Barriers to escalate	Attendance at the project meetings has been poor. Meetings being rescheduled: • ESC Steering Group Meeting – monthly • ESC Project Group- 3 monthly. • Expansion to include pleural taps/aspirations on the ascitic pathway is dependent on identifying additional space for recoveree as well as additional funding. • Expansions of the ESC Clininc pathways is dependent on additional funding of a further Band 7 CNS.
Good News	• Funding is secured until March 2023. It has been confirmed that any remaining budget from the project does not have to be paid back to NHSE/I.

	• Continued excellent feedback from patients and clinicians. • Referral to both pathways is increasing.



Appendix 2 - Outstanding Care EoLC Action Plan

Outstanding Care EoLC Action Plan

Date	16/1/23
RAG	AMBER

Embedding EoLC documentation	It prompts clinicians to consider key issues for delivering excellent EoLC and provides evidence for participation in local and national audits.	All adult patients who are considered to be within the last days of life have a comprehensive individualised care plan completed, that takes account of their preferences and wishes for EoLC (and where appropriate those important to them).
EoLC Repository	To provide clinical teams with comprehensive resource's and information to provide good EoLC.	A one stop repository that supports clinical teams to provide the best care possible for EoLC patients.
Advance Care Planning.	Assesses key clinical priorities to identify robust management plans for patients, eg TEP/AMBER/ReSPECT.	All adult patients with uncertain recovery to have discussions re preferences and wishes for care and a plan of care in place in case of deterioration.
SWAN initiative	To improve the experience of EoLC for the patients relatives	All wards to have successfully implemented the Swan Initiative and for it to be well evaluated through the Bereaved Carers Survey.
EoLC Volunteer	To provide additional support to EoLC patients and those important to them.	EoLC volunteers available on adult wards sit with patients who are dying when relatives are unable to and to provide additional support to wards.

Priority Areas

- **Safe** - Embedding EoLC documentation. Increase % individualised Care plans for the Dying patient and associated documentation. 90% compliance with EoLC mandatory training. Revision of MTW Care of the Dying and Deceased Policy and Procedure.
- **Effective-** EoLC repository on Intranet. Continuous feedback on our delivery of EoLC from bereaved relatives/those important to the deceased patient to inform service development. Analyse EoLC complaints for themes- agree action plan to address issues/concerns. Mechanism to engage staff in EoLC service developments and forums for them to share concerns, good practice etc.
- **Caring** - Implementation of SWAN initiative across adult wards. Introduction of EoLC Volunteers.
- **Responsive**- Promote and agree process for utilising the ReSPECT document in MTW.
- **Well Led**– Assess Trust compliance against 21/22 NACEL report .EoLC Strategy .

How will you measure progress for each area identified?

- **Safe**-Annual audit of ICP/ EoLC documentation. Monitor monthly compliance with Mandatory EoLC training. Ratification
- **Effective**- Clinicians evaluation of repository via focus groups/survey monkey. Monitor complaints, themes reported through EoLC Steering Committee, formulate action plan. Undertake continuous "Bereaved Carers Survey", results reported to EoLC Steering Committee, action plan formulated and monitored via the committee. Reinstate/invigorate EoLC Hubs
- **Caring** SWAN initiative imbedded on each ward and evaluation from relatives through the Bereaved Carers Survey.
- **Responsive-** Progress against NACEL action plan reported to Cancer Division ,directorate meetings and EoLC Steering Committee.
- **Well Led-** MTW EoLC Strategy to be monitored via EoLC Steering Committee. Participation in annual NACEL Audit and results compared against previous results. Action plan monitored though EoLC Steering Committee.

Achievements

- EoLC banner is now being promoted on the intranet- highlighting key priorities and documentation.
- Data from the first covid waves (90 patient deaths) has been completed and an action plan agreed.
- Introduction of pilot for EoLC Volunteers

Active Monitoring

- MTW EoLC Strategy – to be monitored via EoLC Steering Committee.
- NACEL annual audit- action plan to be monitored via EoLC Steering Committee.
- EoLC Complaints
- Bereaved Carers Survey
- Annual ICP audit.
- Any EoLC deaths identified associated with complaints, issues monitored through Mortality Surveillance meetings.

Appendix 2 - Outstanding Care EoLC Action Plan

Continuing Focus	Reason for focus	Service update	RAG status
Patient Experience (FFT, AIS, Engagement ALWAYS events)	To ensure that the patient experience is the 'Golden Thread' running through the core of all services and care delivery across the Trust. Our Quality vision is to deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work at.	NACEL audit deferred in 2022 to undertake analysis into results from 2020, and to develop an action plan to improve future results. Bereaved Carers survey undertaken continuously- report for 2021 in progress and will be shared throughout the organisation.	
Safety Culture (Learning from Incidents & Shared Learning)	To embed an open culture of shared learning and continuous improvement. Working together to put quality at the heart of all we do. Achieving outstanding clinical outcomes and ensuring no patient comes to any harm which could have been avoided.	We aim to disseminate results of the following through the organisation and develop shared action plan with the findings; • Bereaved Carers Survey • Participation in NACEL • Complaints report	
Staff Welfare & Engagement (Culture & Development)	Make MTW a great place to work . We want our staff to be exceptional and deliver outstanding care. Make MTW a great place to work . To embed cultures that enable the delivery of continuously improving, high quality, safe and compassionate care.	Staff survey as a new additional measure to the NACEL audit EoLC Hubs- inviting people to come and talk to members of the palliative and EoLC team to share ideas/concerns ne initiatives.	
Insight Report	To action any data provided in the CQC insight report that highlights a need for monitoring or improvement		

Safe- Embedding Documentation=- *ICP version 4 due to be launched as part of an EoLC launch during winter 2022- deferred due to delays with EPR****.*** *Palliative care CNS aligned to each adult ward – to regularly check key documentation is available and being used on an ongoing basis. Attendance at Board rounds by DLT on key wards to prompt use of key documentation and ask the two key questions.* ***Effective- EoLC repository on the intranet-*** *key documentation, guidance and resources to be accessible In one place, Winter 2022.* ***Responsiveness-*** *Implementing EoLC Volunteer in collaboration with Ann Robson Foundation****. Caring-*** *Disseminate Bereaved carers survey results through the organisation Winter 2022.* ***Well Led-*** *NACEL audit 2021 submitted and preliminary for comments released 12/11/21, final national report issued in July 2022, results shared at EoLC Steering Committee and other key forums. A3 thinking being undertaken in relation to results that we were below the national average in recognising patients dying in a timely way.*

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Integrated Performance Report (IPR) for May 2023	**Chief Executive / Members of the Executive Team**

The IPR for month 2, 2023/24, 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, 27/06/23

Reason for submission to 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

Integrated Performance Report

May 2023

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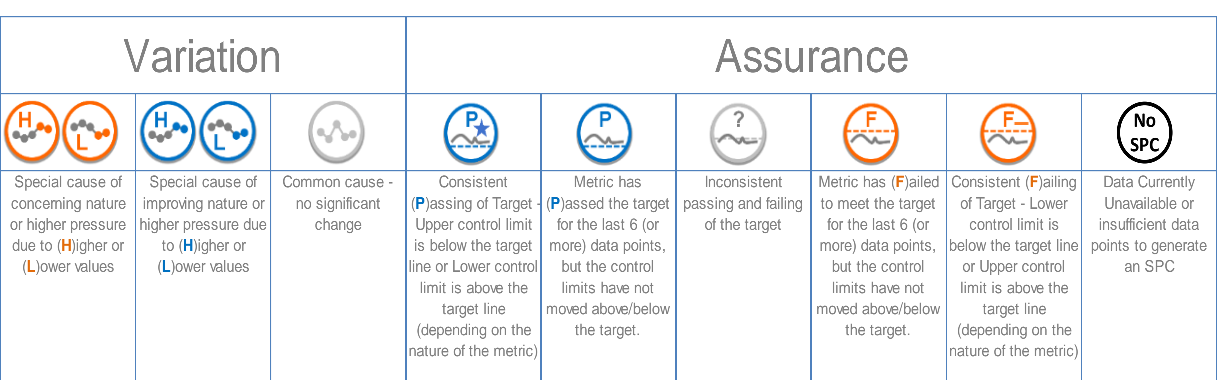
Note: Detailed dashboards and a deep dive into each SDR and CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

Key to KPI Variation and Assurance Icons



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.

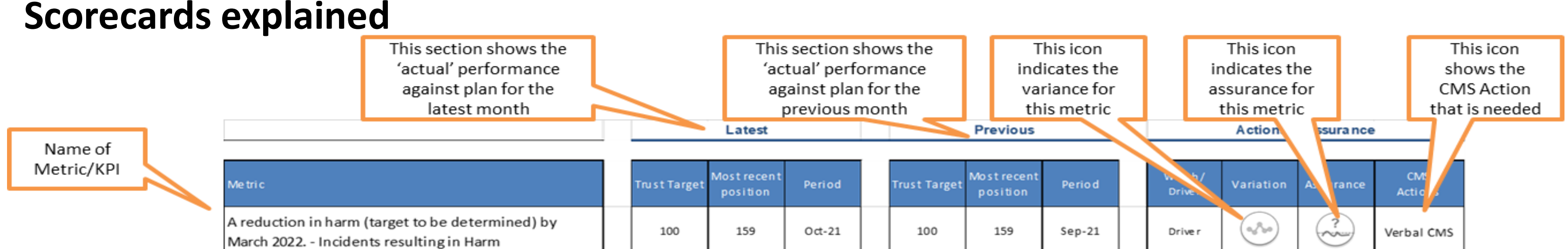
Escalation Rules:

Please see the Business Rules for the five areas of Assurance: Consistently Failing, Not achieving target >=6 months, Hit or Miss, Consistently Passing and Achieving target >=6 months (three slides in the last Appendix)

Escalation Pages:

SPC Charts that have been escalated as have triggered the Business Rule for Full Escalation have a Red Border

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

Executive Summary: The Trust Vacancy Rate continues to experience special cause variation of an improving nature and passing the target for 6+ months. Turnover Rate in now experiencing common cause variation but has failed the target for more than six months. Agency spend has achieved the target for May 23 and has moved into common cause variation and variable achievement of the target. It is therefore no longer escalated. Sickness levels remain in variable achievement of the target and common cause variation. The Trust Appraisal window only opened mid-April so the Appraisal rate is expected to increase significantly before the window closes at the end of July 2023, with a phased trajectory upwards to 95% . Statutory and Mandatory Training achieved the target again in May 23 but remains in special cause variation of a concerning nature and variable achievement of the target. With regards to the National Equality and Diversity Indicators (EDI) both the percentage of staff Afc 8a or above that are female or have a disability have achieved the target in April and May 23. The indicator for those that are BAME is consistently failing the target but is in special cause variation of an improving nature. The Trust was £2.2m in deficit in the month which was on plan. Year to Date the Trust is £2.7m in deficit which is £0.3m adverse to plan.

With the continued lower level Nursing Vacancy Rate, the Nursing Safe Staffing Levels remain above target. The rate of inpatient falls continues to experience common cause variation and variable achievement of the target. Hospital on-set of COVID remains in escalation. These indicators also impact the Incidents resulting in harm indicator which is now experiencing special cause variation of a concerning nature and failing the target for more than six months. Complaints response times have failed the target for >6 months and therefore remains escalated. Friends and Family Response times remain challenging but have seen some improvements in Inpatients and A&E, both experiencing special cause variation of an improving nature.

Diagnostic Waiting Times has achieved the recovery trajectory target set for May 23 and is therefore no longer escalated as is now experiencing common cause variation and variable achievement of the target. RTT performance remains below the recovery trajectory, now experiencing special cause variation of a concerning nature and not achieving the trajectory target for more than six months. We remain one of the best performing trusts in the country for longer waiters. Performance for First outpatient activity levels is likely to achieve around 99% of the plan for May-23, experiencing common cause variation and failing the target for more than six months. Outpatient Utilisation is now experiencing special cause variation of an improving nature but is consistently failing the target. Diagnostic Activity levels remain below plan for May 2023 due to equipment issues, phasing of the Community Diagnostic Centre (CDC) and operational challenges, but remain above 1920 levels. Elective (inpatient and day case combined) activity has once again achieved the target for May 2023 and continues to experience common cause variation of an improving nature and passing the target for more than six consecutive months.

The number of patients leaving our hospitals before noon is now experiencing common cause variation and consistently failing the target. A&E 4hr performance was just below trajectory for May 23 (-0.2%), but continues to experience common cause variation and variable achievement of the target. The Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers continue to experience common cause variation and variable achievement of the target and are no longer escalated. The Trust has once again achieved the Cancer Waiting Times 62 Day standard for the month of April and has continued to achieve the national 2 Week Wait (2WW) Standard. Achievement of these standards continues to remain increasingly challenging.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.8)
- Sickness Rate (P.9)*
- % of Afc 8c and above that have a Disability (P.9)
- % of Afc 8c and above that are BAME (P.9)

Patient Safety & Clinical Effectiveness:
- Incidents resulting in Harm (P.11)
- Infection Control - COVID (P.12)

Patient Access:
- RTT Performance (P.14)
- Planned levels of new outpatients activity (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- Planned levels of Diagnostics activity (P.16)

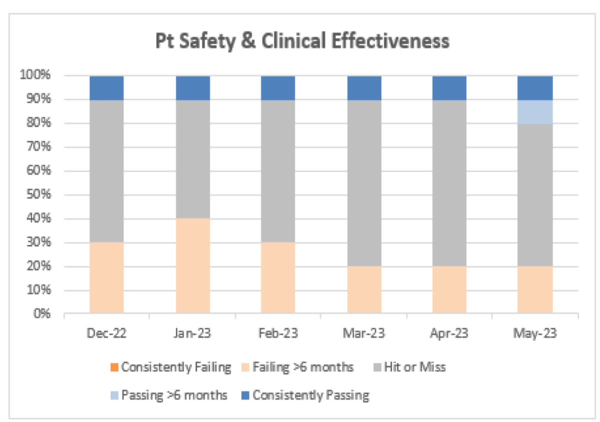
Patient Experience:
- Complaints responded within target (P.18)
- FFT Response Rates - Inpatients, A&E, Outpatients and Maternity (P.18)

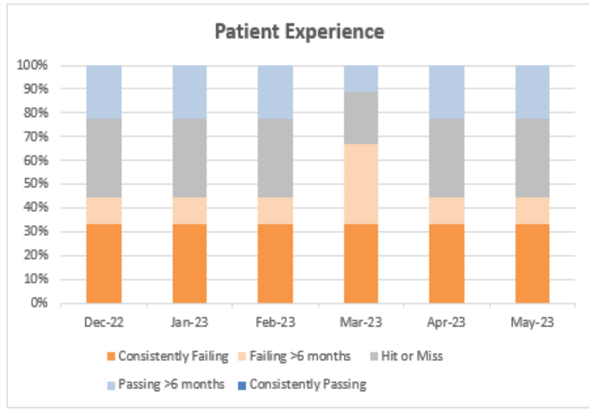
Systems:
- Discharges before Noon (P.20)

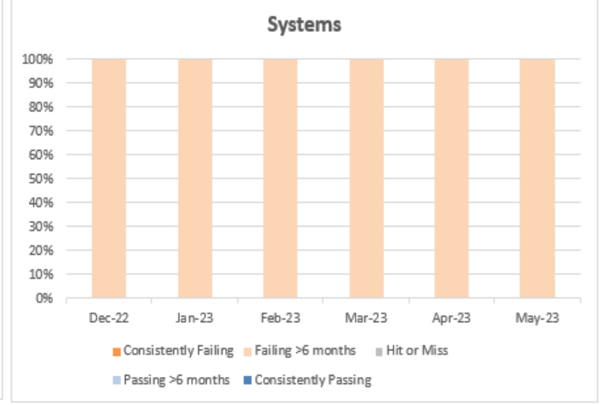
Sustainability: None

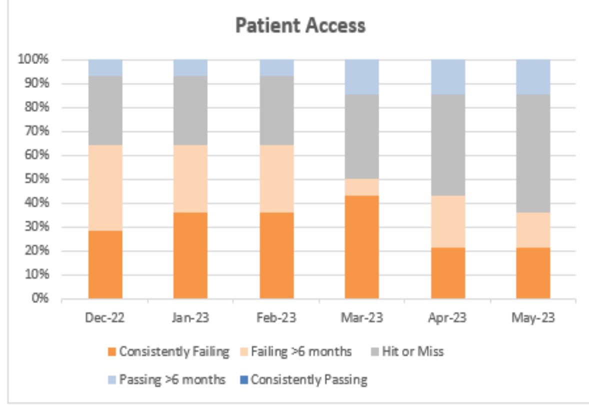
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

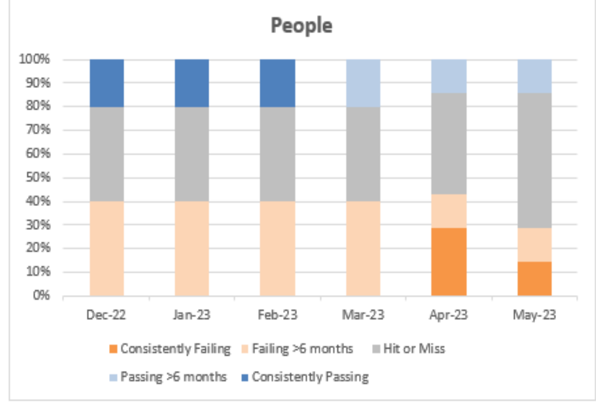
Assurance Stacked Bar Charts by Strategic Theme

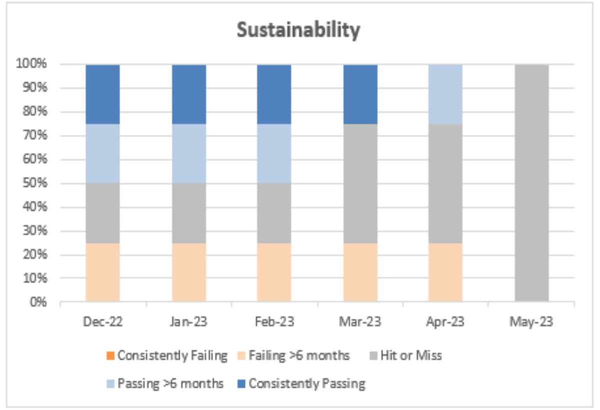












Matrix Summary

May 2023

Variance	Assurance: Pass★	Pass	Hit and Miss	Fail	Fail -
Special Cause - Improvement		Reduce the Trust wide vacancy rate to 12% To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Never Events Complaints Rate per 1,000 occupied beddays	Percentage of AfC 8c and above that are Female To reduce the overall number of complaints or concerns each month Cancer - 62 Day Friends and Family (FFT) % Response Rate: Inpatients		Transformation: % OP Clinics Utilised (slots) Friends and Family (FFT) % Response Rate: A&E Percentage of AfC 8c and above that are BAME
Common Cause	Summary Hospital-level Mortality Indicator (SHMI)	Ensure activity levels for theatres match those pre-Covid - Total Elective Cancer - 2 Week Wait	Percentage of AfC 8c and above that have a Disability RTT Patients waiting longer than 40 weeks for treatment Delivery of financial plan, including operational delivery of capital investment plan. Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients Reduce the amount of money the Trusts spends on premium workforce spend Number of New SIs in month Access to Diagnostics (<6weeks standard) A&E 4 hr Performance Safe Staffing Levels Cash Balance (£k) Capital Expenditure (£k) Sickness Absence IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Flow: Ambulance Handover Delays >30mins Flow: % of Emergency Admissions into Assessment Areas Standardised Mortality HSMR	Reduce Turnover Rate to 12% Achieve the Trust RTT Trajectory To achieve the planned levels of new outpatients activity (shown as a % 19/20) Infection Control - Hospital Acquired Covid % complaints responded to within target	Diagnostic Activity (MRI,NOUS,CT Combined) Friends and Family (FFT) % Response Rate: Maternity To increase the number of patients leaving our hospitals by noon on the day of discharge Transformation: CAU Calls answered <1 minute
Special Cause - Concern			Statutory and Mandatory Training % VTE Risk Assessment (one month behind)	Reduction in incidents resulting in harm by 8.2%	Friends and Family (FFT) % Response Rate: Outpatients

Strategic Theme: People

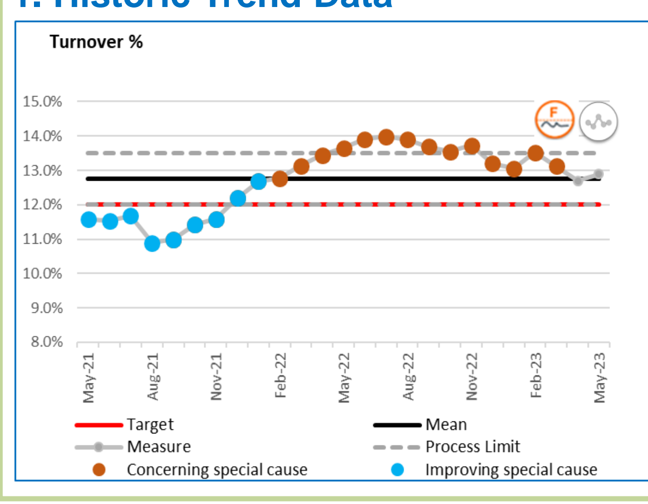
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%	12%	10.2%	May-23	12%	10.4%	Apr-23	Driver	L	P	Note Performance
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%	12%	12.9%	May-23	12%	12.7%	Apr-23	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	3.5%	Apr-23	4.5%	4.2%	Mar-23	Driver		?	Not Escalated
	Well Led	Appraisal Completeness	10.0%	13.1%	May-23	0.0%	1.3%	Apr-23	Driver	No SPC	No SPC	Not Escalated
	Well Led	Statutory and Mandatory Training	85.0%	87.3%	May-23	85.0%	87.3%	Apr-23	Driver	L	?	Not Escalated
	Well Led	Percentage of AfC 8c and above that are Female	62.0%	66.9%	May-23	62.0%	65.5%	Apr-23	Driver	H	?	Not Escalated
	Well Led	Percentage of AfC 8c and above that have a Disability	3.2%	3.3%	May-23	3.2%	3.5%	Apr-23	Driver		?	Not Escalated
	Well Led	Percentage of AfC 8c and above that are BAME	12.0%	9.1%	May-23	12.0%	7.1%	Apr-23	Driver	H	F	Escalation

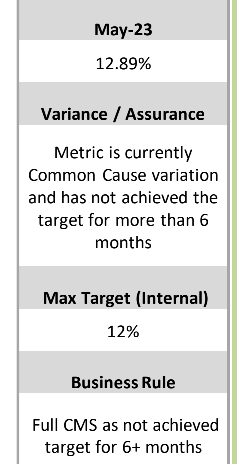
Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data





May-23

12.89%

Variance / Assurance

Metric is currently Common Cause variation and has not achieved the target for more than 6 months

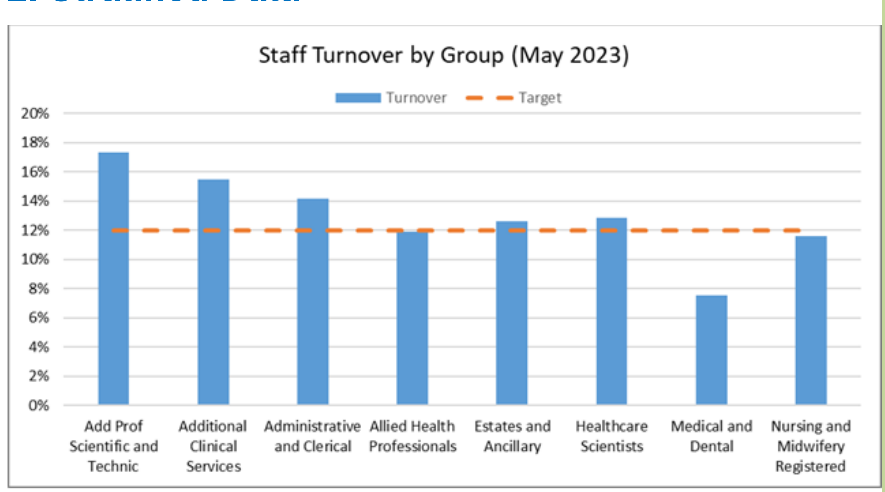
Max Target (Internal)

12%

Business Rule

Full CMS as not achieved target for 6+ months

2. Stratified Data



3. Top Contributors

These are some of the main contributors of focus for the working groups

Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership capability
	Not enough locally trained staff / Lack of staff development

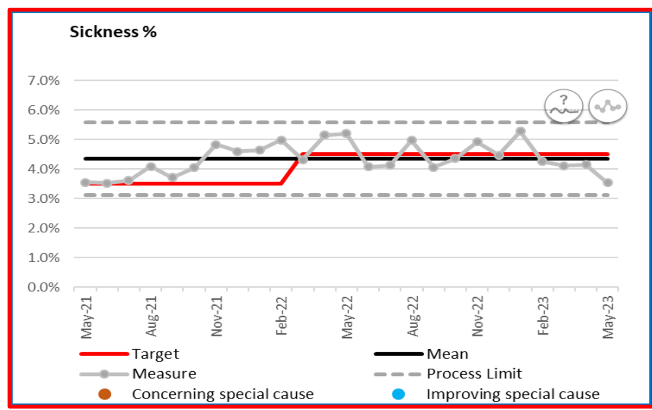
Processes	Retention
Retire and return policy out of date, putting people off returning	Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action
TRAC process takes too long, leading to delays / lack of transparency in recruitment	No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere

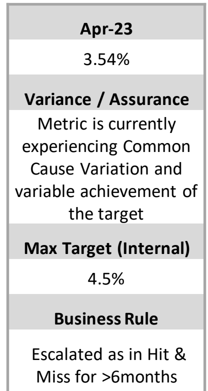
4. Action Plan

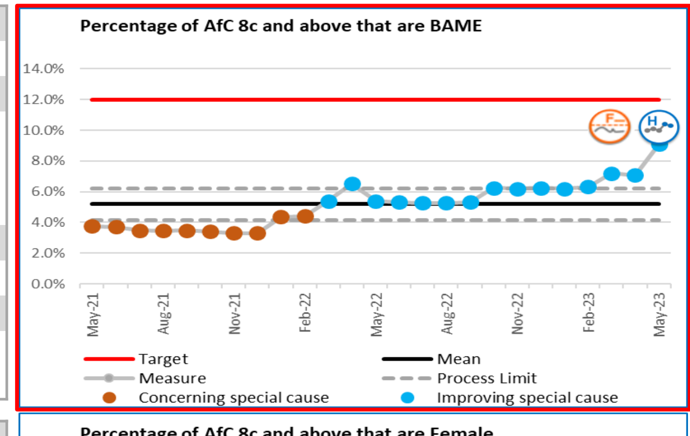
A full action plan by the working groups has been developed; some of the key actions shown:

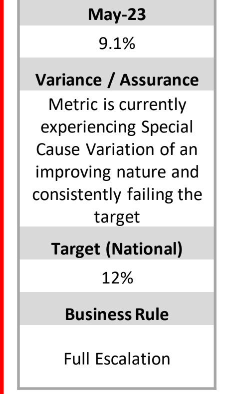
Countermeasures	Target Completion Date
Introduce localised trust-based incentives for both attraction and retention	Jun-23
Retire and return policy to be reviewed to reduce barriers for ex-employees returning to MTW	Jun-23
Create talent pool/ list of names of people interested in promotion	Aug-23
Introduce virtual onboarding info pack	Jun-23
Introduce stay interviews	Jun-23
Introduce staff voice box	Jun-23

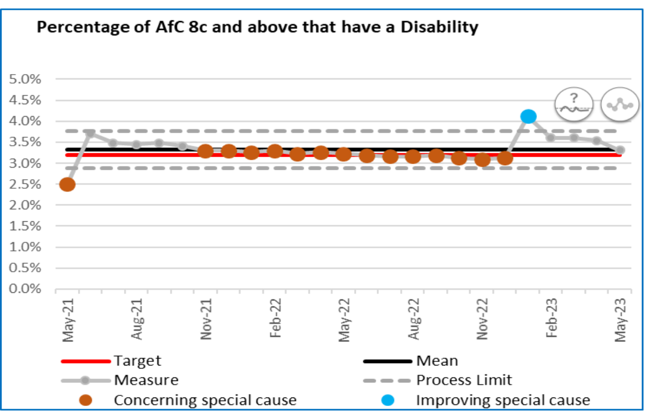
People – Workforce: CQC: Well-Led

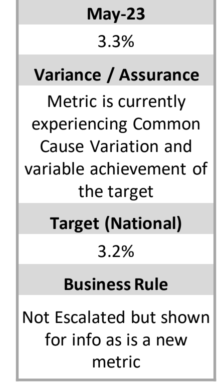


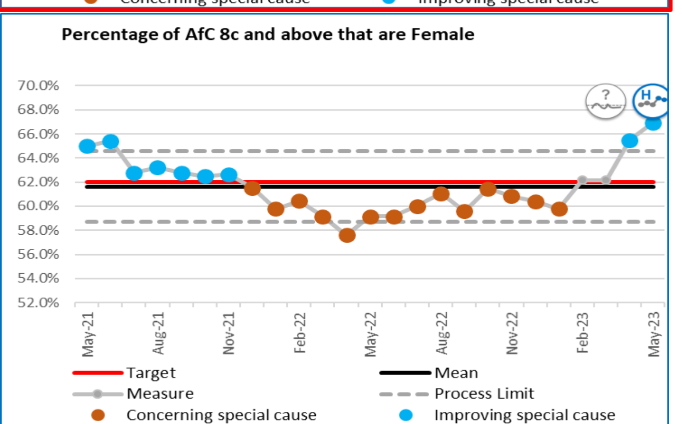












May-23

66.9%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and variable achievement of the target

Target (National)

62%

Business Rule

Not Escalated but shown for info as is a new metric

Summary:

Sickness % - This metric is experiencing Common Cause Variation and variable achievement of the Target

Three new indicators that form part of the National Single Oversight Framework have now been included:

% of AfC 8c and above that are BAME: This metric is experiencing special cause variation of an improving nature and consistently failing the target.

% of AfC 8c and above that have a Disability: This metric is experiencing common cause variation and variable achievement of the target.

% of AfC 8c and above that are Female: This metric is experiencing special cause variation of an improving nature and variable achievement of the target.

Actions:

Sickness: Current levels of sickness are in line with seasonal variations at this time of year, with a slightly improved absence rate compared to 12 months ago (once covid absence is removed). No absence due to covid now for the past 3 months.

% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME :

As at May 23 the current number of staff (WTEs) that are AfC 8c and above is 121. Of these 4 have a disability , 11 are BAME and 81 are female.

Actions:

- Communications targeted at bands 8c and above to promote updated EDI data on ESR through ESS.
- Mandate for EDI recruitment reps to be on all interview panels of 8C and above

Assurance & Timescales for Improvement:

Sickness: EfM remains an outlier when compared to other divisions, although follows the trend of improving absence rates. Long term absence drives the rate up in this area and there is a focus on resolving a number of these cases this month, so we would expect to see this trend to continue to improve.

% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:

Develop and deliver values based recruitment training by July 2023, targeting recruiting managers in Divisions with high turnover.

NB: These are not rapidly changing indicators

Strategic Theme: Patient Safety & Clinical Effectiveness

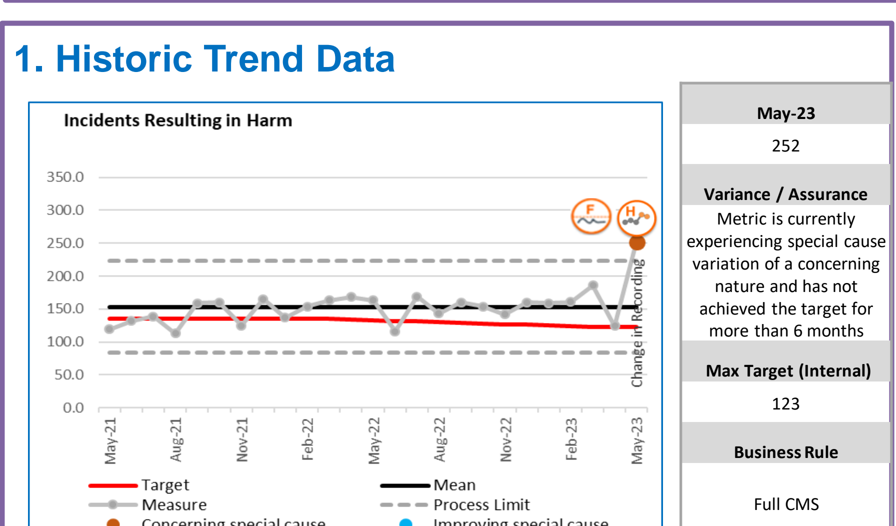
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	Reduction in incidents resulting in harm by 8.2%	123	252	May-23	123	124	Apr-23	Driver			Full CMS
Breakthrough Objectives	Safe	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days	6.36	5.18	May-23	6.36	7.28	Apr-23	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	11	May-23	11	7	Apr-23	Driver			Not Escalated
	Safe	Standardised Mortality HSMR	100.0	98.4	Feb-23	100.0	100.4	Jan-23	Driver			Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	92.0	Feb-23	100.0	91.5	Jan-23	Driver			Not Escalated
	Safe	Never Events	0	0	May-23	0	0	Apr-23	Driver			Not Escalated
	Safe	Safe Staffing Levels	93.5%	95.6%	May-23	93.5%	99.3%	Apr-23	Driver			Not Escalated
	Safe	Infection Control - Hospital Acquired Covid	0	17	May-23	0	15	Apr-23	Driver			Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	46.6	May-23	22.7	21.6	Apr-23	Driver			Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	0	May-23	0	0	Apr-23	Driver			Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduction in harm : Incidents resulting in harm

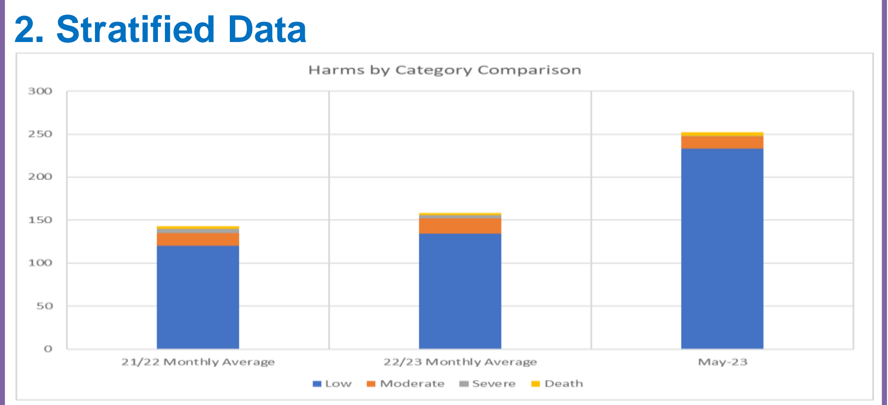
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



May-23
252
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has not achieved the target for more than 6 months
Max Target (Internal)
123
Business Rule
Full CMS

2. Stratified Data



The data has increased in May 23. This is due to a change in the way harm is reported and graded on the new In-phase system , there are now much clearer thresholds for the harm levels which has led to an increase in low harm incidents that may previously have been graded as no harm. In addition, the Trust has run a lot of incident reporting training sessions explaining this so there is more education and awareness

3. Top Contributors

Equipment

Equipment to access real time information

Patient

Complexity

Obesity

Comorbidities

Frailty

Atypical presentation

Patient's carers not listened to, assumptions made

Process/ Procedure

Lack of real time information from wards to ED to outreach team to monitor deteriorating patients

Introduction of sunrise has impacted completion of documentation as clinicians adjust to new system

Introduction of sunrise has impacted completion of documentation as clinicians adjust to new system

Lack of continuity of care in ED

Lack of real time information from wards /ED to outreach team to monitor deteriorating patients

Lack of handover to ward staff

Lack of interoperability

Incidents resulting in Harm

External/other

Failure to identify deteriorating patients in the community

Community acquired pressure ulcers

Lack of adequate community resources, to mange patient in the community

Place/Environment

Space for learning , training, feedback and discussion

Outlier

Single/ Side rooms

People

Reluctance to act Leadership variation

Failure to escalate

Level of Skills mix/ Right skills

Unconscious bias

Lack of professional curiosity

Lack of training to enhance recognition

Failure to complete screening tool

Poor Handover Ambulance to ED to Ward

Silo working, resistance to collaborate

Inconsistent application of processes

Inability to recognise deteriorating patients

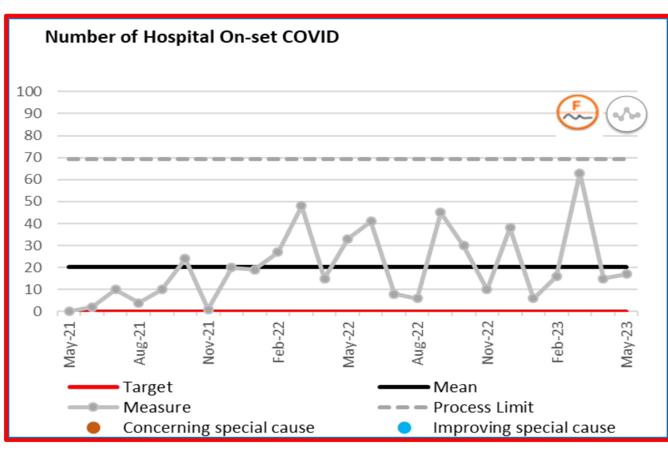
Failure to complete screening tool

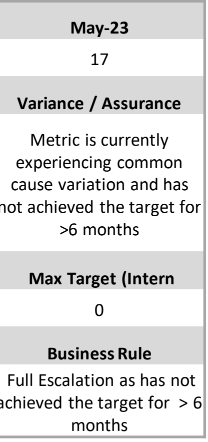
High stress levels amongst staff

4. Action Plan

Contributor	solution /countermeasure	Owner	Due By
Workforce	Safer staffing fill rate levels	CNO/CPO	Ongoing
Environment/ Equipment/ Process	**Focus on Slips, trips and falls,** as major contributing factor to incidents resulting in severe harm (30%). -Falls have continued to see a decline with 101 recorded falls in May compared to 135 in April across the trust. **Harm A3 Engagement Session** was held in May 2023 with stakeholders from the divisions, patient safety and representatives from significant areas of harm impact including pressure ulcer, outreach, sunrise and resus. Countermeasures identified from the session are being developed into a working plan to address the top contributors to Harm. The focus will be on moderate to severe harm which result in the greatest impact to patients, their loves ones and staff members. Falls – Fall will continue to be an ongoing initiative, returning to business as usual with a focus on monitoring and sustaining initiatives implemented. Some of the area of focus being developed include deteriorating patients, failure to escalate, sepsis, Acute Kidney Injury (AKI), missed diagnostics and pressure ulcers.	Medical Director	Ongoing - BAU

Patient Safety and Clinical Effectiveness: CQC: Safe





Summary:

Hospital on-set COVID: This indicator is experiencing common cause variation and has failed to achieve the target of zero for more than six months.

Actions:

Infection Control: Following national guidance, changes to patient and staff COVID testing was introduced at the end of April. For patients this meant that lateral flow tests (LFTs) are no longer required to stepdown immunocompetent patients. These patients can be stepped down after 5 days as long as they are 48 hours without a temperature and had a clinical assessment. Immunocompromised patients still require LFTs and can be stepped down after 10 days. Staff working with immunocompetent patients are no longer required to test if they are symptomatic, they should feel well enough to come to work (without a temperature) and wear a mask if they have respiratory symptoms. LFTs are still required for symptomatic staff working with immunocompromised patients

Assurance & Timescales for Improvement:

Infection Control: The numbers of COVID in our hospitals have reduced, with less patients presenting through ED and as inpatients. We still identify some patients as positive on their discharge LFT test to care home and see sporadic outbreaks involving both patients and staff. IPC control measures are put in place in any areas identified as having an outbreak including enhanced cleaning and the wearing of masks for all staff entering or working in that area.

Strategic Theme: Patient Access

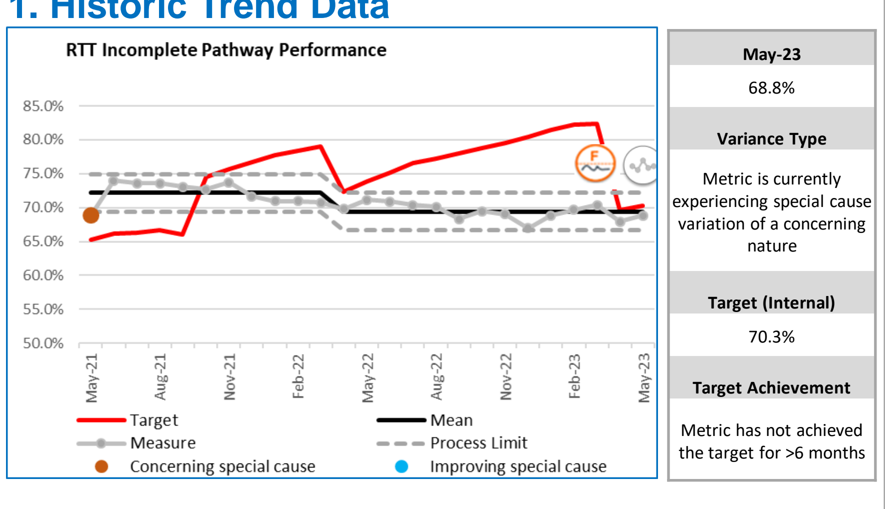
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory	70.3%	68.8%	May-23	69.7%	67.9%	Apr-23	Driver		F	Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	112.9%	110.4%	May-23	101.1%	98.8%	Apr-23	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	659	622	May-23	663	704	Apr-23	Driver		?	Not Escalated
	Responsive	Access to Diagnostics (<6weeks standard)	86.1%	92.8%	May-23	86.2%	89.4%	Apr-23	Driver		?	Not Escalated
	Responsive	A&E 4 hr Performance	87.4%	87.2%	May-23	88.3%	89.6%	Apr-23	Driver		?	Not Escalated
	Responsive	Cancer - 2 Week Wait	93.0%	93.6%	Apr-23	93.0%	93.9%	Mar-23	Driver		P	Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.1%	Apr-23	85.0%	85.3%	Mar-23	Driver	H	?	Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	75.3%	May-23	85.0%	76.1%	Apr-23	Driver	H	F	Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	5.6%	May-23	1.5%	4.5%	Apr-23	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	57.2%	May-23	90.0%	60.0%	Apr-23	Driver		F	Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	4.9%	May-23	5.0%	3.9%	Apr-23	Driver		?	Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	62.6%	May-23	65.0%	66.0%	Apr-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	96.6%	103.0%	May-23	92.8%	96.5%	Apr-23	Driver		P	Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	101.0%	105.7%	May-23	90.5%	97.0%	Apr-23	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	143.2%	130.8%	May-23	143.6%	128.2%	Apr-23	Driver		F	Escalation

Vision: Counter Measure Summary

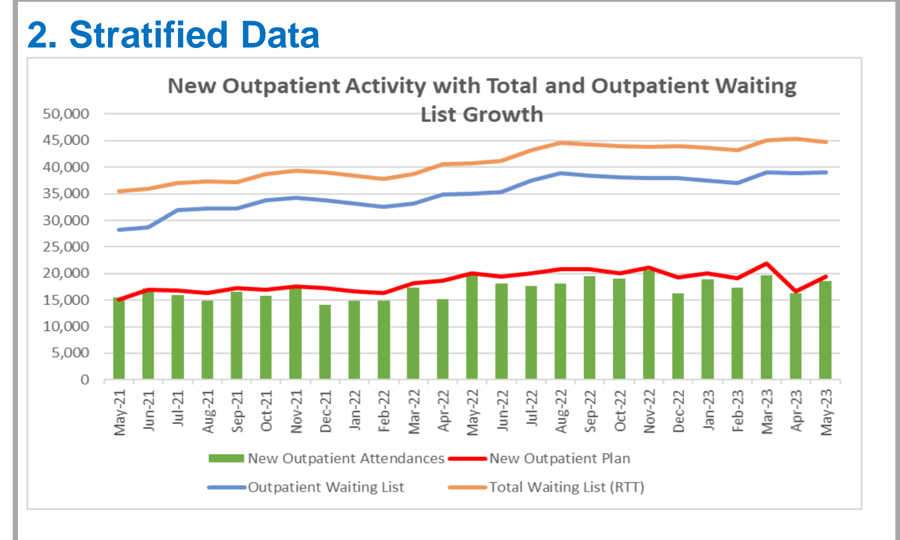
Project/Metric Name – Achieve the Trust RTT

Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data



3. Top Contributors

RTT A3 from last year has been completed.

RTT performance data being reviewed for this year which will be presented at Finance and Performance Committee in September.

Top 5 underperforming RTT specialties

- Neurology
- Gastro
- Gynae
- Urology
- ENT

BAU actions within action plan continue

4. Action Plan

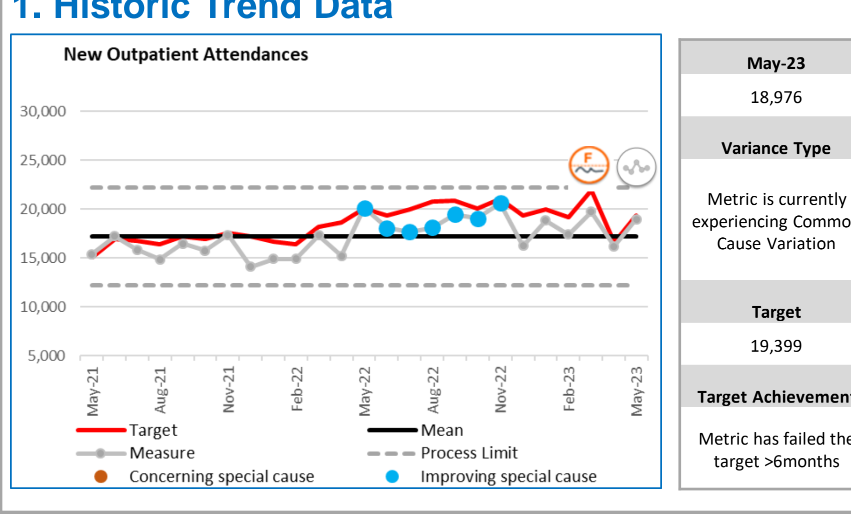
Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on the Breakthrough Objective to Increase New Outpatient Activity	SP	Ongoing
Additional PTL	Gynae team – focus on patients from 28 weeks to longest waiter	Specialty GM, Patient Access and Deputy COO	Ongoing
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting	RTT Lead and PAT team	Weekly and in progress
Update RTT top contributors	Develop new A3 with updated RTT data	SC/BI/PMO	End June 23

Breakthrough Objective: Counter Measure Summary

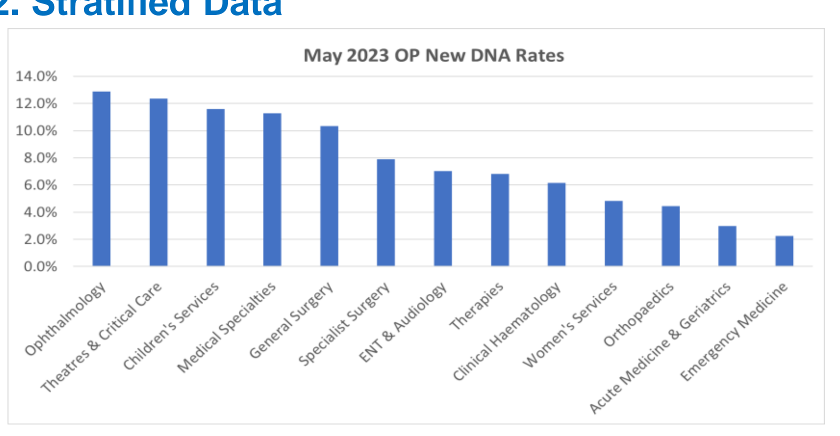
Project/Metric Name – To achieve the planned levels of New Outpatient Activity

Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data

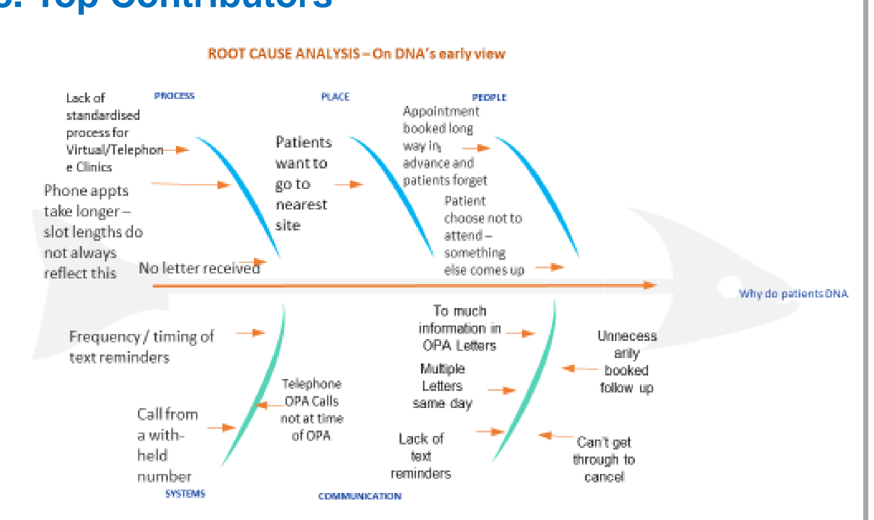


2. Stratified Data



Although the Trust is near its 5% target the specialties that are not achieving activity levels have a DNA rate of 9% or above

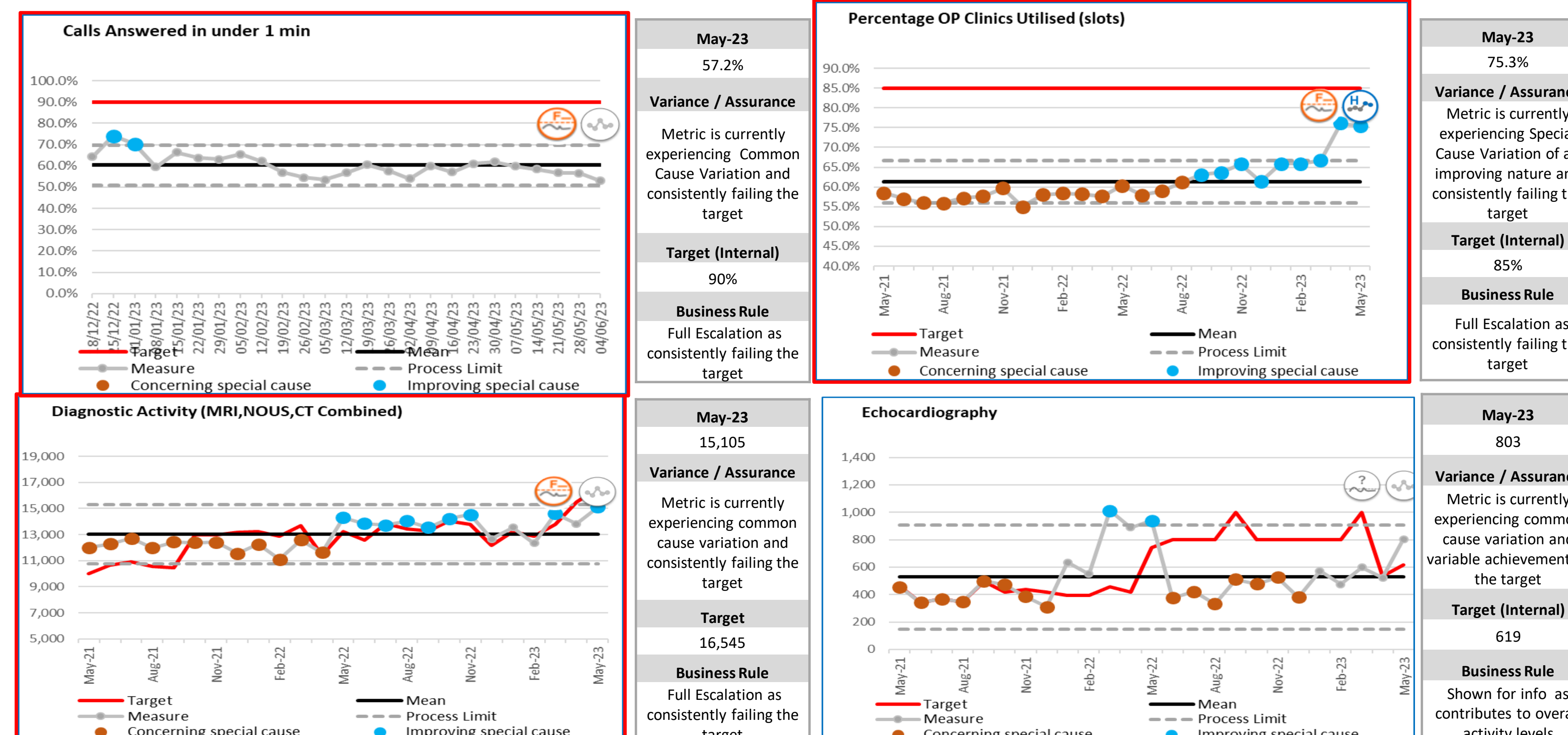
3. Top Contributors



4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Two way text	Implementation plan developed	Project Team	Complete
	Operational process flows for CAU to be agreed	Project team	Feb 23
	IT Load balancers installed. AllIT works completed 5.6.23	IT	Y
	Go live planned for 23.6.23	Project Team	N
Switch on Paediatric Text under 13's reminders (agreed for Ophth)	SOP & Policy Document sign off by Governance and W&C directorate . Awaiting sign off by governance by end June 23	SP/KS/JT	partial
Telephone Clinics – review of letters & OPA flow	Monitor Telephone Clinic DNA's to see improvement. OP team auditing virtual clinics to identify areas of improvements	SC/LL/FS	In progress
Comms Plan	ICB Posters to be updated with MTW details and circulated to OP areas/intranet site	FJ/SC	In progress

Patient Access: CQC: Responsive



Calls Answered in under 1 min

May-23
57.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target

Percentage OP Clinics Utilised (slots)

May-23
75.3%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation as consistently failing the target

Diagnostic Activity (MRI,NOUS,CT Combined)

May-23
15,105
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target
16,545
Business Rule
Full Escalation as consistently failing the target

Echocardiography

May-23
803
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (Internal)
619
Business Rule
Shown for info as contributes to overall activity levels

Summary:

Calls Answered <1 min: is experiencing common cause variation and remains consistently failing the target. The areas with the lowest rate is 2WW, Women & Children, Surgical Specialties and General Surgery.

Outpatient Utilisation: is experiencing special cause variation of an improving nature and consistently failing the target. The Divisions below 75% are Medicine, Pre-Op and Women & Children's Services.

Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS but are experiencing common cause variation and consistently failing the target.

Diagnostic Echocardiography Activity: Activity was above the revised recovery trajectory set for May 23. Metric is now experiencing common cause variation and variable achievement of the target.

Actions:

Performance against the under 1 minute KPI: no speciality achieved the target. Ophthalmology had the strongest performance >70%. 2WW was particularly low at 32%.

Outpatient Clinic Slot Utilisation: the OPD team will continue to work with the CAU's on their clinic templates and the utilisation of clinic slots. Slot utilisation is discussed at the RTT meeting. Reporting has not been able to effectively dictate

Diagnostic Activity: MRI and CT activity is below plan for May 2023 due to equipment issues; planning is in place to divert activity to the more resilient scanners.

Echocardiography Activity: was above the recovery trajectory for May 2023. Activity being monitored weekly which also led to an improvement in the Diagnostic Waiting Times indicator

Assurance & Timescales for Improvement:

Calls Answered within 1 minute in the CAUs: New contract centre team recruited, start date July 2023 – this is when we expect to see the largest increase in performance. Many CAUs are reporting short staffing, however, new gynae admin funding has been secured and new starters are due to join the cancer 2ww office and general surgery. We are working with specialities to design a rota with the staff they have based on busiest call times.

The IT telephone systems went down for 1 day which impacted the months performance by 1%.

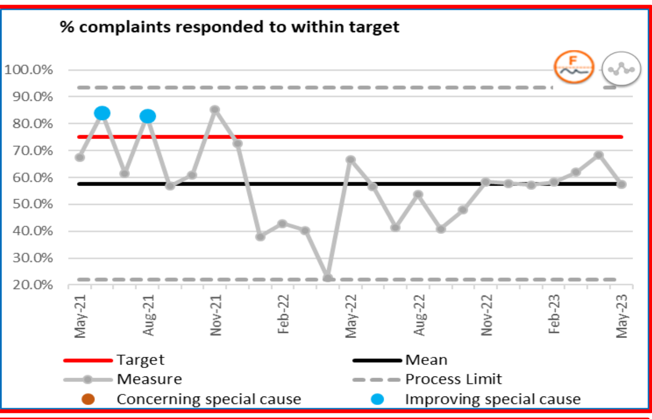
Outpatient Slot Utilisation: Focus areas on certain specialities e.g. haematology – seen an increase from below 60% utilisation to above 80%. Some clinic templates remaining in the system that don't fall under a particular specialty however, these are now being captured and reviewed to ensure any old templates are closed.

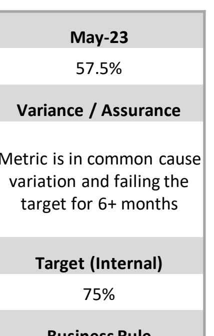
The most recent week of date is still being validated as clinics are being cashed up.

Strategic Theme: Patient Experience

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month	36	42	May-23	36	34	Apr-23	Driver			Note Performance
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	24	6	May-23	24	12	Apr-23	Driver			Note Performance
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays	3.9	2.2	May-23	3.9	2	Apr-23	Driver			Not Escalated
	Caring	% complaints responded to within target	75.0%	57.5%	May-23	75.0%	68.4%	Apr-23	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	94.2%	Apr-23	95.0%	94.8%	Mar-23	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	29.0%	May-23	25.0%	28.6%	Apr-23	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	6.7%	May-23	15.0%	6.3%	Apr-23	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	14.5%	May-23	25.0%	29.6%	Apr-23	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	6.8%	May-23	20.0%	4.1%	Apr-23	Driver			Escalation

Patient Experience: CQC: Caring





May-23

57.5%

Variance / Assurance

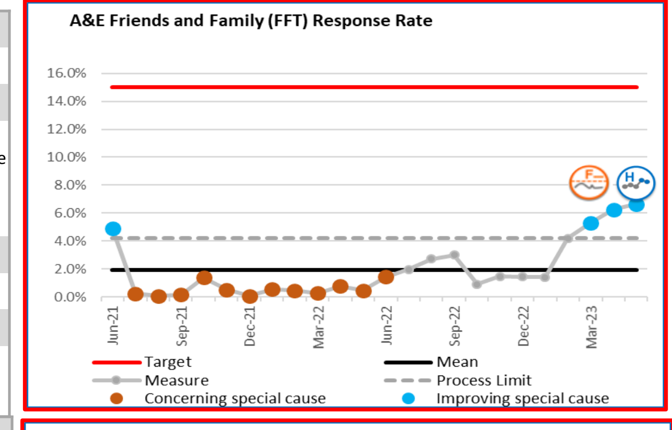
Metric is in common cause variation and failing the target for 6+ months

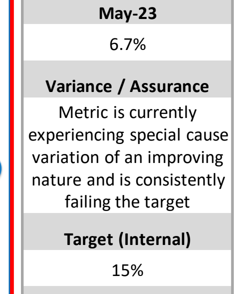
Target (Internal)

75%

Business Rule

Full Escalation as failed the target 6+ months





May-23

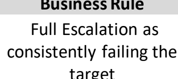
6.7%

Variance / Assurance

Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target

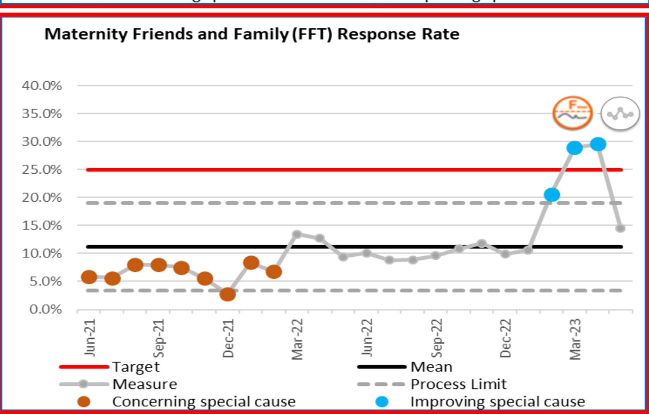
Target (Internal)

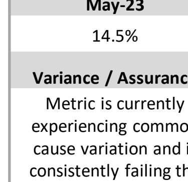
15%



Business Rule

Full Escalation as consistently failing the target





May-23

14.5%

Variance / Assurance

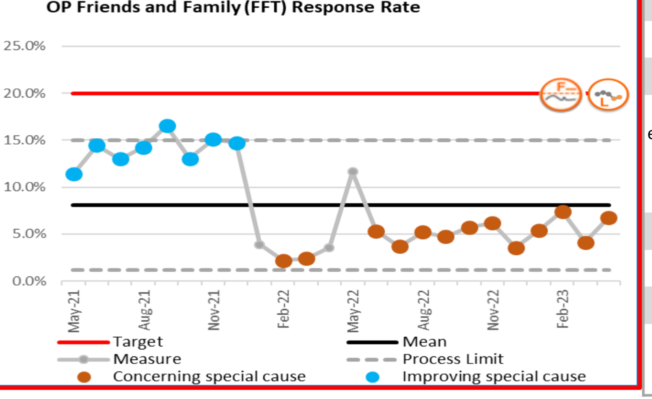
Metric is currently experiencing common cause variation and is consistently failing the target

Target (Internal)

25%

Business Rule

Full Escalation as consistently failing the target



May-23

6.8%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target

Target (Internal)

20%

Business Rule

Full escalation as is consistently failing the target

Summary:

% Complaints responded to within target: this indicator is experiencing common cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
Recommended Rate is 89.8%

Friends and Family Response Rate - Maternity: Is experiencing Common Cause Variation, but is consistently failing the target.
Recommended Rate is 98.0%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of a concerning nature and is consistently failing the target
Recommended Rate is 95.8%
Word clouds being reviewed for key sentiments and shared with divisions.

Actions:

Complaints Response Rate: Complaints performance recovery and stabilisation actions include;

- Weekly oversight meetings led by CN and DQG
- Business case for revised complaints model submitted
- Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times
- Introduction of new 40 day target to support more complex cases

A&E: ED is an improving picture. **C**ontinue with current methodology. Hybrid method using text, QR code and online. Ongoing meetings with Netcall and ED to review progress and to continue to monitor and support.

Maternity: Meeting held with the directorate to support improvements to FFT response rate. Volunteers are supporting with FFT collection.

Outpatients: SMS text messaging - initial review indicated poor patient response rate. Problem identified with mapping and text messaging and link to PAS . To be raised at DQSG in June.

FFT Response All: Overall response rate for May was >7,000, our highest ever monthly return. In the final stages of identifying a new provider to provide FFT responses and surveys.

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Trust aiming to hit sustained delivery of the target response (75%) by September 2023, increasing to 90% by December 2023

Friends and Family (FFT) response Rates: Continue monthly review.
Meetings with Netcall, ED and OP to monitor and review. Improvements identified to mapping for Netcall to implement for OP texts. Further meeting in June planned with ED and OP to work through concerns.
Meetings held with ED and Maternity to review FFT and actions put in place including updating IQVIA hierarchy, printing and supplying FFT posters, using iPads and volunteers supporting with FFT collection.
Updated FFT reports circulated to staff.
Imperial Research project
Comms put out reminding staff about FFT. Internet page updated to include more information about FFT and an accessibility information.
We will continue to monitor all aspects of FFT.

Strategic Theme: Systems

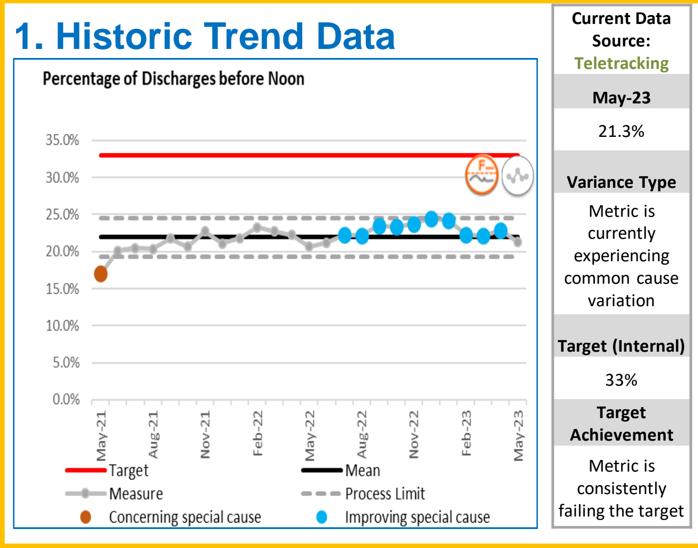
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	9.8	May-23	3.5	11.3	Apr-23	Driver	No SPC	No SPC	-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	33.0%	21.3%	May-23	33.0%	22.9%	Apr-23	Driver			Full CMS

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

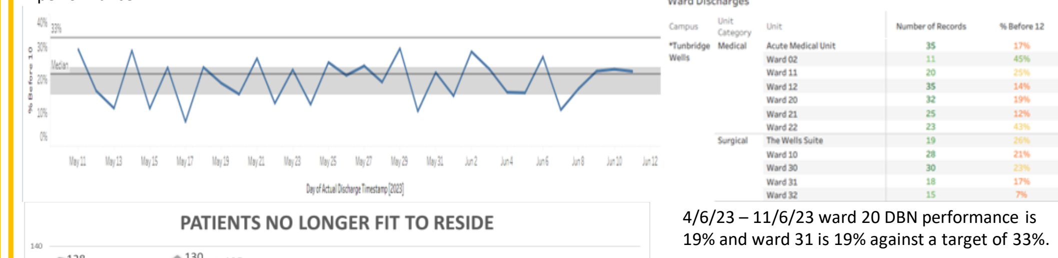
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data

TT DBN Data: It is hoped that the EDN programme rollout throughout will help to improve performance in June and July. Wards 20 and 31 are the only current wards to have rolled out EDNs onto Sunrise. These wards will be monitored for improvements in DBN performance.



4/6/23 – 11/6/23 ward 20 DBN performance is 19% and ward 31 is 19% against a target of 33%.

PATIENTS NO LONGER FIT TO RESIDE

NCTR: 1st -10th May average NCTR: 112, June 1st -10th average is 101.

Delay Reasons:
12/05 – 10/06 Overall trend decrease for NCTR inpatients.

Teletracking amendments underway to remove 'NULL'

Delay Reasons	
Null	1,018
Awaiting clinician to com..	680
Awaiting Pharmacist to s..	137
Awaiting to be dispensed	111
Awaiting pharmacy to re..	79
Awaiting CLT	41
Awaiting Hilton	39

3. Top Contributors

Area of Analysis	Considered a Top Contributor?
EDN Completion Times	EDNS are a top contributor in delays in discharge time. There is a clinically led EDN project group focussing on this including utilising Sunrise for a more integrated EDN: EPMA process.
Criteria Led Discharge	The data in Aug 2022 showed that Criteria Led Discharge was only utilised in 1.3% of all discharges, therefore there is an opportunity to increase DBN using this process.

4. Action Plan

CM	Action	Who	When	Complete
Criteria Led Discharge	• Stroke CLD nurse training and competency sign off commenced. Meeting with surgical team to discuss implementation. • CLD embedment into clinical pathways being developed i.e. board rounds/ handover sheets.	KC/ FR / NP	31.06.23	In Progress
EDN	• Pilot for EDN in sunrise commenced. Programme of works underway with expectation of TWH wards rollout throughout June. • To undertake an assessment of the impact of the EDN project on orthopaedic wards – currently at 19%	RG / SF / JS	30.06.23	In Progress
Delay Reason	• Utilising Teletracking further to determine cause of delays by removing the 'NULL' option on teletracking	RS/ RG	31.07.23	In Progress

Strategic Theme: Sustainability

	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	-2,273	-2,247	May-23	-127	-430	Apr-23	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	1380	1316	May-23	1295	1648	Apr-23	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	1056	823	May-23	993	519	Apr-23	Driver	No SPC	No SPC	Not Escalated
	Well Led	Cash Balance (£k)	17968	12701	May-23	15698	16377	Apr-23	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	6410	2422	May-23	2687	124	Apr-23	Driver			Not Escalated

Appendices

SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
H L	F F	Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is showing a Special Cause for Concern. Consider escalating to a driver metric.
	F F	Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is in Common Cause variation. Consider next steps.
H L	F F	Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
H L	?	Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A verbal CMS is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is in Common Cause, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
	?	Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A verbal CMS is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is Hitting & Missing the Target and is in Common Cause variation. Note performance, but do not consider escalating to a driver metric
H L	?	Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. Note performance	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. Note performance
Any	?	Assurance indicates inconsistently hitting or missing the target.	A Driver Metric that remains in Hit & Miss for 6 months or more will need to complete a full CMS	N/A

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
H L	P P	Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target, but is showing a Special Cause for Concern. A verbal CMS is required to support continued delivery of the target	Metric is Passing the Target, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
	P P	Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is in Common Cause variation. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is in Common Cause variation. Note performance
H L	P P	Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

The **upper** control limit **below** the target line for metrics that need to be **below the target**

The **lower** control limit **above** the target line for metrics that need to be **above the target**

A metric achieving the target for 6 months or more will be flagged as passing

Metrics that are **hit and miss** have:

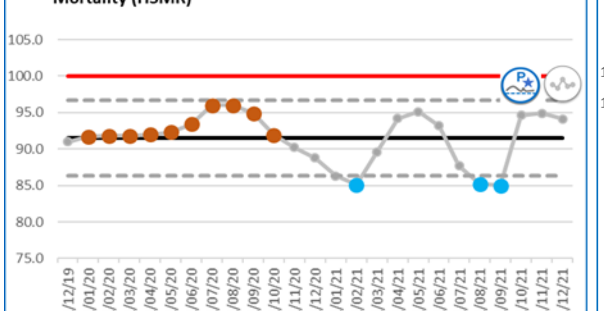
The **target** line **between** the **upper** and **lower** control limit for all metric types

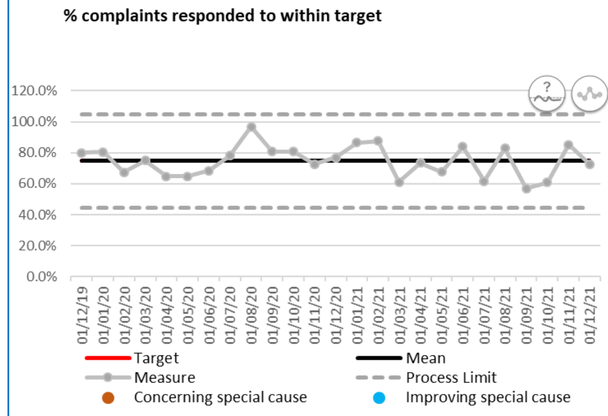
Metrics that consistently **fail** have:

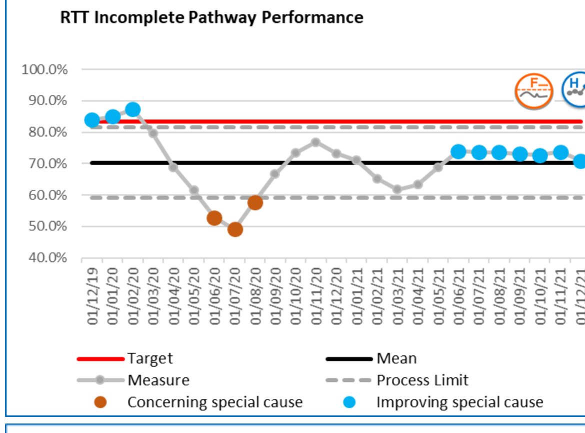
The **lower** control limit **above** the target line for metrics that need to be **below the target**

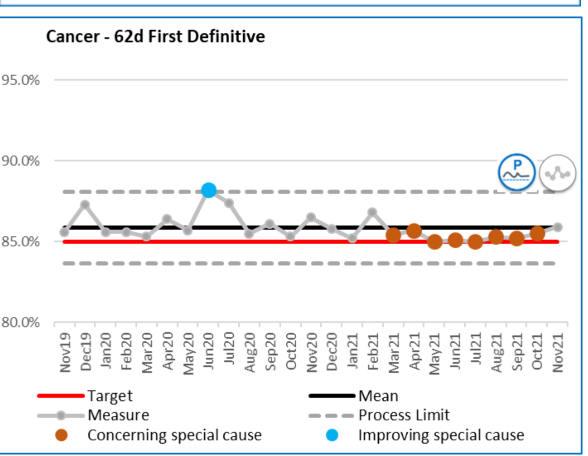
The **upper** control limit **below** the target line for metrics that need to be **above the target**

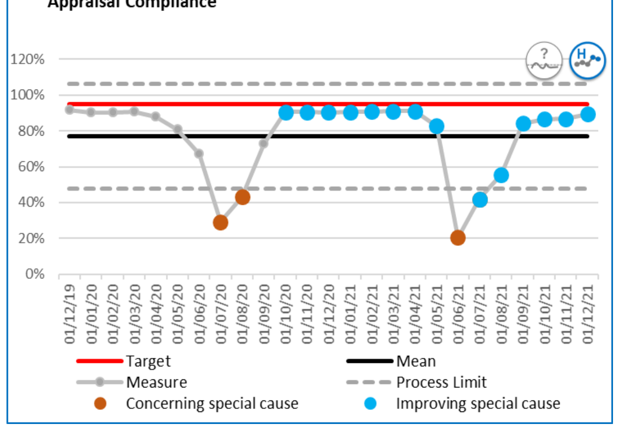
A metric not achieving the target for 6 months or more will be flagged as failing

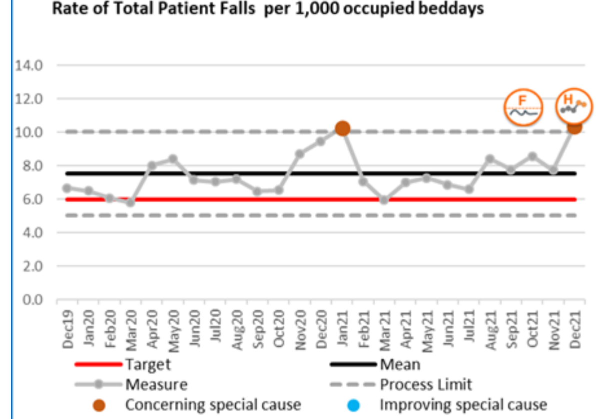












Executive Summary

- The Trust was £2.2m in deficit in May which was breakeven to plan. Year to date the Trust is £2.7m in deficit which is £0.3m adverse to plan.
- The key pressure is within pay budgets which are adverse to plan by £2.8m after 2 months which included an additional £1.4m of costs above plan associated with the 5% Agenda for Change (AFC) pay award offer. Therefore the normalised position was £1.4m adverse to plan. The estimated cost associated with the junior doctor industrial action in April was c£0.4m therefore leaving £1m overspend associated with other pressures.
- Cost Improvement Plans (CIP) are behind plan by £0.7m year to date.
- Variable related clinical income has overperformed after 2 months by £0.5m

Current Month Financial Position

- The Trust was £2.2m in deficit in the month which was on plan.
- The Key variance to plan are:
    - Income overperformed by £1.1m in May which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was £0.4m favourable to plan which relates to variable income overperformance mainly within day case activity.
    - Pay overspent by £0.7m in the month which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was breakeven to plan.
        - The trust overspent on temporary staffing by £0.7m which was offset by underspend on substantive staffing (£0.7m), agency spend as a percentage of total pay was 3.85% which was 0.18% less than planned. The total pay spend reduced between months by £0.5m. Temporary staffing spend reduced by £1m, £0.4m relating to one off strike costs in April, £0.4m due to less payroll weeks in May and £0.2m relating to one off benefit. Substantive staff costs increase between months by £0.5m
- Non Pay underspent by £0.4m in the month which was mainly due underspends within clinical supplies within Theatres (£0.6m) which was partly offset by reduction in doubtful debt (£0.1m)

Year to Date Financial Position

- The Trust is in deficit by £2.7m which is £0.3m adverse to plan.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - Pay budgets overspent (excluding impact of AFC pay award) by £1.4m which includes £0.4m associated with the Junior Doctors industrial action. The main pressure is within Support to Nursing (£0.6m) and Medical (£0.5m) with the majority of the overspend within Medicine and Emergency Division.
    - **Favourable Variances**
        - Variable Income overperformance mainly relating to day case activity = £0.5m
        - Non-recurrent benefits = £0.6m

Risks

- **Variable Income -** Linked to the above uncertainty with the Contracts means that the current assessment of variable income may be overstated because no final agreement on the targets to be applied in the contracts with NHS England and the Associate ICB Commissioners has been reached. Currently the Month 1 & 2 assessment is based on the Trusts planning assumptions.
- **QFIT Service funding** – The Trust has an unpaid old year debt of £0.6m relating to the QFIT service, additionally there is currently no formal agreement of funding in 2023/24 (£0.7m for the year) which remains a risk to achievement of the plan. The Trust has had notification from the

ICB that funding will be allocated for 23/24 however this has not been formally confirmed or received to date.

- **Community Diagnostic Centre (CDC)** delay to full capacity – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan of £0.7m which is expected to continue until November 23 at the earliest. There is a risk that costs won't be reduced to fully offset the loss in income. A revised forecast of activity, income and expenditure is being carried out.
- **CIP Delivery** - The Trust has a large CIP target for 2023/24 and there is £10.2m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Pay award Income** - The position assumes the pay award will be funded in full and includes £1.4m of income to offset the costs above plan (plan was for 2.1% pay award however 5% for AFC staff will be paid in June)
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions.
- **Medical Bank Increase** - The Trust has agreed to increase the consultant medical bank rate to be closer to the BMA rate card, this is estimated to cost c£1.5m per annum.

<u>Cashflow position:</u>

- The Trust carried forward an opening cash balance of £7.9m from 2022/23. The cashflow reduces throughout the year as commitments are realised with the closing cash balance forecast for March 2024 of £2m.
- The closing cash balance for May was £12.7m which is lower than the plan value of £17.9m. This variance primarily relates to the phasing of the capital PDC draw down relating to the Kent and Medway Orthopaedic Centre (KMOC) as the original phasing information provided for the capital plan was based on orders rather than actual completion.
- The Trust is working with Suppliers, Procurement Department and budget holders/authorised signatories to ensure invoices are receipted, approved and paid as promptly as possible, this is to assist with the Trust adhering to the BPPC (Better Payment Practice Code) target of 95%. Currently the Trust is meeting this in two of the four aspects:

  1. Trade suppliers by value 94.6%
  2. Trade suppliers by volume 96.6%
  3. NHS suppliers by value 91.0%
  4. NHS suppliers by volume 91.9%

<u>Capital Position</u>

- The Trust's annual capital plan including potential IFRS 16 liabilities is £67.9m, this consists of £38.5m internal funds agreed with the ICB for 2023/24 and £29.4m of potential IFRS 16 liabilities.
- The year to date spend at Month 2 is £2.5m against a budget of £8.1m. The variance relates to the Kent and Medway Orthopaedic Centre project where the expected spend has not been incurred in the first two months – the external Project Management agent has chased the contractors for invoices due, but it is also understood that the phasing information provided for the capital plan was based on orders rather than actual completion, so the plan year to date is ahead of expected delivery.

Finance Report

Month 2
2023/24

Dashboard

May 2023/24

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-throu	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	56.2	55.1	1.1	(0.0)	1.1	111.0	109.0	2.1	(0.1)	2.1
Expenditure	(54.2)	(53.1)	(1.1)	0.0	(1.1)	(105.2)	(102.9)	(2.3)	0.1	(2.4)
EBITDA (Income less Expenditure)	2.0	1.9	0.1	0.0	0.1	5.8	6.0	(0.3)	0.0	(0.3)
Financing Costs	(4.3)	(4.3)	(0.0)	0.0	(0.0)	(8.6)	(8.5)	(0.0)	0.0	(0.0)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0
Net Surplus / Deficit	**(2.24)**	**(2.27)**	**0.03**	**0.0**	**0.03**	**(2.7)**	**(2.4)**	**(0.3)**	**0.0**	**(0.3)**
Cash Balance	12.7	18.0	(5.3)		(5.3)	12.7	18.0	(5.3)		(5.3)
Capital Expenditure (Incl Donated Assets and IFRS16)	2.4	6.4	4.0		4.0	2.5	9.1	(6.6)		(6.6)
Cost Improvement Plan	0.8	1.1	(0.2)		(0.2)	1.3	2.0	(0.7)		(0.7)

Summary Current Month:

- The Trust was £2.2m in deficit in the month which was on plan. The May position includes £0.7m of costs and income relating to the 5% pay award offer for staff on Agenda for Change contract which was 2.9% more than the plan. The funding for this increase has not been confirmed therefore there is a risk that if the funding received is less than the current estimate this will cause a pressure in future months.
- The Key variance to plan are:
- Income overperformed by £1.1m in May which included £0.7m above plan associated with the 5% AFC pay award offer therefore the normalised position was £0.4m favourable to plan which relates to variable income overperformance mainly within day case activity.
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- Non Pay underspent by £0.4m in the month which was mainly due underspends within clinical supplies within Theatres (£0.6m) which was partly offset by reduction in doubtful debt (£0.1m)

CIP (Savings)

- The Trust has a savings target for 2023/24 of £33.3m and has delivered £1.3m year to date which is £0.7m adverse to plan.

Year to date overview:

- The Trust is £2.7m in deficit which is £0.3m adverse to plan.
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay pressure (excluding impact of AFC payaward) £1.4m, which includes £0.4m associated with Junior Doctor Industrial Action

Favourable Variances

- Variable Income overperformance mainly relating to day case activity = £0.5m
- Non recurrent benefits = £0.6m

Risks

- **Variable Income** - Linked to the above uncertainty with the Contracts means that the current assessment of variable income may be overstated because no final agreement on the targets to be applied in the contracts with NHS England and the Associate ICB Commissioners has been reached. Currently the Month 1 & 2 assessment is based on the Trusts planning assumptions.
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May-23		DAY				NIGHT				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	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					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	106.7%	108.6%	-	-	120.7%	112.6%	-	-	32.4%	49.9%	102	6.82	17	11.3	15.5%	90.0%	2	0		168,393	189,547	(21,154)
MAIDSTONE	Stroke Unit (M) - NK551	104.6%	109.7%	-	100.0%	214.4%	110.5%	-	100.0%	40.3%	78.5%	250	17.06	25	12.2	22.2%	100.0%	3	1		279,628	366,997	(87,369)
MAIDSTONE	Cornwallis (M) - NS959	5.1%	2.2%	-	-	29.0%	51.6%	-	-	2.2%	39.1%	7	0.48	2	2.3	12.5%	100.0%	0	0	Cornwallis closure during Mid May 2023	0	-1,847	1,847
MAIDSTONE	Culpepper Ward (M) - NS551	92.3%	88.1%	-	-	101.6%	136.1%	-	-	21.6%	87.4%	14	1.02	2	5.4	0.0%	100.0%	1	0		115,145	109,819	5,326
MAIDSTONE	Edith Cavell - NS459	101.6%	116.6%	-	100.0%	97.7%	140.0%	-	-	41.1%	80.6%	56	3.97	9	6.4	55.6%	100.0%	4	0		117,739	153,545	(35,806)
MAIDSTONE	Foster Clark - NS251	94.9%	99.1%	-	-	104.0%	103.2%	-	-	23.4%	79.4%	90	6.13	17	8.1	33.1%	97.8%	3	1		155,754	161,611	(5,857)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	99.9%	112.2%	-	-	103.9%	134.2%	-	-	30.0%	78.0%	89	6.12	6	7.1	91.4%	96.9%	7	0		152,114	175,475	(23,361)
MAIDSTONE	Intensive Care (M) - NA251	91.3%	92.2%	-	-	90.7%	73.0%	-	-	1.7%	100.0%	16	1.08	6	71.4	850.0%	100.0%	0	0		233,434	234,233	(799)
MAIDSTONE	Lord North Ward (M) - NF651	100.6%	85.8%	-	100.0%	100.0%	100.0%	-	-	6.1%	94.5%	19	1.41	6	6.9	52.4%	90.9%	4	0		116,373	115,875	498
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	99.1%	67.6%	-	100.0%	82.3%	-	-	-	12.8%	96.1%	10	0.67	1	17.0	0.0%	98.3%	1	0		58,744	58,950	(206)
MAIDSTONE	Mercer Ward (M) - NJ251	108.7%	131.0%	-	100.0%	125.0%	133.9%	-	-	28.5%	55.6%	65	4.61	7	6.8	116.7%	90.5%	6	0		110,963	149,371	(38,408)
MAIDSTONE	Peale Ward COVID - ND451	101.2%	146.2%	-	100.0%	108.7%	151.9%	-	-	30.0%	59.3%	55	3.54	3	11.0	64.7%	100.0%	0	1		125,094	118,896	6,198
MAIDSTONE	Pye Oliver (Medical) - NK259	105.9%	129.0%	-	100.0%	110.8%	152.1%	-	-	40.9%	70.4%	74	5.08	4	7.4	18.0%	90.9%	2	0		132,233	167,433	(35,200)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	83.7%	81.4%	-	-	72.5%	-	-	-	25.8%	87.7%	45	2.79	8	28.9	0.0%	99.0%	0	0		56,832	61,351	(4,519)
MAIDSTONE	Whatman Ward - NK959	119.4%	109.9%	-	100.0%	108.0%	141.9%	-	-	52.3%	82.0%	85	5.83	1	7.2	78.9%	100.0%	6	1		101,589	147,582	(45,993)
MAIDSTONE	Maidstone Birth Centre - NP751	108.3%	96.8%	-	-	102.4%	90.3%	-	-	8.4%	100.0%	23	1.16	1	40.3	0.0%	100.0%	0	0		75,428	90,344	(14,916)
TWH	Acute Medical Unit (TW) - NA901	94.5%	93.9%	-	100.0%	105.2%	104.9%	-	100.0%	31.5%	72.6%	158	11.27	47	9.2	23.7%	90.9%	4	0		239,173	265,233	(26,060)
TWH	Coronary Care Unit (TW) - NP301	94.3%	96.8%	-	-	100.2%	-	-	-	15.3%	94.0%	34	2.46	5	11.6	104.2%	100.0%	0	0		73,863	71,934	1,929
TWH	Hedgehog Ward (TW) - ND702	92.7%	71.5%	-	-	110.6%	142.0%	-	-	33.1%	83.8%	120	7.88	14	10.4	13.6%	100.0%	0	0		148,934	147,949	985
TWH	Intensive Care (TW) - NA201	90.6%	110.8%	-	-	100.3%	63.4%	-	-	6.1%	100.0%	85	5.63	13	37.7	0.0%	100.0%	0	0		371,120	388,398	(17,278)
TWH	Private Patient Unit (TW) - NR702	106.5%	91.5%	-	-	92.1%	112.9%	-	-	23.6%	93.7%	42	2.78	8	9.8	71.8%	100.0%	0	0		71,438	77,755	(6,317)
TWH	Ward 2 (TW) - NG442	88.2%	125.3%	-	100.0%	108.7%	165.5%	-	100.0%	39.9%	61.9%	91	6.32	23	7.9	85.2%	82.6%	3	1		178,255	196,223	(17,968)
TWH	Ward 10 (TW) - NG131	96.8%	102.5%	-	-	95.9%	162.9%	-	-	32.8%	83.9%	81	5.58	9	6.5	13.9%	93.8%	3	0		145,708	174,278	(28,570)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	107.6%	118.7%	-	-	133.1%	92.1%	-	-	58.1%	53.5%	274.00	19.38	49.00	7.7	37.3%	95.5%	4	3		202,407	219,379	(16,972)
TWH	Ward 12 (TW) - NG132	91.6%	152.0%	-	100.0%	115.4%	111.4%	-	100.0%	52.6%	53.7%	192	12.86		7.6	11.4%	100.0%	1	0		145,809	198,820	(53,011)
TWH	Ward 20 (TW) - NG230	83.7%	118.1%	-	100.0%	118.1%	114.5%	-	-	52.0%	56.7%	204	13.94	47	6.9	53.8%	91.4%	8	0		171,810	211,947	(40,137)
TWH	Ward 21 (TW) - NG231	94.2%	110.8%	-	100.0%	102.6%	109.7%	-	-	23.2%	74.2%	113	7.48	19	6.7	21.5%	94.1%	2	0		148,348	171,921	(23,573)
TWH	Ward 22 (TW) - NG332	84.9%	131.9%	-	100.0%	96.9%	124.2%	-	-	41.4%	66.4%	157	11.10	31	6.7	57.5%	95.7%	10	3		146,125	160,800	(14,675)
TWH	Ward 30 (TW) - NG330	92.8%	91.6%	-	100.0%	95.1%	136.5%	-	-	40.9%	81.2%	148	9.24	30	6.5	17.8%	100.0%	13	2		124,959	164,797	(39,838)
TWH	Ward 31 (TW) - NG331	89.8%	119.8%	-	100.0%	96.9%	130.2%	-	-	38.8%	74.4%	158	9.95	23	6.8	28.0%	100.0%	12	4		138,666	179,881	(41,215)
TWH	Ward 32 (TW) - NG130	86.8%	93.9%	-	100.0%	93.5%	89.8%	-	100.0%	21.6%	63.7%	95	6.58	16	8.6	0.0%	90.5%	0	0		147,114	160,673	(13,559)
TWH	Ward 33 (Gynae) (TW) - ND302	97.1%	96.8%	-	-	100.0%	100.0%	-	-	24.0%	100.0%	40	2.46	4	7.7	6.1%	100.0%	0	1		100,085	97,333	2,752
TWH	SCBU (TW) - NA102	102.0%	123.4%	-	-	110.4%	53.8%	-	-	22.7%	95.1%	122	6.98	8	12.0	81.8%	88.9%	0	0		206,830	206,104	726
TWH	Short Stay Surgical Unit (TW) - NE901	84.9%	80.7%	-	100.0%	100.0%	106.7%	-	100.0%	11.6%	100.0%	23	1.59	5	12.0	5.8%	95.5%	1	0		81,504	88,493	(6,989)
TWH	Surgical Assessment Unit (TW) - NE701	99.3%	163.0%	-	-	98.0%	100.0%	-	-	29.2%	94.0%	66	4.29	10	23.6	3.8%	100.0%	0	0		76,580	77,947	(1,367)
TWH	Midwifery (multiple rosters)	60.2%	40.6%	-	-	89.4%	99.4%	-	-	13.7%	96.7%	623	34.92	116	**8.6**	52.1%	98.9%	**0**	**0**		**819,551**	**868,702**	**(49,151)**
Crowborough	Crowborough Birth Centre (CBC) - NP775	89.2%	103.2%	-	-	74.1%	96.8%	-	-	12.6%	100.0%	37	2.27	2	183.1	31.0%	100.0%	0	0		145,028	97,932	47,096
MAIDSTONE	Accident & Emergency (M) - NA351	99.8%	105.8%	-	100.0%	102.8%	100.9%	-	-	37.2%	61.7%	414	29.13	36	-	0.0%	88.4%	4	0		376,140	417,305	(41,165)
TWH	Accident & Emergency (TW) - NA301	98.2%	87.1%	-	100.0%	98.1%	88.6%	-	100.0%	37.9%	55.6%	426	29.73	33	-	7.1%	89.6%	5	0		404,954	447,767	(42,813)

		Budget £	Actual £	Variance £ (overspend)
Total Established Wards		**6,663,864**	**7,390,749**	**(726,885)**
Additional Capacity bed:	Cath Labs	56,309	43,757	12,552
	Whatman			
Other associated nursing costs		5,162,312	5,032,370	129,942
Total		**11,882,485**	**12,466,876**	**(584,391)**

Under fill		Overfill			
(green)		(green, shaded)			
(amber)		(amber, shaded)			
(red)		(red, shaded)			

Green: equal to or greater than 90% but less than 110%

Amber Less than 90% OR equal to or greater than 110%

Red equal to or less than 80% OR equal to or greater than 130%

Trust Board meeting – 29th June 2023

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, 10/05/23

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

Discussion 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

MORTALITY – SUMMARY REPORT

June 2023

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Healthcare Intelligence Portal tool, this report examines in-hospital mortality, for all inpatient admissions for the 12-month time period Mar 2022 - Feb 2023.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including December 2022(unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period Feb-22 – Jan-23 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

HEADLINES

Data Period: Mar 2022 - Feb 2023

Metric	Result
HSMR	98.4 (within expected) (93.3 – 103.7)
Next month HSMR preview (Mar-22 to Feb-23)	*98.2 (within expected)*
HSMR position vs. peers	Regional acute peer group = 18 trusts: • 12 lower-than-expected • 5 within expected • 1 higher-than-expected Peer group = 92.3 (lower-than-expected) (91.1 – 93.5)
All Diagnosis SMR	95.0 (lower-than-expected)
Significant Diagnosis Groups	• **Acute and unspecified renal failure (468 superspells; 59 deaths)** • Congestive heart failure, nonhypertensive (729 superspells; 98 deaths) • Other acquired deformities (85 superspells; 2 deaths) • Septicemia (except in labour) (782 superspells; 178 deaths)
CUSUM breaches	• Septicemia (except in labour) (Dec-22) **(Feb-23)** • Congestive heart failure, nonhypertensive (Oct-22) (Dec-22) • Substance-related mental disorders (Oct-22) • Conduction disorders (Aug-22)
SHMI position	(Feb-22 to Jan-23) 89.95 (as expected)

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

HSMR for Feb-23 is 90.30 and "within expected", based on 3864 superspells and 120 deaths (crude rate 3.11%).

HSMR for the period Mar-22 to Feb-23 is 98.39 and "within expected", based on 45,835 superspells and 1408 deaths (crude rate 3.07%). This is the lowest rolling HSMR value to report in this financial year.

Figure 1 – HSMR Monthly Trend

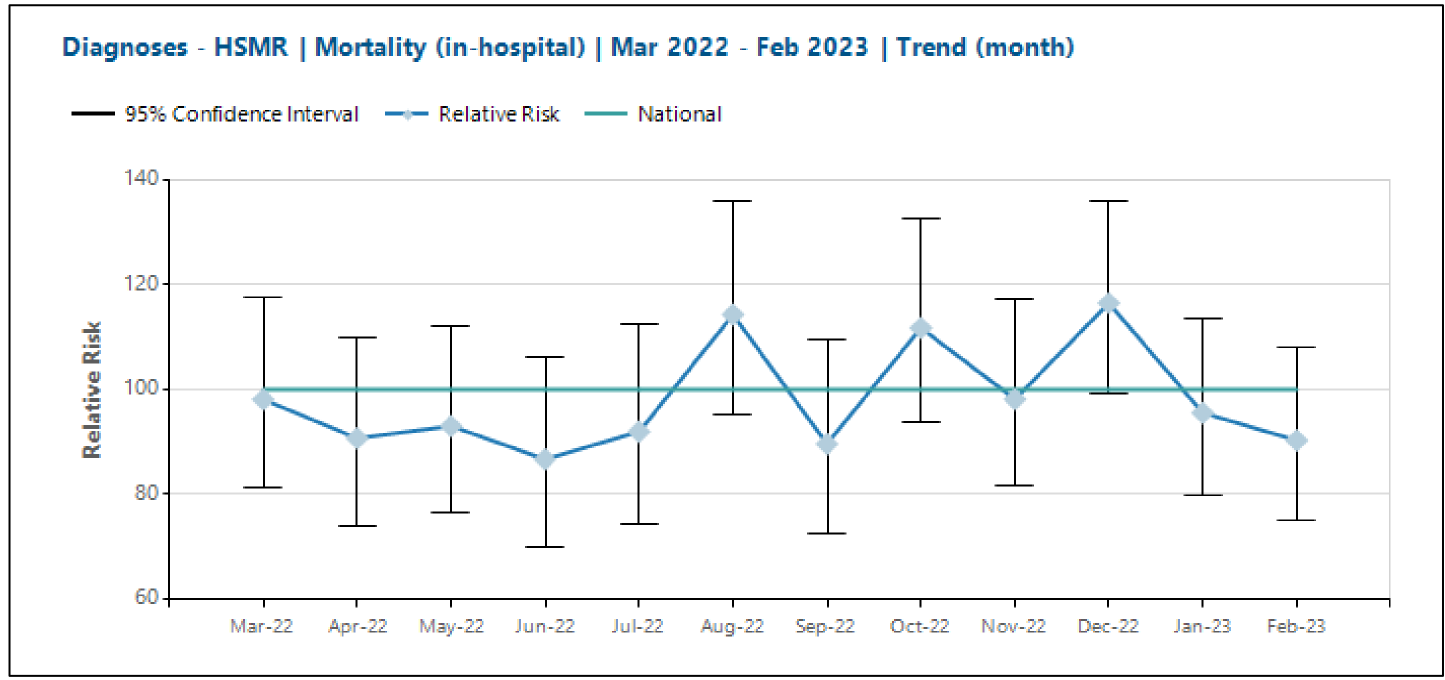


Figure 2 – HSMR 12 Month Rolling Trend

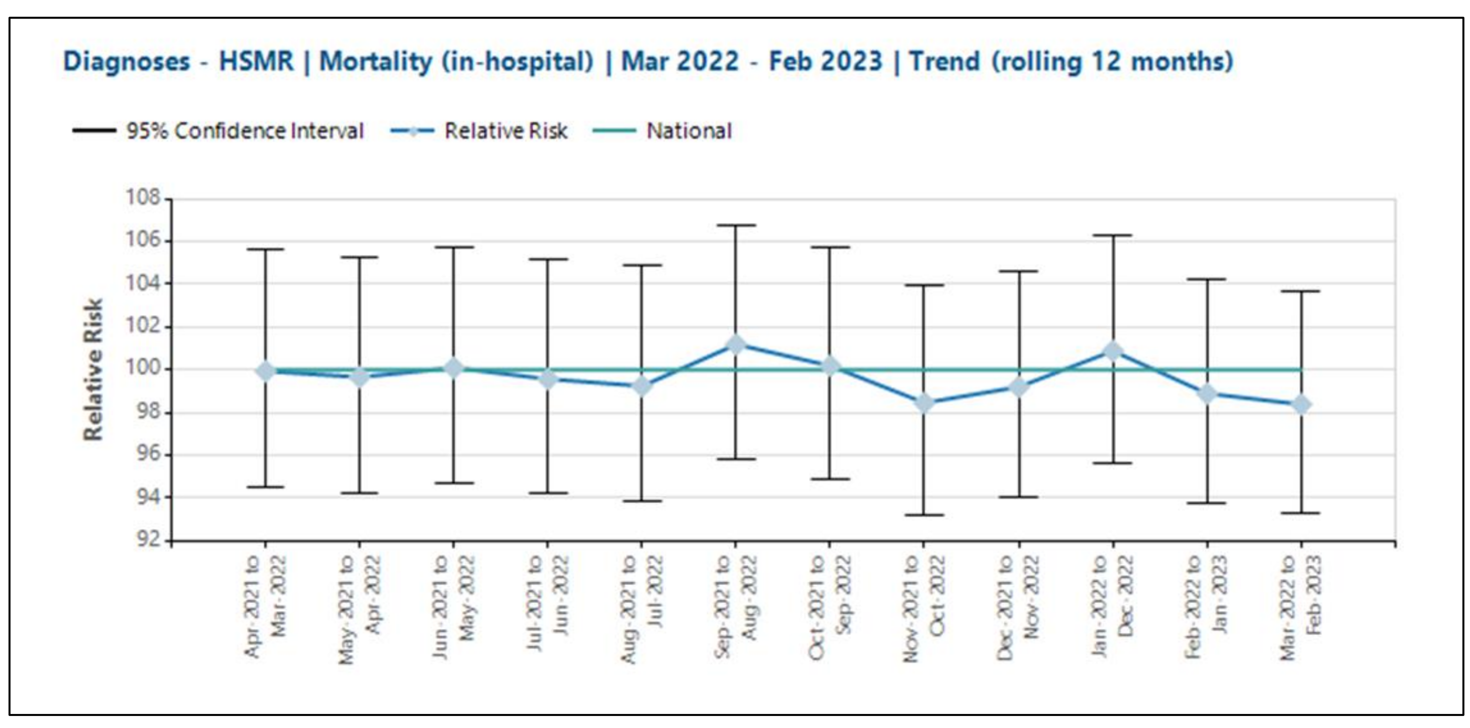


Figure 3 – HSMR 12 Month Peer Comparison

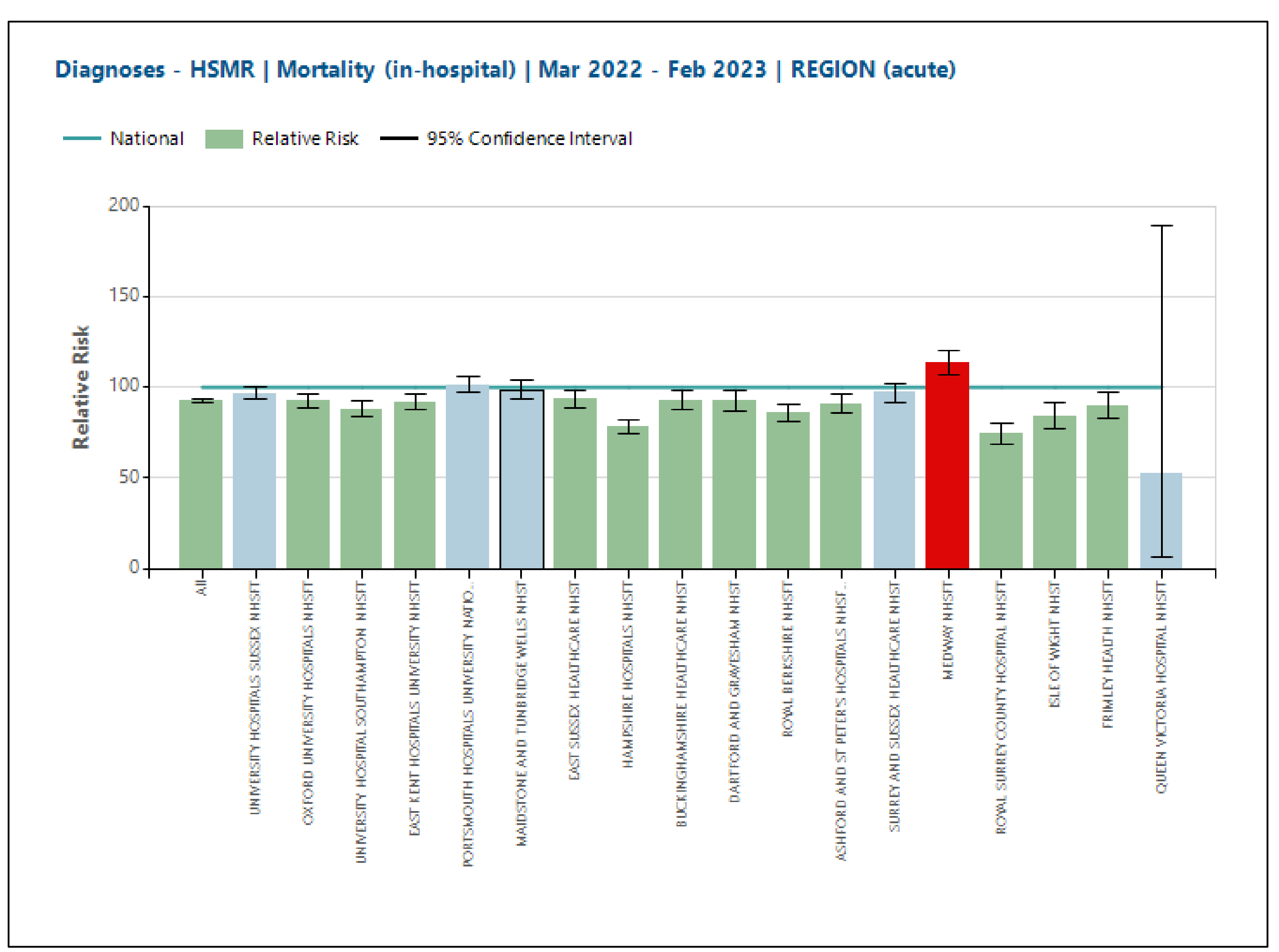
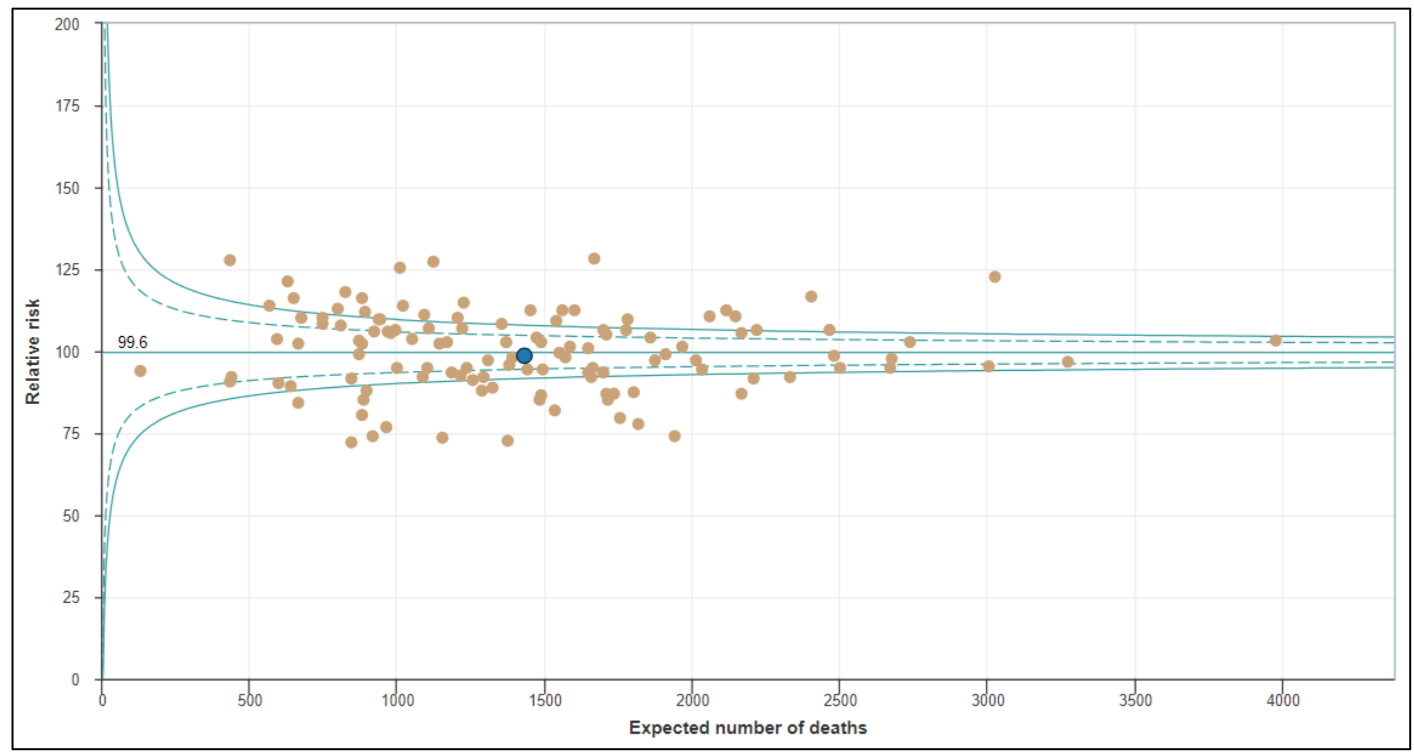


Figure 3.1 – HSMR 12 Month Peer Comparison: National (Acute, Non-Specialist) Funnel Plot
(MTW = blue; all other Trusts = brown)



MONTHLY SHMI

Key points

SHMI for the period Feb-22 to Jan-23 is 89.95 and 'as expected'. There are no diagnosis groups with 'higher-than-expected' values.

Trust-level data

As expected SHMI

86,745	2,205	2,455	0.8995
Provider spells	Observed deaths	Expected deaths	SHMI value

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RWFTW	The Tunbridge Wells Hospital	57,465	1,165	1,335	0.8754	As expected SHMI
RWF03	The Maidstone Hospital	28,230	1,040	1,120	0.9289	As expected SHMI

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Acute bronchitis	74	1,185	20	25	0.7748	As expected
Acute myocardial infarction	57	335	20	25	0.7979	As expected
Cancer of bronchus; lung	15	75	35	30	1.1569	As expected
Fluid and electrolyte disorders	37	700	45	40	1.0721	As expected
Fracture of neck of femur (hip)	120	695	40	55	0.7543	As expected
Gastrointestinal hemorrhage	96	600	25	30	0.8100	As expected
Pneumonia (excluding TB/STD)	73	1,580	240	255	0.9475	As expected
Secondary malignancies	30	355	80	80	0.9805	As expected
Septicaemia (except in labour), Shock	2	695	175	160	1.0940	As expected
Urinary tract infections	101	1,225	45	50	0.8663	As expected

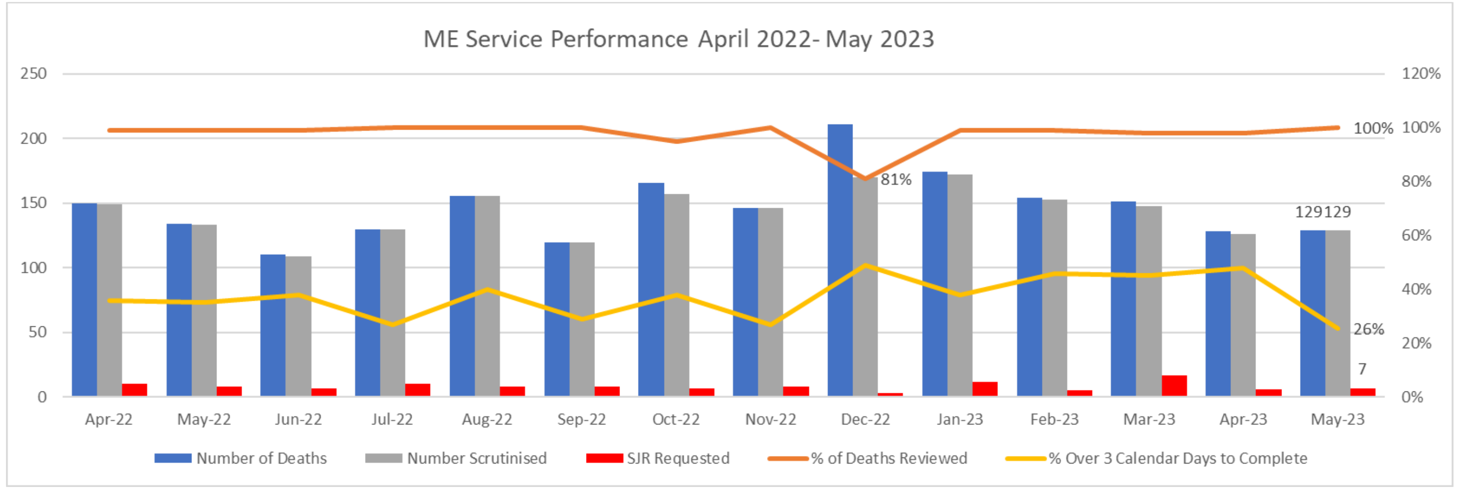
Mortality Surveillance Group (MSG) and Medical Examiner Service Update

Medical Examiner Service

ME Service Update

- The numbers of deaths month on month have seen a significant decline from the start of the year, stabilising at 128 and 129 in the months of April and May respectively.
- The Service continues to perform outstandingly, scrutinising a high percentage of cases within the month. 98% of deaths in April were scrutinised and 100% of all May deaths were scrutinised by the Service. The deep in performance in December 2022 was due to staffing issues during the holiday period which could not be back filled.
- There has been a gradual increase in the number of community deaths scrutinised by the Service as GP surgeries are onboarded as part of the community roll out project. The Service is working to the tentatively scheduled April 2024 date when legislation putting the Service on a statutory footing is expected.

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
Nov-22	146	146	100%	39	27%
Dec-22	211	170	81%	83	49%
Jan-23	174	172	99%	65	38%
Feb-23	154	153	99%	70	46%
Mar-23	151	148	98%	67	45%
Apr-23	128	126	98%	60	48%
May-23	129	129	100%	33	26%



Challenges faced by the ME Service

- ME Service procedures have currently reversed back to a manual paper-based process due to the trust IT issues linked to the server.
- This has led to difficulty in completing paperwork and delays in the ME process.
- Timeliness of death summary completion by attending physicians impacts on the ability of the Service to complete the scrutiny process within the stipulated 3 days.

MTW exceptional people, outstanding care

- Inadequate funding by NHSE/I to operate a good quality Service is an ongoing issue

Community Me Service Roll out

- 25 of the 54 GP surgeries in West Kent have signed the Data Sharing Agreement on the ICP Gateway. This puts the Service in good standing towards achieving the full roll out plan scheduled tentatively for April 2024.
- The Service is ahead with the community roll out project compared to other trusts and has been approached by several trusts to share learning on project planning and implementation.

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.

Learning from Mortality reviews identified the following needs:

- In a case discussed at MSG, a patient's learning difficulties was cited as one of the clinical reasons why resus would be not be appropriate/unsuccessful/or not be in patient's best interest. This was highlighted as poor practice.
- If it is known that a patient has scheduled injections in the community, this should feature in the EDN and a direct handover required to ensure this is continued in intermediate care.
- The practice of Clinical teams failing to accept clearly sick and frail patients without CT imaging and bloods can lead to inappropriate delay was highlighted as poor practices
- Adherence to sepsis screening and sepsis six protocol

The following practice was highlighted in

- Good linking in with learning disabilities nurse who could advise on aspects of patient's care. The learning disability nurse also attends the MSG meeting and gives insight on LeDeR cases being discussed at the meeting.
- Excellent communication with family/carers and evidence of multidisciplinary working

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.

Year	Outstanding SJRs	Completed SJRs
Apr 20 to Mar 21	0	63
Apr 21 to Mar 22	12	106
Apr 22 to Mar 23	19	90
Apr 23 to Mar 24	10	10
SJR Total backlog	41	269

- A closely monitored SJR backlog trajectory is in place, working with SJR reviewers to clear the SJR backlog. Two additional SJR reviewers have been identified and training is being scheduled to support the SJR backlog position.
- The backlog is steadily declining as cases within the backlog are monitored and reviewed. However, the rise in deaths month on month accompanied by the efficiency of the ME Service means the rate of SJRs being raised has significantly increased.
- The current SJR backlog position is 41, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4-week stipulated SJR turnaround time.
- There are 5 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 46.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Apr-23	9	1	0
May-23	9	3	2

- In April, there was 1 SJR with an overall assessment of 'Poor care' discussed at MSG.
- In May, the Mortality Surveillance Group reviewed 2 SJRs with an overall assessment of 'Very Poor care' and 3 SJRs assessed as 'Poor care'.
- Learning from both very poor/poor care and good practices highlighted from cases reviewed at MSG continue to be fed back to directorates

Actions from 'Poor care' SJR Reviews

- There were 2 SJRs with an overall assessment of 'Poor care' discussed at the April and May MSG meeting and 4 SJRs with a 'Very Poor care' rating.
- 2 SJRs resulted in an SI being raised and 1 SJR is yet to reviewed at the SI panel to determine if it meets the criteria for an SI declaration.
- Learning from all SJRs have been feedback to Directorates through Clinical Governance meetings.

Next steps

- Introduce divisional mortality meetings to support the learning from deaths process.
- Continue to monitor SJR backlog trajectory.
- Continue to progress the Medical Examiner community roll out project.

Trust Board meeting – 29th June 2023

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) (incl. to approve the Memorandum of Understanding (MoU) with the West Kent HCP)	**Director of Strategy, Planning and Partnerships**

The attached MOU has been drafted to set out the terms on which MTW (as the host organization for West Kent H&CP) will accept oversight and responsibility for delegation of functions, responsibilities and work areas from the ICB as part of the wider developing work of the West Kent HCP. The MOU is a precursor to more formal delegation agreement that will be developed over the next 12-18 months.

The ICC team and their associated work areas have been under the line management of the Director of the West Kent HCP since April 2023. This work was contractually covered by a 'letter of comfort' setting out the shared agreement about how the team will work and its areas of responsibility.

The West Kent executive group and the West Kent HCP Development Board have reviewed and recommended subject to minor amendments that have been made. This MOU will be signed subject to the outcome of the design work the ICB are undertaking on future form and function.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 20/06/23

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

Delegation of Commissioning Functions from Kent and Medway ICB to West Kent Health and Care Partnership

Memorandum of Understanding

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Version: 3.8
Date: 16th June 2023

Version Control:

Version	Date	Author	Comments	Status
1.1	4/1/2023	Louise Parker	Draft based on similar documents used previously and Letter of Comfort	Working Draft
1.2	25/1/2023	Louise Parker	Updated with comments from ICB Governance Team and H&CP core team. Schedule 1 updated in line with agreements with the ICB EMT. Enabler template added to Schedule 3	Working Draft
1.3	22/2/2023	Louise Parker	Updated with section on external scrutiny	Working draft
2	1/3/2023	Louise Parker	Updated with ICB comments. Additional changes highlighted in yellow	Working draft.
2.1	8/3/2023	Louise Parker	Updated with comments from H&CP Partners changes highlighted in yellow.	Working draft
3	18/05/2023	Sally MacKinnon	Updated with WK priorities/operating model embedded	Final draft before final ICB enablers, finances staffing approach agreed
3.1	18/05/2023	Sally MacKinnon	Updated with ICB enabler sections	First complete draft
3.2	18/05/2023	Tim Wilson	Minor amendments and updates	Draft
3.3	18/05/2023	Tim Wilson	Update of IC Strategy strategic priorities	Draft
3.4	26/05/2023	Tim Wilson	Update following meeting with Sally Mackinnon 18/05/2023	Draft
3.5	31/05/2023	Sally Mackinnon	Further updated version	Draft
3.6	01/06/2023	Tim Wilson	Addition of Mike Gilbert amendments	Draft
3.7	02/06/2023	Nicola Smith and Sally McKinnon	Joint review and finalisation	Final draft
3.8	16/06/2023	Sally McKinnon and Tim Wilson	Final amendments for MTW Board	Final draft

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Contents:

1. Executive Summary:

1.1. Background:

The NHSE Integrated Care System Design Framework, published in June 2021, describes the key elements of an integrated care system (ICS) and how the constituent parts of the system are expected to work together to:

- **Improve outcomes** in population health and healthcare;
- **Tackle inequalities** in outcomes, experience and access;
- Enhance **productivity and value for money**; and
- Help the NHS support broader **social and economic development**.

The Design Framework made clear the key role of 'place-based partnerships' in bringing together both statutory and non-statutory providers of health and care services and other relevant local stakeholders in meaningful geographic communities, to plan design and deliver health and care services for local people. Thriving Places, published by NHSE and the Local Government Association in September 2021, provided more detailed guidance on the role, purpose and potential governance options for these partnerships, which were expected to build upon existing local partnership arrangements.

In defining the roles of place-based partnership, Thriving Places set out some of the programmes and activities that they might undertake. These included:

- Health and care strategy and planning for their local area;
- Service planning for health and social care services focused on shared outcomes and objectives;
- Service delivery and transformation, integrating and co-ordinate the delivery of services to best meet the needs of local people;
- Population health management, using segmentation and modelling to understand future demand across population groups and care settings;
- Connecting support in the community, working with the widest range of local partners and investing in community assets to improve the health and well-being of local people;
- Promoting health and well-being; and
- Aligning and sharing management and other resources to support partners and make the best use of available resources.

Place-based partnerships would be enabled and encouraged, over time, to take on delegated statutory functions from the Integrated Care Board (ICB), local councils and

NHS providers working in the local area. This could include the delegation of commissioning functions where this would support the place-based partnership to improve the health and well-being of local people and tackle the health inequalities faced by local communities.

1.2. Kent and Medway Integrated Care System:

Kent and Medway it is home to some of the most affluent areas of England. it is also home to some of the most (bottom 10%) socially deprived areas in the country. This correlates with the health outcomes achieved. With the current cost of living crisis, these disparities will persist or worsen without our concerted, collective effort.

The Kent and Medway Integrated Care System (ICS) covers a population of around 1.8 million people living in Kent and Medway. It is comprised of
of partners including NHS Kent and Medway, Kent County Council, Medway Council, Ashford Borough Council, Canterbury City Council, Dartford Borough Council, Dover District Council, Folkstone and Hythe District Council, Gravesham Borough Council, Maidstone Borough Council, Sevenoaks District Council, Shepway District Council, Swale Borough Council, Thanet District Council, Tonbridge and Malling Borough Council, Tunbridge Wells Borough Council, Dartford and Gravesham NHS Trust, East Kent Hospital University NHS Foundation Trust, Kent and Medway NHS and Social Care Partnership Trust, Kent Community NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust, Medway Community Health Care CIC, South East Coast Ambulance Service NHS Trust, Kent Healthwatch, Medway Health Watch and Social Enterprise Kent.

Within the ICS there are 4 ‘place-based partnerships’, known locally as Health and Care Partnership (H&CPs), and 41 Primary Care Networks (PCNs).

The Kent and Medway Integrated Care Strategy has been produced by NHS Kent and Medway, Kent County Council and Medway Council, supported by district councils, Healthwatch organisations and the voluntary sector. It looks at how health and care colleagues from the NHS and local councils can work together to make improvements.

Its priorities include:

- giving children the best start in life and working to make sure they are not disadvantaged by where they live or their background and are free from fear or discrimination
- helping the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place
- helping people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years

- supporting people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing
- ensuring that when people need hospital services, most are available from people's nearest hospital; while providing centres of excellence for specialist care where that improves quality, safety and sustainability
- making Kent and Medway a great place for our colleagues to live, work and learn.

1.3. NHS Kent and Medway Integrated Care Board:

NHS Kent and Medway Integrated Care Board (the ICB) is accountable for developing strategy and overseeing delivery of plans to meet the required outcomes to improve the health and care needs of the population and to ensure sufficient healthcare services are secured and effectively delivered. The ICB is also responsible alongside the local authorities for the development and oversight of a wider integrated care strategy that improves the broader well-being of the population and enhances social and economic development. The ICB has an annual budget of circa £3.9 billion to provide the best possible health care for people living in Kent and Medway. Its vision and priorities mirror those of the wider integrated care system.

The ICB is responsible for:

- Allocating resources and overseeing collective controls;
- Securing provision of high quality, effective healthcare services;
- Overseeing assurance and performance management to secure delivery of the agreed strategies, plans and outcomes;
- Establishing joint working and governance arrangements for collaborative and integrated working;
- Leading development and oversight of the Kent and Medway system people and digital plans; and
- Ensuring effective, inclusive clinical, professional and citizen involvement

1.4. West Kent Health and Care Partnership:

West Kent Health and Care Partnership (the H&CP) was established in April 2017. Members of the H&CP include local health care providers (Maidstone and Tunbridge Wells Foundation Trust, Kent Community Health NHS Foundation Trust, NHS Kent and Medway NHS and Social Care Partnership Trust, North East London Foundation Trust, Kent and Medway LMC; West Kent Primary Care Networks (PCNs); West Kent Primary Care – WK Federation, Kent County Council, Maidstone, Sevenoaks, Tonbridge and Malling and Tunbridge Wells Borough Councils; NHS Kent and

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Medway; Involve representing the voluntary and community sector organisations in West Kent ; and Healthwatch Kent.

The West Kent H&CP's vision is:

The West Kent Place Based Partnership is working together, to improve the health and well-being of the residents of West Kent. We are working together with residents to:

- make health and care services more accessible and joined up
- improve health and well-being of residents and reducing inequalities
- ensure we get best value from the resources invested in West Kent health and care
- support broader social and economic development

Our agreed approach is embedded in our principles which are:

- Openly sharing information
- Deficit or failure in any part of the system is a failure of the whole system
- Risks and issues are shared and jointly owned/managed
- Collaborative working with aligned aims, incentives, plans and actions providing a commonality of vision
- Focus on system-wide, place based working
- Emphasis on value: cost, efficiency, effectiveness and quality
- Contractual arrangements that enable transformation
- Success measures will align and be jointly monitored and supported
- Plans will be co-designed and future service models developed with clear input from all members and key stakeholders, including patients and third sector
- Appropriate engagement with patients/residents
- Appropriate engagement with all relevant partner

Each year we refresh and update our priorities, in 2023-24 we are focusing on the following priorities for integrated working:

- Children's and Adults mental health
- Frailty & Complex Needs
- Maidstone Inequalities
- Integrated Neighbourhood Teams

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- Discharge & Flow

In support of delivering these we have a range of enabler workstreams that ensure we are delivering the key changes we are aiming to secure across the West Kent system including:

- Workforce
- Engagement/ Co-production
- Finance/contracts
- Digital
- Estates
- Population health/prevention

2. Delegation of Commissioning Functions from the ICB to H&CPs:

2.1. The Role of H&CPs:

Partners from across the ICS see H&CPs as the engine room of the Kent and Medway ICS. The system has agreed a joint ambition that services are co-designed, commissioned and delivered in partnership with local communities, as close to the service user as possible. Services will reflect their lives, their needs and their lived experiences. H&CPs will be responsible for bringing together these plans and ensuring they are delivered. H&CPs will:

- Commission and deliver at place level activities that address the wider determinants of health;
- Develop a compelling and widely owned vision for tackling health inequalities;
- Join up commissioning and planning functions;
- Develop asset-based approaches which build on the strengths of their communities; and
- Invest in systems leadership, developing a collaborative approach to leadership.

2.2. Principles for the Delegation of Commissioning Functions to H&CPs:

The following principles have been agreed to underpin the delegation of commissioning functions from the ICB to H&CPs:

- We will work to the principle of “Nothing about us without us” across every part of the system.
- Any delegation of responsibility will come the with necessary resources.
- Delegation will only happen with the necessary consent from all parties.

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- Decisions on delegation will always be made on the basis of the best value for our population.
- Delegation discussions should always be designed around the concept of subsidiarity – commissioning decisions should always be made a close to the service users as possible. Our consideration should always be “why not” delegate rather than “why”.
- We will work to a consistent framework for delegation across all H&CPs, but which will allow local nuances.
- Throughout the process we will learn and share as we progress.
- Things may not go as planned, we will commit to learning from mistakes and ensuring the system improves as a result.
- Even where an H&CP does not take delegated responsibility, it is still a requirement for the ICB to ensure they are communicated with and engaged on commissioning responsibilities on their patch.
- Where possible, teams working together around commissioning priorities will remain doing so in order to achieve the necessary critical mass.

2.3. Commissioning Responsibilities Reserved to the ICB:

It is envisioned that the following commissioning responsibilities will be retained by the ICB, and will not be subject to delegation to H&CPs:

- System strategic planning.
- Formal oversight of contracts and providers.
- Procurement of health and care services.
- Quality surveillance.
- Primary Care Contracting – while under a delegation from NHS England.
- Continuing healthcare.
- Funded nursing care.
- Single PTL for elective services
- Commissioning of:
  - ⇒ Critical care services.
  - ⇒ NICU services.
  - ⇒ POD services.
  - ⇒ CAMHS Tier 4 services.
  - ⇒ Specialised Commissioning – when delegated from NHS England.
  - ⇒ Adult Secure MH Services.

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The details of the specific delegation to the H&CP are set out in Schedule 1.

3. Purpose of this Memorandum of Understanding:

In line with the aspirations described in section 2 above, the H&CP has been working with the ICB to consider which functions and responsibilities might be delegated to the H&CP. Following the transfer of some line management and Integrated Care Commissioning responsibilities to the H&CP in December 2022, the ICB and H&CP have agreed to the delegation of a range of responsibilities and functions to the H&CP. The purpose of this Memorandum of Understanding (MoU) is to describe the:

- Process by which an agreed range of commissioning functions will be delegated to the H&CP;
- Respective roles of the ICB, H&CP and other local partners in the successful delegation of commissioning functions to the H&CP;
- Resources that will transfer from the ICB to the H&CP to support these commissioning functions, and the method by which they will be transferred; and
- Governance arrangements covering this delegation of commissioning functions.

It is envisaged that this MoU will act as the precursor to more formal delegation agreement between the ICB and the H&CP. This delegation agreement will be developed over the next 12-18 months as national and local policy relating to the delegation of commissioning functions to place-based partnerships develops.

It should be recognised that the delegated responsibilities set out in this agreement are agreed on the basis of the resources in Schedule 3 being available to the H&CP. If there are any material changes to this resource as a result of the KM ICB “Be the Best” programme, it may be necessary to revisit this MOU.

4. Parties and Accountabilities:

4.1. Parties to the MoU:

The Parties to this MoU are:

- Maidstone And Tunbridge Wells NHS Trust on behalf of West Kent H&CP
- NHS Kent and Medway Integrated Care Board (the ICB)

4.2. Accountabilities:

The H&CP and the ICB have agreed that Maidstone & Tunbridge Wells NHS Trust (MTW) will be the host organisation for the WK H&CP and for the responsibilities outlined in this MoU on behalf of the H&CP. This is documented in the minutes of:

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- the West Kent H&CP Board, dated 15th June 2023
- the Maidstone and Tunbridge Wells NHS Trust board dated 29th June 2023

MTW will be accountable to other partners in the H&CP for the effective oversight and delivery of any responsibilities transferred by the ICB, in accordance with the relevant H&CP governance arrangements in place.

MTW will be accountable on behalf of the H&CP to the ICB for the effective oversight, delivery and reporting of any responsibilities transferred to them by the ICB, in accordance with this letter of comfort and any supporting governance agreements and contracts, for example honorary contracts, committee terms of reference, secondment agreements etc.

All other organisations in the partnership (listed in section 1.4) will be responsible for supporting MTW in delivering the responsibilities transferred by the ICB through this agreement. Where relevant separate agreements will be put in place between these parties and other H&CP partners to ensure that these accountabilities are effectively shared between H&CP partners.

5. Principles and Behaviours:

5.1. Principles

The Parties agree to work within the following overarching principles:

- The Parties recognise that the ICB is the commissioner of services for the population of West Kent, and retains the accountability for any commissioning responsibilities delegated to the H&CP.
- This MoU is separate to any contract for the provision of NHS services by any other Parties to the ICB.
- ICB staff working for the H&CP will work under the day-to-day management of the H&CP Director, who is accountable to the H&CP Senior Responsible Officer. The ICB has agreed that the employment arrangements for staff will be considered as part of the ICB redesign programme to ensure equity and consistency. The design phase is due to conclude in June 2023, after which plans will be made collaboratively for implementation.
- MTW will continue to act as the host for the H&CP and its leadership team.
- Decisions will be based on the interests and outcomes of patients and people in West Kent, and parties will collaborate to prioritise those interests wherever this is possible.
- Local Primary Care Networks (PCNs) and the developing Integrated Neighbourhood Teams are central to the development and delivery of integrated local care and ensuring that services are designed around the needs of local

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communities. As such they are central to the functioning of the H&CP. The H&CP will ensure that local PCNs are actively engaged in the commissioning functions delegated to the H&CP.

- The H&CP and the ICB will actively engage with service users, local people and clinicians and other professional staff to create new integrated models of care and decision-making that meet local needs.
- Local decision-making will be underpinned by transparency and the open sharing of information between member organisations.
- H&CP will seek to engage with partners in the wider Kent and Medway ICS to share best practice; and to ensure that its proposed approach does not adversely impact on the wider health and care system.
- The health and care system in West Kent will work to become financially sustainable through the development and implementation of our response to the NHS Long Term Plan and the redesign of local systems and services.

5.2. Behaviours

The Parties will:

- Adopt all reasonable measures and use their best endeavours to ensure the effective delivery of the delegated functions.
- Conduct all activities in ways that are consistent with the guiding principles and take all steps to ensure that any employees, partners and associates involved in carrying out activities do likewise.
- Take collective and shared responsibility for the actions, performance and outcomes related to the delegated commissioning functions.
- Work together to agree how the H&CP will be engaged in, and actively support, the delivery of the financial obligations of the H&CP and the wider ICS.
- Promote co-operation and innovation by:
  - ⇒ Working together in a co-operative and innovative manner for the purpose of meeting or exceeding agreed objectives and fully complying with the principles set out in 5.1;
  - ⇒ Ensuring that the activities are carried out in a co-ordinated and efficient manner; and
  - ⇒ Sharing all information relevant to the activities in an honest, open and timely manner.

6. Term and Variation:

6.1. Term:

This MoU will remain in place until:

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- any party gives notice to terminate the arrangements, by providing no less than 6 months written notice to the other parties; or
- all parties mutually agree to terminate the letter of comfort at an earlier date; or
- all parties formally agree terms within a successor delegation agreement which would render this MoU and all conditions referenced within it as terminated, except the following conditions which would survive:
  - ⇒ All statutory and indemnity liabilities incurred by any party as a result of the arrangements within this latter of comfort.
  - ⇒ Any contractual agreements, and obligations within those agreements, where both parties agree that these may continue beyond the term of this MoU, for example honorary contracts, committee terms of reference, etc.

6.2. Variation:

This MoU may be varied at any time with the written agreement of all parties, such agreement or variation being made at Company or Executive Director level.

7. Scope of the Delegation:

Schedule 1 sets out the service areas for which commissioning responsibility will be delegated from the ICB to the H&CP; and for each of these service areas the specific commissioning functions that the H&CP will undertake.

The ICB will retain the accountability for the commissioning of services set out in Schedule 1 and will retain the financial resources for the commissioning of these services. The ICB will continue to undertake system-wide needs assessment, strategic planning and outcome development for these services, and will continue to procure and place and hold contracts for the services set out in **Schedule 1**.

Schedule 8 sets out the current version of the System 'Finance Principles and Governance Model' which provides the financial flexibilities which H&CP Partners can utilise within the scope of delegation. This version is in the process of being updated and when the new version is agreed this will supersede the current version.

Schedule 9 sets out the metrics which have been identified to support the measurement and reporting of success of the H&CPs during 2023/24. The metrics align with each H&CP local priority programmes, including population health management priorities, specific delegated responsibilities and the contribution to the ICB K&M wide transformation programmes. On many of these measures, the H&CP will be a contributor to the delivery of the metric in its entirety.

8. Enabling Functions:

ICB corporate teams and enabling functions will continue to provide support for the commissioning functions delegated to the H&CP through this MoU.

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The details of the support provided to the H&CP, including staff specifically aligned to support the H&CP, is set out in **Schedule 2.**

It is anticipated that, overtime increasing number of ICB staff who support the commissioning of services for West Kent will be aligned or seconded to the H&CP.

9. Resources Associated with Delegated Functions:

9.1. Staff:

Schedule 3 sets out the team structure for the staff to undertake the commissioning functions delegated to the H&CP. These staff will be managed by the WK H&C Partnership Director.

Where appropriate, details of roles from ICB enabling functions aligned to the H&CP are set out in **Schedule 2,** along with the wider range of support provided by ICB teams for delegated functions.

As the H&CP Director responsible for the commissioning functions delegated to the H&CP, the Director will:

- be subject to all relevant MTW/ICB policies, procedures and governance arrangements, with particular attention to confirming understanding of the ICB's Standing Financial Instructions, Standards of Business Conduct and completion of all relevant MTW Statutory and Mandatory training; and
- have access to ICB support services and processes to enable them to undertake their role. This may include access to the ICB Employee Service Records (ESR), NHS Shared Business Service (SBS), etc. This will be subject to the appropriate support functions prior approvals; and
- not have delegated authority to approve business cases or other financial investments that have not had prior approval from the appropriate ICB decision making individual or forum

9.2. Budgets:

The ICB will continue to provide the H&CP with an annual budget to support the development and leadership of the H&CP. The value of this budget in 2023/24 is £350,000 development monies and a contribution of £78,000 to the PMO function.

The ICB will continue to provide the H&CP with an annual budget to support lay engagement in the work of the H&CP. The value of this budget in 2023/24 is £20,000 and a budget of £75,000 for the Population Health Management role.

The budget for staff working for the H&CP to support the delegation of commissioning functions to the H&CP will remain with the ICB, but will be ring-fenced for use by the H&CP specifically to support the commissioning functions delegated to the H&CP. The WK H&C Partnership Director will act as the budget holder for this budget.

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The parties are committed to the principle of proportionate allocation of staffing budgets and other budgets within the scope of delegation to reflect the population size and profile of the H&CP area.

Budgets identified in this section are subject to change because of the re-design exercise being undertaken by the ICB. The design phase is due to conclude in June 2023. If it is proposed that any staffing budgets reflected in this agreement are reduced then the relevant schedules and list of delegated service areas within the MoU will be subject to review to be revised in line with the budget.

Other than where specifically identified in this MoU or an associated document, the budgets for the commissioning of services delegated to the H&CP will remain with the ICB.

Financial delegation is the passing of the budget for the commissioning of an agreed range of services from the ICB to an H&CP (or its designated host organisation) under a formal delegation agreement. Where formal financial delegation has not yet taken place, and subject to the agreement of the ICB, the H&CP will act as a budget holder for the ICB, exercising its authority to commit resources on behalf of the ICB to agreed limits and only with the express consent of its Place Committee, in line with the ICB's Scheme of Reservation and Delegation (attached in **Schedule 7**).

9.3. Use of ICB Equipment and Offices

In the course of their duties the WK H&C Partnership Director and the ICB staff working for the H&CP may utilise the ICB offices and any other facilities and equipment.

Equipment or other items provided to the WK H&C Partnership Director and ICB staff working for the H&CP:

- Shall be provided at the ICB's sole discretion;
- Shall be maintained in accordance with the ICB's policies and procedures; and
- Shall be returned to the ICB within any agreed timescales for such return or otherwise upon the request of the ICB.

10. Governance Arrangements:

10.1. Governance of West Kent H&CP

Schedule 4 sets out the governance structure for West Kent H&CP.

Day-to day oversight of the commissioning functions delegated to the H&CP will be through the H&CP Executive Group, who supported by the clinical, professional and quality group will be responsible for ensuring that the H&CP commissions services safely and effectively, and in line with this MoU and other relevant guidance and legislation. The H&CP Executive Group will be accountable to the H&CP Board and

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the ICB West Kent Place Committee for the commissioning functions delegated by the ICB. **Schedule 6** sets out the Terms of Reference for the H&CP Executive Group.

10.2. West Kent Place Committee

The West Kent Place Committee has been established as a formal sub-committee of the ICB Board to provide the ICB with assurance that the H&CP is delivering the delegated functions and responsibilities in a way that secures delivery of the ICB and wider system's strategies, priorities and delivery plans.

The Committee will achieve this by seeking reports and assurance as required on the adequacy of systems and controls in place to monitor on-going performance and delivery against those functions and responsibilities delegated by the ICB to the H&CP. **Schedule 5** sets out the Terms of Reference for the West Kent Place Committee.

In particular the Committee is responsible for:

- Providing assurance to the ICB Board that delegated functions and responsibilities are being carried out by H&CP partners in a safe, effective and efficient manner, with a continuous focus on quality improvement
- Ensuring an effective framework is in place that identifies and assesses any material risks or challenges associated with delegated functions and responsibilities in a timely manner, and ensure appropriate actions are put in place by partners to mitigate risk as much as possible
- Ensuring any financial, staffing or other resource seconded or transferred to the H&CP for the purposes of the delegation arrangements, is effectively deployed to achieve the outcomes and purposes that it intended for.
- Ensuring a robust and effective H&CP governance framework is in place that enables safe, compliant, transparent and effective decisions to be made, without the potential of exposing the ICB or other system partners to unnecessary risk or successful challenge.
- Ensuring appropriate arrangements are in place that continuously focus on improving quality, safety, safeguarding, patient experience and the performance of delegated functions and responsibilities; and that there are clear local controls in place for oversight and assurance of these.

11. Confidentiality:

As an honorary contract holder with the ICB, the WK H&C Partnership Director will only seek to access data that relates to their role in the Health and Care Partnership and that this is only used for the purpose for which the role requires.

12. Conflicts of Interest:

12.1. General:

The Parties agree that they will reduce and or manage conflicts of interest by:

- All parties will ensure transparency and will disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this MoU or the performance of the activities, immediately upon becoming aware of the conflict of interest whether that conflict concerns us or any person employed or retained by us for or in connection with the performance of the activities;
- Not allow themselves to be placed in a position of conflict of interest or duty in regard to any of our rights or obligations under this Memorandum (without the prior consent of each other) before we participate in any decision in respect of that matter; and
- Using best endeavours to ensure that their staff and other associates also comply with the requirements of the provisions set out in this document when acting in connection with the H&CP's programme of work

12.2. Specific:

In accordance with the ICB Policy on Business Standards, the WK H&C Partnership Director will declare all appropriate interests, and these will be included on the ICB register of interests.

Due to the nature of the WK H&C Partnership Director's role, there are likely to be occasions where a conflict of interest arises. This should be considered in the first instance by the ICB Chief Delivery Officer, where appropriate in discussion with the ICB Corporate Governance Team. Any decisions made or actions taken to mitigate or manage a conflict of interest should be formally recorded for audit and transparency purposes.

13. External Scrutiny

Health services in Kent and Medway are subject to independent scrutiny in matters relating to the planning, provision and operation. This can be at a Kent and Medway level; through the Kent Heath Overview and Scrutiny Committee (HOSC), or the Kent & Medway Health and Wellbeing Board; or at a more local level through District Council HOSCs or Local Strategic Boards. Responsibility for presentation and attendance at each will vary according to the subject under discussion and the lead partner for the relevant commissioning function:

- Kent and Medway System Level – the ICB will be responsible on matters that are managed on a Kent-wide basis;
- Local level – responsibility will depend upon whether the issue being discussed is the H&CP or the ICB that holds the commissioning responsibility for the service area under discussion/subject to scrutiny. In some cases the responsibility may require both the ICB and H&CP to respond jointly.

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It is essential that commissioners of health services in Kent and Medway communicate in a co-ordinated and effective way with external scrutiny bodies, and that both parties sign off papers relating to commissioning issues submitted to such committees and boards before they are submitted.

14. Dispute Resolution:

The Parties agree that they will use their best endeavours to avoid disputes between each other, notify each other of perceived or real differences of opinion as soon as they arise, and attempt to promptly resolve those differences.

If any member has issues, concerns or complaints about the operation of this MoU that member shall notify the ICB Chief Executive or WK H&CP SRO as appropriate, who will seek to resolve the issue by a process of consultation.

If the issue cannot be resolved through consultation the matter shall be escalated to the H&CP Place Committee, who shall decide on the appropriate course of action to take. Where the Committee is not able to resolve the dispute it will be referred to the ICB Board, through the ICB executive management team.

If any Party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the programme, the matter shall be promptly referred to the relevant provider or to the H&C Partnership Director.

15. Disclaimer:

It should be noted that by signing this document the parties are not committing to legally binding obligations. It is intended that the partners remain independent of each other and that their collaboration and use of the term ‘partner’ does not constitute the creation of a legal entity, nor authorise the entry into a commitment for or on behalf of each other.

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Organisation: NHS Kent and Medway ICB

Name: **Title:**

Signature:

Date:

Organisation: Maidstone and Tunbridge Wells NHS Trust

Name: **Title:**

Signature:

Date:

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Schedule 1 - Programme Areas: Delegated Programmes (Detail 1 of 3)

Programme (clinical)	Current activity / programme area	Delegated to place?	Comment
Cancer	Cancer: Screening	N	The H&CP will continue with local programmes, such as QFiT, TLHC pilot and the vague symptom pilot; these programmes are not formally delegated functions.
	Cancer: Prevention	N	
	Cancer: Early Diagnosis	N	
	Cancer: Treatment	N	
	Cancer: End of Life Care	N	
	Cancer: Personalised Care and Support	N	
Children and Young People	CAMHS (Children & Adolescent Mental Health Services): Tiers 1-2	N	
	CAMHS: Tiers 1-3	N	
	CAMHS: Tier 4	N	
	Maternity	N	
	Neonatal	N	
	Acute Paediatrics	N	
	Specialist Community Children's Services	N	Includes community paediatrics, SEN (Special Educational Needs) and Allied health professional / therapies
	Looked After Children	N	
	Health Visiting (LA Commissioned)	N	
	School Nursing	N	
	End of Life Care	N	
	ASD (Autism Spectrum Disorder)	N	
LTC	CVD/Cardiology (Acute)	N	Attend network/supporting K&M wide work and representing WK interests
	CVD/Cardiology (Community)	Y	"
	Respiratory Disease (Acute)	N	"
	Respiratory Disease (Community)	Y	"
	Diabetes (Acute)	N	"
	Diabetes (Community)	Y	"
	Community stroke	Y	"
	Elective Recovery	N	

Schedule 1 - Programme Areas: Delegated Programmes (Detail 2 of 3)

Programme (clinical)	Current activity / programme area	Delegated to place?	Comment
Adult Mental Health and LD	**Adult MH: Crisis Care**	N	
	Adult MH: Acute Care	N	
	Adult MH: Community Services	N	
	Adult MH: IAPT (Improving Access to Psychological Therapies)	N	
	LD (Learning Disability) and Autism	N	
	Physical health checks	N	
Personalised Care	**Continuing Health Care**	N	
	Personal Health Budgets	N	
	Funded Nursing Care	N	
Primary, Community and Local Care	**Frailty**	Y	
	Primary Care Contracting (GMS/GDP/GOP/GPS)	N	
	PCQS / Enhanced access	N	
	Community Nursing	Y	
	Community Therapies	Y	
	Other Primary, Community and Local Care Services	Y	
	Homelessness project	Y	
	Social Prescribing	Y	
	Anticipatory Care (Aging Well - AW)	Y	
	UCR (AW)	Y	
	Frailty SPA (AW)	Y	
	MDT review and development	Y	
	PCN development	N	
	Virtual Wards	Y	
	Meds optimisation	N	To be considered in 1B
	Vaccination Programme (COVID & Flu)	N	

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Schedule 1 - Programme Areas: Delegated Programmes (Detail 3 of 3)

Programme (clinical)	Current activity / programme area	Delegated to place?	Comment
Urgent and Emergency Care	**Emergency Department**	N	
	111/999	N	
	Ambulance Services	N	
	UTC (Urgent Treatment Centre)	Y	
	GP OOH	N	
	Winter Planning	Y	
	Discharge Pathways	Y	
	Critical Care	N	
	Rapid Response	Y	
	Ambulatory Care	Y	
	Hospital at Home	Y	Includes HARIS, Minster Beds, P1 re-work, K&M ICB P1&3
	Surge and escalation support	Y	
	Discharge and Flow	Y	
	Primary Care (Non- GMS) e.g. extended access	N	
Planned Care	**Elective Specialties: Pre-FOP**	Y	
	Elective Specialties: FOP-DTA (Decision to Admit)	N	
	Elective Specialties: DTA-Surgery	N	
	Elective Specialties: Surgery-Discharge	N	
	RTT (Referral to Treatment)	N	Single PTL, managing capacity ICB lead
	Outpatient transformation	N	
	CDC (Community Diagnostics Centre)	Y	
	Out of hospital planned care/alternative pathways	Y	
Other			
	BAU: SBS invoices and budgets, FOI, complaints, MPs, queries, mtgs, admin, Team business, etc		**NA – not delegated but delivered by H&CP on behalf of ICB**
	H&CP development, System FRP		
	Partnership Commissioning		
	INNF / IFF / Procedures of limited clinical value		

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In addition to the functions and responsibilities set out in the tables in this **Schedule 1**, the ICB team working for the H&CP will also undertake the following business as usual tasks:

- Supporting ICB Contracting and Performance Teams with queries and issues relating to delegated work areas and would provide information to support contract/performance meetings.
- Supporting procurement activities relating to delegated work areas development etc.
- Co-ordinating planning round activities relating to delegated work areas.
- Responding to Freedom of Information requests; MP queries and letters; and complaints relating to delegated work areas.
- Processing invoices and inputting to ICB budget setting and invoice queries relating to delegated work areas.

The team will not:

- Participate in contract and performance meetings with local providers.
- Lead formal procurement programmes on behalf of the ICB or contract meetings.

Schedule 2 – ICB Enabler and staff support the WKH&CP

Enabler: Finance (including Contracting)		
Support to be provided to the H&CP:	The areas of support detailed in this document include aligned staff, development of reporting mechanisms and development of a shared approach to financial delegation.	
Support provided by the H&CP:	•	
Are staff aligned to the H&CP?	Yes	The Finance Directorate is composed of central teams and four finance teams aligned to each of the H&CPs in the ICS. The finance staff aligned to the West Kent H&CP are: • Rebecca Gibson – Deputy Director of Finance – 1.0 WTE • Matthew Tucker – Senior Finance Business Partner – 1.0 WTE • Serena Kieu – Finance Business Partner – 1.0 WTE • Snezana Barbieri – Management Accountant – 1.0 WTE • Zanele Fox – Management Accounts Assistant – 0.6 WTE (job share) • Jaki Ray – Management Accounts Assistant – 0.4 WTE (job share) – Bank

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Are staff aligned to the H&CP?	Yes	The finance staff aligned to the H&CP also undertake work related to the work of the ICB and wider ICS as part of their core roles. The work programmes for the aligned finance staff include: • Managing the financial relationships with the provider organisations and key ICP partners in the H&CP areas. In the case of West Kent H&CP this includes Maidstone and Tunbridge Wells NHS Trust, Kent Community Health NHS Foundation Trust, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge and Malling Borough Council and Tunbridge Wells Borough Council • Engaging H&CP leaders in the work of the ICB's Finance Team where relevant in line with the principle of "nothing about us without us". • Financial planning, reporting and management in the ICS on matters relating to the H&CP. This may include support on matters such as business cases. • Providing monthly finance reports to the H&CP and leading work to develop these reports in ways which support the needs of the ICB and H&CP. The reporting will be developed in a way which aligns with the arrangements in other H&CPs wherever possible. • Finance staff in H&CP teams will likely have additional responsibilities linked to the wider objectives of the team which may not be directly related to the work of the H&CP. Examples include leading on professional development programmes in the finance team. The Contracting Team in the Finance Directorate of the ICB will manage contracts with NHS Trusts, private sector contracts and voluntary sector, prioritising resources on a risk-basis. In line with the agreed 'delegation ask' staff working for the H&CP will not take part in contract meetings. The H&CP will provide summary reports as required for delegated services to support the contract management process. The risk-based management framework for contracts includes escalation and support to prioritise expertise and resources aligned to risk. This will include a copy of ICB

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		contracts registers for West Kent services and access to ICB contracts risk register to monitor risks and mitigation (via Decision Time). A Contracts Business Partner will be aligned to West Kent to provide contractual advice and support.

Has a development programme been agreed between the ICB and H&CP?	No	The key areas of development work are: • **Reporting**: The ICB Finance Team will lead work to develop these reports in way which supports the needs of the ICB and H&CP. The reporting will be developed in a way which aligns with the arrangements in other H&CPs wherever possible. Reporting is happening now and the reports will evolve through the delegation process. The ICB Finance Team will work with the H&CPs to agree the best approach to ensure the H&CPs are engaged in this process. • **Delegation**: The timetable for full financial delegation has not yet been agreed. The first step will be a paper to the ICB Executive in April 2023 on the current state (including budgetary control and access to ICB systems) principles for this work and the expected next stages. The nature of the delegation work means that further discussion and agreement of the work involved, and final planned state is required before a detailed timetable can be agreed. • **Financial Recovery**: Working with local partners to develop a system-wide FRP and long term financial model, ensuring that the local FRP complements rather than conflicts with the ICS FRP.
ICB meetings requiring H&CP input:		The ICB and system meetings requiring H&CP support to ensure effective meetings are Quarterly provider contract review meetings and Provider assurance meetings. In line with the agreed 'delegation ask' staff working for the H&CP will not take part in contract meetings. The H&CP will provide reports as necessary for delegated services to support the contract management process. As the delegation process progresses, we expect that H&CP representation will be required at a wider range of meetings. The ICB and H&CP will work together to identify where H&CP representation may be invited even where it is not required.

H&CP meetings requiring ICB representation:	• H&CP Productivity and Finance Board • Other H&CP meetings as required.
H&CP reporting requirements:	The H&CP will be provided with the information required for it to effectively discharge the commissioning responsibilities delegated to it by the ICB. The ICB Finance Team (which includes the H&CP-aligned team) will provide monthly finance reports to the H&CPs. These reports will be sufficiently detailed to enable the H&CP to understand the available commissioning resources and their current usage to support decisions on how they might be more effectively used. The team will lead work to develop these reports in way which supports the needs of the ICB and H&CP. The reporting will be developed in a way which aligns with the arrangements in other H&CPs wherever possible.
ICB Reporting Requirements:	None at present. This will be kept under review, particularly as the co-designed finance pack evolves and the H&CP becomes more involved in the financial recovery of the ICS.
Any other relevant information:	None identified
Agreed By (ICB):	Shona Metcalfe, Director of Finance (NHS Kent & Medway)
Agreed By (H&CP):	Sally MacKinnon, H&CP Director
Review Date:	August 2024

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Enabler: Business Intelligence	
Support to Be Provided to the H&CP:	• The ICB BI team will produce system wide BI products available through the PowerBI platform, and work with the H&CP to utilise and further develop and tailor this suite of reports. Existing reports include (but are not limited to): ⇒ IQPR ⇒ Acute Activity ⇒ GP Appointments ⇒ Dementia Diagnosis ⇒ Eating Disorders ⇒ Talking Therapies ⇒ MH Physical Health Checks ⇒ MH Urgent and Emergency Care ⇒ OBH segmentation ⇒ UTC analysis ⇒ Waiting lists ⇒ UEC ⇒ AEDB/UEC programme board reports • The ICB BI team will provide support to the H&CP to access and utilise NHSEI intelligence products, including but not limited to the Lightfoot analytics tools, to produce tailored insights and analysis.

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Support to Be Provided to the H&CP:	• Proposed commitment from the ICB BI Team is to support each H&CP in understanding their unique data requirements and liaising with provider BI colleagues where necessary to provide a system wide package of BI support. This support would extend beyond the generic system reports above to focus on specific H&CP issues, such as developing winter resilience plans, or developing and monitoring system transformation plans. These programmes of work are likely to require provider level data not available to the ICB. The ICB BI team will support the H&CP to develop the data reporting requirements and work with our provider BI colleagues to develop jointly supporting intelligence. • West Kent H&CP: the following reports to be provided Urgent Care, Planned Care and Datasets held by NHSE (Provider daily SITREPs). It has been agreed that the two teams can work together to develop reporting with the offer of a BI group (meeting as often as weekly if required) that shares tasks.	
Support Provided by the H&CP:	• None identified.	
Are Staff Aligned to the H&CP?	No	
Has a Development Programme Been Agreed Between the ICB and H&CP?	No	• It has been agreed that the ICB BI team will work with H&CP BI Leads to develop reporting. This may include the development of a BI Group (meeting as often as weekly if required) that shares tasks.

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ICB Meetings Requiring H&CP Representation:	• None identified.
H&CP Meetings Requiring ICB Representation:	• None identified.
H&CP Reporting Requirements:	• None identified
ICB Reporting Requirements:	• None identified.
Any Other Relevant Information:	• None identified
Agreed By (ICB):	Clara Wessinger, Head of Planning and Performance
Agreed By (H&CP):	Sally MacKinnon, Director
Review Date:	Sep 2024

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<table>
<tr><td colspan="3">Enabler: CORPORATE SERVICES</td></tr>
<tr><td>Support to Be Provided to the H&CP:</td><td colspan="2">• Development and delivery of Kent and Medway Strategic Estate Plan and NHS Greener Plan.
• Management of ICB corporate governance activities relevant to east Kent Commissioning Functions (including FOI, complaints and audit and risk.)</td></tr>
<tr><td>Support Provided by the H&CP:</td><td colspan="2">• Development of local strategic estates plan aligned to local commissioning and service development plans.
• Support with relevant ICB business as usual activities (including FOI, complaints, tier 1 EPRR on-call and audit and risk.)</td></tr>
<tr><td rowspan="2">Are Staff Aligned to the H&CP?</td><td rowspan="2">No</td><td>Nigel Scott, Deputy Director Corporate Governance, will act as Relationship Manager for the H&CP</td></tr>
<tr><td>Agreed Work Programme/Areas for Aligned Staff:
N/A</td></tr>
<tr><td>Has a Development Programme Been Agreed Between the ICB and H&CP?</td><td>No</td><td></td></tr>
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ICB Meetings Requiring H&CP Representation:	• System Estates Meeting
H&CP Meetings Requiring ICB Representation:	• WK H&CP Estates Group (currently meeting as required)
H&CP Reporting Requirements:	• None
ICB Reporting Requirements:	• None
Any Other Relevant Information:	• Relevant H&CP team members will be offered the opportunity to join the ICB Tier 1 on-call rota as required.
Agreed By (ICB):	Nigel Scott - Deputy Director Corporate Governance
Agreed By (H&CP):	Sally MacKinnon - Director
Review Date:	Sep 2024

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<table>
<tr><td colspan="3">Enabler: Internal HR and OD for H&CP facing teams under the MoU</td></tr>
<tr><td>Support to Be Provided to the H&CP:</td><td colspan="2">HR Business Partner and HR advisory support for the H&CP Director and teams
Recruitment to H&CP vacancies for the teams under the agreement
Contracts, T&Cs, and policy advice
Team development as required</td></tr>
<tr><td>Support Provided by the H&CP:</td><td colspan="2">Line Manager leadership of the team with associated responsibilities in line with the policies and procedures of the K&M ICB including annual appraisal via ESR self-service.</td></tr>
<tr><td rowspan="2">Are Staff Aligned to the H&CP?</td><td rowspan="2">Yes</td><td>Details of Staff Aligned:
HR Business Partner covers H&CP facing teams along with other named Directorates.</td></tr>
<tr><td>Agreed Work Programme/Areas for Aligned Staff:
HR Business Partner and HR Advisory service support as required.</td></tr>
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<table>
<tr><td>Has a Development Programme Been Agreed Between the ICB and H&CP?</td><td>No</td><td>Attach Development Plan or Confirm Timescale for Agreeing Development Plan:
This is ongoing HR Business Partner support. A development plan needs to be agreed with the H&CP.</td></tr>
<tr><td colspan="2">ICB Meetings Requiring H&CP Representation:</td><td>• ICB Organisational Design engagement meetings (by invite)</td></tr>
<tr><td colspan="2">H&CP Meetings Requiring ICB Representation:</td><td>• Business as usual meetings such as team meetings (by invite).</td></tr>
<tr><td colspan="2">H&CP Reporting Requirements:</td><td></td></tr>
<tr><td colspan="2">ICB Reporting Requirements:</td><td>• Use of ESR self-service for management and staff changes, completion of statutory and mandatory training.
• Use of Giltbyte (Easy Expenses system) to claim expenses.
• Use of NHS Jobs to support recruitment activity.</td></tr>
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Enabler: ICB EXTERNAL WORKFORCE & OD	
Support to Be Provided to the H&CP:	Reduction in duplication through co-ordination of collaborative working Communication of key workforce ambitions / priorities (driven by national, regional and local programmes) and support for key workforce development needs highlighted Workforce agreements in place / support with workforce sharing agreements Directory of education with colleges and schools Digital resources for IAG via VR/AR, Sim and virtual mobile classroom (SDF2) Academy website with open and closed source resources for IAG, education staff and professional networks Support with workforce planning / modelling – support to understand workforce challenges / hard to recruit roles Support to develop communities of practice / talent management / organisational development / leadership Sharing good practice examples / case studies of workforce development opportunities
Support Provided by the H&CP:	Sharing of good practice / case studies Leadership of communities of practice Engagement with PCNs / Practices / GP Federations in supporting key initiatives/ opportunities Access to opportunities within employers for entry and placement support Widening Participation activity via employer team meetings and apprenticeship programme design

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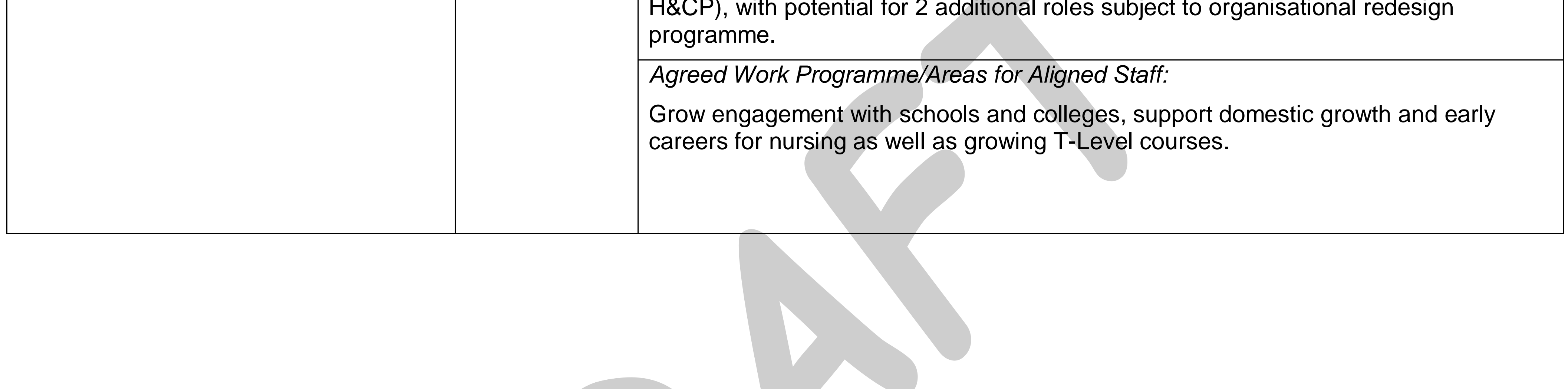

Are Staff Aligned to the H&CP?	No	*Details of Staff Aligned:* Future plans for 2 x ICB Schools and College leads to be aligned to H&CPs (0.5 per H&CP), with potential for 2 additional roles subject to organisational redesign programme.
		Agreed Work Programme/Areas for Aligned Staff: Grow engagement with schools and colleges, support domestic growth and early careers for nursing as well as growing T-Level courses.

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Has a Development Programme Been Agreed Between the ICB and H&CP?	No	Work is underway within the H&CPs in relation to a workforce programme
ICB Meetings Requiring H&CP Representation:		The H&CP will be invited to the following meetings if there is a specific agenda item and / or the ICB will share papers and actions if there is a decision needed. • Growing occupational health and wellbeing services steering group • K&M staff Mental Health and Wellbeing service – strategic oversight group Other potential 'People' meetings in the future relating to integrated care, education and training, attraction, recruitment and retention.
H&CP Meetings Requiring ICB Representation:		• West Kent Workforce development meetings
H&CP Reporting Requirements:		• West Kent Workforce summary to inform work of WK Workforce group
ICB Reporting Requirements:		•

Any Other Relevant Information:	
Agreed By (ICB):	Helen Edmunds – Director of People Strategy
Agreed By (H&CP):	Sally MacKinnon – Director
Review Date:	Sep 2024

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Enabler: QUALITY		
Support to Be Provided to the H&CP:	• Quality staff will work closely with providers in a H&CP as part of standard quality oversight and contract management, as well as support the development of quality strategies and plans at H&CP level, supporting Place's to focus on the local population needs • Support H&CP Quality forums • Ensure an understanding of place-level Quality issues • Implement the Quality & Risk Framework to manage escalated risks for each provider within the H&CP	

Support Provided by the H&CP:	• Lead the H&CP Quality Forums as defined in the NQB guidance at least monthly, to cover:
	  ○ Improvement and learning focused on quality across pathways and journeys of care
	  ○ Inform and oversee provider collaboration
	  ○ Comprehensive understanding of risks and improvements, which may in turn improve provider performance
	• Ensure the HCP has a representative on the monthly System Quality Group (SQG) to feed in learning/intelligence and escalate when issues have an ICS impact or require an ICB response	

Are Staff Aligned to the H&CP?	No	

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Has a Development Programme Been Agreed Between the ICB and H&CP?	In development	First meeting taken place to agree a workplan incorporating core elements/work areas/ways of working/escalation routes.
ICB/ICS Meetings Requiring H&CP Representation:		• System Quality Group (SQG)
H&CP Meetings Requiring ICB Representation:		• West Kent Clinical, Professional and Quality Advisory Group
H&CP Reporting Requirements:	• Verbal feedback at monthly SQG	
ICB Reporting Requirements:	• Providers within the H&CP are required to submit schedule 4/6a contract documents related specifically to quality monthly.	
Any Other Relevant Information:		
Agreed By (ICB):	Siobhan Jordan - Director of Quality and Safety and Deputy Chief Nursing Officer	
Agreed By (H&CP):	Sally MacKinnon	
Review Date:	Sep 2024	

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Enabler: COMMUNICATIONS AND ENGAGEMENT	
Support to Be Provided to the H&CP:	General: • Work with colleagues in our partner organisations to support the H&CP comms and engagement requirements. • An experienced communications and engagement lead will be the named point of contact for the H&CPs. • Support the H&CP to develop a place-based communications and engagement workplan, working with colleagues within the ICB/system Comms and Engagement Team (the Team) to deliver this together with colleagues from partner organisations. • Each H&CP also has an engagement link from the Team, who can provide strategic advice on involving people and communities.(Currently available 1 day a week) • Provide a summary of activity to each H&CP on a quarterly basis. • Any concerns about delivery, capacity and quality of work will be raised in the first instance with the named lead and can be escalated to the Deputy Director of Communications and Engagement, and Executive Director of Communications and Engagement Matt Tee. Delegation Specific: • The Team will provide communication and engagement support for the commissioning functions delegated from the ICB to the H&CP. • Access to this support will be through a completed work request form for any communications and engagement support needed from the Team. This work will then be allocated to a member of the team and a timescale for delivery will be advised.

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<table>
<tr><td>Support Provided by the H&CP:</td><td colspan="2">The H&CP SEAG will be responsible for ensuring communications and engagement colleague from local partners also support the delivery of the H&CP Comms and Engagement Workplan.</td></tr>
<tr><td rowspan="2">Are Staff Aligned to the H&CP?</td><td rowspan="2">No</td><td>Relationship Manager: Julia Walsh

Comms and Engagement Link: Clare Delap</td></tr>
<tr><td>Agreed Work Programme/Areas for Aligned Staff:
Not Applicable.</td></tr>
<tr><td>Has a Development Programme Been Agreed Between the ICB and H&CP?</td><td>No</td><td>The H&CP Comms and Engagement Workplan for 2023/24 is in development target June 2023</td></tr>
<tr><td colspan="2">ICB Meetings Requiring H&CP Representation:</td><td></td></tr>
<tr><td colspan="2">H&CP Meetings Requiring ICB Representation:</td><td>West Kent Health and Care Partnership Board (as required)
West Kent Stakeholder Engagement Advisory Group
Pathway/redesign meetings as required.</td></tr>
</table>

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H&CP Reporting Requirements:	Quarterly update on Comms and Engagement support provided to the H&CP.
ICB Reporting Requirements:	ICB to confirm.
Any Other Relevant Information:	
Agreed By (ICB):	Fay Sinclair - Associate Director of Communications and Engagement
Agreed By (H&CP):	Sally MacKinnon - Director
Review Date:	September 2024

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Schedule 3 – ICB staff team working for the WK H&CP

HCP STAFFING 2/2
West Kent Integrated Care Commissioning (11/1/23)

West Kent
Health and Care Partnership

- **KM ICB Chief of Delivery**
  - **Sally MacKinnon** – Director of Integrated Care Commissioning, West Kent – Sally.mackinnon1@nhs.net
    - **VACANT** – Personal Assistant
    - **Douglas McLaren** – Associate Director of Integrated Care Commissioning – douglasmclaren@nhs.net
      - **Frances Schmocker** – Senior Programme Manager, Urgent Care – frances.schmocker@nhs.net
        - **Alexander Thompson** – Programme Manager, Urgent Care – alexander.thompson11@nhs.net
          - **Jennifer Skinner** – Commissioning Assistant
          - **David Miller** – Senior Project Support, Urgent/community care
      - **Martine McCahon** – Senior Programme Manager, Community Care – martine.mccahon1@nhs.net
        - **Karen Hardy** – Project Manager
        - **Charlotte King** – Project Manager
    - **Anthony Harris** – Associate Director of Integrated Care Commissioning – anthony.harris6@nhs.net
      - **Sarvinoz Cornell** – Senior Programme Manager, Planned Care/ LTC – sarvinoz.cornell@nhs.net
        - **Laura Tilley** – Programme Manager, Long Term Conditions – laura.tilley@nhs.net
          - **Natalie Barton** – Project Manager, LTC – natalie.barton1@nhs.net
            - **Rachael Barnes** – Senior Project Support, Community/planned care – rachael.barnes@nhs.net
        - **Hannah McKie** – Project Manager, Planned Care – hannah.mckie@nhs.net
          - **Lauren Clark** – Senior Project Support, Community/planned care
          - **Natalie Green** – Project Manager, Planned Care – n.jgreen12@nhs.net
            - **Jo Knaves** – Commissioning Assistant – joanna.knaves1@nhs.net

Sub-Function	Grade	Budgeted Headcount	Budgeted WTE	Budget
West Kent HaCP	8c	2	2.00	191,824
West Kent HaCP	8b	3	2.43	195,598
West Kent HaCP	8a	2	2.00	136,380
West Kent HaCP	7	5	3.95	227,872
West Kent HaCP	6	3	2.60	121,303
West Kent HaCP	4	3	3.00	102,456
West Kent HaCP Total		**18**	**15.98**	**975,433**
Grand Total		**18**	**15.98**	**975,433**

Schedule 4 – WKHCP Governance

WEST KENT HCP - REVISED GOVERNANCE (Jan 2023)

ICB

ICP

PLACE BASED COMMITTEE (OVERSIGHT)

WEST KENT HEALTH & CARE PARTNERSHIP DEVELOPMENT BOARD

WEST KENT HEALTH & CARE PARTNERSHIP EXECUTIVE GROUP

WEST KENT HEALTH & CARE PARTNERSHIP OPERATIONAL GROUP

ADVISORY
- Clinical, Professional & Quality Advisory Group
- Members Advisory Group

ENABLERS
- FINANCE & CONTRACTING
- WORKFORCE
- POPULATION HEALTH & PREVENTION
- ENGAGEMENT & COMMS GROUP (SEAG)
- ESTATES (VIRTUAL)
- DIGITAL & DATA (VIRTUAL)

TRANSFORMATION PRIORITIES
- ADULT & CHILDREN'S MENTAL HEALTH
- MAIDSTONE HEALTH INEQUALITIES
- PRIMARY/ COMMUNITY TRANSFORMATION
- DISCHARGE & FLOW
- FRAILTY AND COMPLEX NEEDS
- URGENT & EMERGENCY CARE

Schedule 5

Kent and Medway Integrated Care Board
West Kent Place Committee

Terms of Reference

1. Introduction

1.1. NHS Kent and Medway Integrated Care Board (ICB) and the West Kent Health and Care Partnership (WK H&CP) have agreed to establish a West Kent Place Committee (the Committee) of the ICB. This is to support the H&CP to take on mutually agreed delegated functions and responsibilities on behalf of the ICB. As such the Committee is established in accordance with the ICB Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD See Schedule 7).

1.2. These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee. All employees and individuals working for the ICB and on behalf of the H&CP are directed to co-operate with any request made by the Committee.

1.3. The Committee is accountable to the ICB Board (the Board) for the purposes of seeking assurance in relation to the delegated functions and responsibilities given to the H&CP as detailed in the SoRD and associated documents including Memorandum's of Understanding (MOUs) between the two parties.

1.4. The Committee may also be responsible to the ICB and or the H&CP Partnership Board for other responsibilities as determined in these Terms of Reference.

1.5. The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in agreement with the Senior Responsible Officer of the H&CP.

2. Context

2.1. The ICB is accountable for developing strategy and overseeing delivery of plans to meet the required outcomes to improve the health and care needs of the population. The ICB is also responsible alongside the local authorities for the development and oversight of a wider integrated care strategy that improves the well-being of the population and enhances social and economic development. As part of this, the ICB has primary accountability for:

- Allocating resource and overseeing collective controls
- Securing provision of high quality, effective healthcare services
- Overseeing assurance and performance management to secure delivery of the agreed strategies, plans and outcomes
- Establishing joint working and governance arrangements for collaborative and integrated working
- Leading development and oversight of the Kent and Medway system people, digital and estate plans

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- Ensuring effective, inclusive clinical, professional and citizen involvement
- Ensuring appropriate clinical and professional leadership in any clinical service developments

2.2. Whilst the ICB is not responsible for the arrangements individual organisations put in place, it is accountable for ensuring the system as a whole meets its statutory and mandatory duties and obligations. In turn, system partners are responsible for ensuring they effectively collaborate with the ICB and other partners to achieve this.

2.3. Contracts and partnership agreements will be agreed between the ICB and system partners and organisations to support delivery of these accountabilities. As part of this:

- Providers of care, local authorities and other organisations remain accountable for the efficient and effective use of resource allocated directly to them, and for meeting national and local standards and outcome measures agreed as part of that delegation.
- Partnerships such as Health and Care Partnerships, provider collaboratives and system programme boards have been established to enable partner organisations and stakeholders to work within an agreed collaborative framework to jointly plan and deliver health and care services.

  The intent is for the ICB to increasingly delegate appropriate functions, responsibilities and resource over time to partners, through these partnership arrangements, to ensure a greater proportion of decisions are made as part of the health and care arrangements as possible.

2.4. As such, **the ICB and the H&CP Partnership Board have agreed to establish a Place based Committee of the ICB** in the first instance to oversee the development, delivery and assurance of delegated ICB functions and responsibilities as detailed in the ICB SoRD and the Memorandum of Understanding (MoU) between the two parties.

3. Purpose, responsibilities and delegated authority

3.1. The Committee has been established to provide the ICB with assurance that the H&CP is delivering the delegated functions and responsibilities in a way that secures delivery of the ICB and wider system's strategies, priorities and delivery plans that relate to that area.

3.2. The Committee will achieve this by seeking reports and assurance as required on the adequacy of systems and controls in place to monitor on-going performance and delivery against those functions and responsibilities delegated by the ICB to the H&CP.

3.3. In particular the Committee is responsible for:

- Providing assurance to the ICB Board that delegated functions and responsibilities are being carried out by H&CP partners in a safe, effective and efficient manner, with a continuous focus on quality improvement

- Ensuring an effective framework is in place that identifies any material risks or challenges associated with delegated functions and responsibilities in a timely manner, and ensures appropriate actions are put in place by partners to mitigate risk as much as possible

- Ensuring any financial, staffing or other resource transferred to the H&CP for the purposes of the delegation arrangements, is effectively deployed to achieve the outcomes and purposes that it intended for.

- Ensuring a robust and effective H&CP governance framework is in place that enables safe, compliant, transparent and effective decisions to be made, without the potential of exposing the ICB or other system partners to unnecessary risk or successful challenge.

- Ensuring appropriate arrangements are in place that continuously focus on improving quality, safety, safeguarding, patient experience and the performance of delegated functions and responsibilities; and that there are clear local controls in place for oversight and assurance of these.

- Ensuring appropriate arrangements are in place to support H&CP provider partners in their progression against the NHSE Oversight Framework, including providers in the Recovery Support Programme (RSP) with a component of RSP at Place level.

- Reviewing H&CP risks, issues and interventions in response to regulatory notices e.g., following Care Quality Commission (CQC) or Health and Safety Executive (HSE) inspections which apply to individual providers, but which might impact on the H&CP as a whole.

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3.4. The Committee is delegated to make decisions and direct action in accordance with the ICB SoRD, ICB Standing Orders, ICB Standing Financial Instructions and any H&CP governance and policy arrangements. Where there is divergence between ICB and H&CP policies, the ICB arrangements will take precedence.

3.5. The Committee has delegated authority to seek assurance, direct individuals and report on the above responsibilities where they relate to these delegated functions and responsibilities.

3.6. The Committee will scrutinise and gain assurance on matters relating to all relevant directives, regulations, national standards, policies and best practice as they apply to the delegated functions and responsibilities and the NHSE Oversight Framework 2022/23 and associated Memorandum of Understanding

3.7. In achieving the above, the Committee will:

- Receive clear, timely, accurate information, that sufficiently details:

    a. performance delivery against any agreed outcome measures, trajectories and standards; including, but not limited to:
        - Continuous engagement with Health Improvement and System Development Teams supporting place development and delivery of plans:
        - Progress against H&CP and system plans/priorities
        - Local H&CP dashboard (performance, quality, and finance metrics)
        - Development roadmap

- Support of NHS Provider Partner Oversight Framework progression/exit criteria

b.

c. matters to be escalated for further scrutiny and review and for mitigating actions to be identified, agreed and effectively tracked

- Agree the arrangements and escalation triggers for matters to be escalated to the ICB Board, H&CP Partnership Board ICB Improving Outcomes and Experience Committee and other ICB assurance committees as appropriate. This will ensure there are agreed, transparent systems that facilitate local assurance and decision- making arrangements, whilst also being clear on when issues need to be escalated.

- Review and monitor risks through an appropriate risk management framework

3.8. Where ICB Board or H&CP Partnership Board scrutiny or decision is required for related issues, the Committee will review these in advance and provide any recommendations as required.

3.9. The Committee may comment on and direct the development and design of new contractual forms for partnership working where they relate to delegated functions (actual or potential).

3.10. Members of the Committee will engage as appropriate at system, place and neighbourhood levels in order to achieve the Committees remit.

4. Membership and Chair

4.1. Membership of the Committee will be as follows:

A member of K&M ICB will chair the committee
ICB – Chief Delivery Officer
ICB - Chief of Staff
WK H&CP - Director
MTW - SRO West Kent HCP/CE MTW,
MTW – Medical Director
MTW – Executive Director of Strategy and Partnerships
Medical Director (Primary Care)
WK H&CP Lay member for coproduction and engagement
KCHFT – Chair
KCHFT – Deputy Chief Executive
West Kent Primary Care - Chair
KMPT – Chair KMPT
NELFT – Children's Services Director
KCC – Assistant Director WK and Director North and WK
Maidstone BC – Chief Executive
Involve (representing Community/Vol Sector) – Chief Executive
NHSE Locality Director (while H&CPs are still developing)

4.2. In the absence of a Member, the Chair may accept a deputy to represent them, subject to the

deputy being effectively briefed in advance of the meeting and able to make decisions on behalf of the Member they are representing. For clarity, a Member in attendance may not deputise for another Member

4.3. The Chair may call additional individuals to attend meetings to inform discussion. Attendees may receive copies of papers and may present at / contribute to Committee meetings as invited by the Chair but are not allowed to participate in any vote.

5. Meetings and Voting

5.1. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

5.2. Meetings of the Committee will not be open to the public. Papers and minutes of Committees meetings will be subject to the Freedom of Information act and disclosable to the public unless the Chair determines that disclosure would be prejudicial to the public interest or the interests of ICB by reason of the confidential nature of the business transacted or for other special reasons. These should be stated in the documents and minutes of the meeting.

5.3. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

5.4. The Committee is authorised to make decisions in line with the Memorandum of Understanding and the Committee's Terms of Reference, subject always to any decision being within the agreed delegated financial threshold. Any decision above the financial threshold will require ICB approval, as detailed in the ICB Scheme of Reservation and Delegation and ICB Standing Financial Instructions.

5.5. The aim of the Committee will be to achieve consensus decision-making wherever possible. Where a vote is required, each member of the Committee shall have one vote. The Committee shall approve a recommendation subject always to the meeting being quorate and the majority of Members present approving the proposal. The Chair shall have one vote. They shall not have a second, casting vote where the vote is tied.

5.6. All Members, Participants and any other individual involved in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the ICB's policy on business standards and managing conflicts of interest. At the sole discretion of the Chair, individuals who have declared an interest may be allowed to participate in the discussion but will not participate in any vote and may be requested to leave the meeting for any or all of the items in question.

6. Equality and diversity

6.1. Members must demonstrably consider the equality and diversity implications of decisions they make and ensure that their work and approach is inclusive.

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7. Quorum

7.1. The meeting shall be quorate subject to

- there always being at least 50% of member in attendance
- there always being:
  - ⇒ a clinician in attendance
  - ⇒ a representative from NHS Kent and Medway in attendance
  - ⇒ at least one representative from an NHS provider in attendance
  - ⇒ at least one representative from primary care in attendance (clinical or non-clinical)
  - ⇒ at least one representative from the local authority (KCC or district council)

7.2. Members who are not physically present at a Committee meeting but are present through tele-conference or other acceptable media, shall be deemed to be present and count towards the quorum as appropriate.

7.3. If any representative, is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the matter shall be referred to the ICB Board or an appropriate other committee of the ICB Board

Such decisions shall always be recorded in the minutes of the meeting

8. Frequency and Notice of Meetings

8.1. The Committee shall meet at least quarterly and may meet more frequently as agreed by the Committee.

8.2. Triggers for extraordinary meetings

- Meetings may be triggered for the following reasons:
  - o Significant issue affecting place.
  - o External trigger requiring immediate response (e.g., from NHS England / CQC).
  - o Escalation from H&CP or ICB.

8.3. Key Lines of Enquiry (KLOEs)

- Key Lines of Enquiry for standing agenda items relating to NHSE Oversight Framework will be shared with H&CPs at least four weeks in advance of each meeting to allow places sufficient time to prepare.

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- KLOE responses and H&CP submissions will be provided 3 weeks following information requests to enable internal ICB governance prior to Oversight Meetings.

8.4. Notice of any Committee meeting must indicate:

- Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)
- Where it is to take place
- An agenda of the items to be discussed at the meeting and any supporting papers
- If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting

9. Policy and best practice

9.1. The Committee is authorised to instruct professional advisors and request the attendance of individuals and authorities from outside of the organisation with relevant experience and expertise if it considers this necessary for or expedient to the exercise its responsibilities.

9.2. The Committee is authorised to obtain such information from partner members as is necessary and expedient to the fulfilment of its responsibilities and partner members will cooperate with any such reasonable request.

9.3. The Committee is authorised to establish such sub-committees as the Committee deems appropriate in order to assist the committee in discharging its responsibilities, and such sub-committees may have delegated decision-making authority, subject always to such delegation arrangements being approved by the ICB Board and included in the ICB Scheme of Reservation and Delegation or other relevant financial policies.

9.4. The Committee will be conducted in accordance with the ICB policy on business standards, specifically:

- There must be transparency and clear accountability of the Committee.
- The Committee will hold a members Register of Interests which will be presented to each meeting of the Committee
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s) is concluded

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9.5. The Committee shall undertake a self-assessment of its effectiveness at least annually. This may be facilitated by independent advisors if the Committee considers this appropriate or necessary.

9.6. Members of the Committee should aim to attend all scheduled meetings.

9.7. Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:

- The laws of England and Wales
- The spirit and requirements of the NHS Constitution
- The Nolan Principles
- Any additional regulations or codes of practice relevant to the Committee

10. Secretariat

10.1. The ICB Oversight team will provide appropriate secretariat arrangements to the Committee. The duties of the secretariat include but are not limited to:

- Agreement of the agenda with the Chair together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.

10.2. Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) business days in advance of the meeting.

10.3. If a Committee member wishes to include an item on the agenda they must notify the Chair via the Committee's Secretary no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

10.4. A copy of the minutes and or a summary of Committee meetings will be presented to the ICB Board, MTW Board and the H&CP Partnership Board as required.

11. Confidentiality

11.1. Members of the Committee shall respect the confidentiality requirements set out in the ICB's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

11.2. Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

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12. Review

12.1. The Terms of Reference of the Committee shall be reviewed by members of the Committee annually, or as required in line with any developments or changes to the ICB's constitution, national guidance or feedback from auditors, with recommendations made to the ICB Board for approval.

Approved: XXXX

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment

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Schedule 6 – West Kent Executive Group TOR

Title	TERMS OF REFERENCE WEST KENT HEALTH & CARE PARTNERSHIP EXECUTIVE GROUP
Date written / updated	May 2023
Background, Context & Principles	The West Kent HCP is a multi-agency partnership of health and care providers that are working together to integrate care across West Kent. The HCP is part of the developing Integrated Care System (ICS) arrangements and the role and function of the partnership is developing in line with these national developments. The partnership has a shared programme of work including key areas of transformation and enabler activity. The partnership has agreed the following vision: The West Kent HCP is working together, to improve the health and well-being of the residents of West Kent. We are working together with residents to: • make health and care services more accessible and joined up • improve health and well-being of residents and reducing inequalities • ensure we get best value from the resources invested in West Kent health and care • support broader social and economic development The organisations that are part of this partnership arrangement are: • Maidstone and Tunbridge Wells NHS Trust (MTW) • Kent Community Health Foundation Trust (KCHFT) • West Kent Primary Care (WKPC) • Kent and Medway NHS & Social Care Partnership Trust (KMPT) • Kent County Council (KCC) • West Kent District Councils: Maidstone, Sevenoaks, Tonbridge & Malling, Tunbridge Wells • Voluntary & Community Sector partners i.e. Healthwatch Kent, Involve Kent, North East London Foundation Trust (NELFT) • Kent & Medway Integrated Care Board (K&M ICB) The West Kent HCP Executive Group is the group overseeing the agreed HCP programme of work on behalf of the West Kent HCP Development Board. The West Kent HCP Executive Group holds each other to account and through collective agreement progresses the key work areas and priorities set by the Board. Addressing risks and challenges early and escalating any matters the group feel the board need to be aware of. The shared principles that underpin this are: • Openly sharing information • Deficit or failure in any part of the system is a failure of the whole system • Risks and issues are shared and jointly owned/managed • Collaborative working with aligned aims, incentives, plans and actions providing a commonality of vision • Focus on system-wide, place based working • Emphasis on value: cost, efficiency, effectiveness and quality • Contractual arrangements that enable transformation • Success measures will align and be jointly monitored and supported • Plans will be co-designed and future service models developed with clear input from all members and key stakeholders, including patients and third sector • Appropriate engagement with patients/residents • Appropriate engagement with all relevant partners

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Key Responsibilities & Deliverables	The Exec group is particularly responsible for: Proposing to the West Kent HCP Development Board an Integration plan for delivery of the partnership objectives in West Kent based on an area needs assessment • Accountable for successful delivery of sustainable change to deliver either qualitative or quantifiable benefits identified in the plan • Ensure the HCP Delivery Plan is in line with national, Kent & Medway priorities and is informed by member organisations longer term objectives and needs, • Ensure appropriate governance arrangements are in place for oversight of specific initiatives within the programme • Liaise with the Integrated Care Board (ICB) teams to ensure that the HCP activity is appropriately connected to the wider work of the ICB. • • Provide executive drive, accountability, visibility and explicit oversight of delivery and implementation of the joint plan and unblock issues that impede progress, e.g. lack of pace, commitment or resource, providing support and guidance to HCP director and Programme leads • Promoting open discussion of wicked issues that partners are facing in the joint delivery of health and care services • To report on progress of the programme and escalate issue and risk through the West Kent HCP Development Board as required • To keep abreast of national, K&M and/or local issues that impact on the HCP activity now or in the future • Review key reports going to the board notably the programme report and the Oversight report. • Take key operational and budget decisions as required for a value no more than £50k per item ensuring expenditure remains within the HCP allocated budget. • All papers to the board will include a front page summary of no more than 2 pages to support members to engage
Accountability & Reporting Responsibilities	**Accountability:** The West Kent HCP Executive Group is accountable to the West Kent HCP Development Board. **Reporting:** The West Kent HCP Executive Group will report quarterly to the West Kent HCP Development Board, which reports to the ICS oversight meetings on the same cycle.
Membership	**Chair:** (to be reviewed each year with the TOR) **Vice Chair:** TBC **Core Members:** Executive Director, MTW West Kent Service Director, KMPT Chief Executive, WKPC West Kent Assistant Director (Adult Social Care), Kent County Council KCC Nominated District Council representative Director of Operations, NELFT Executive Director for Health Inequalities and Prevention Involve Deputy CE Healthwatch Manager Chair of the WK Clinical Professional and Quality Advisory group West Kent HCP Director K&M ICB Executive Director of Delivery representative Head of West Kent HCP Programme Management Office WK HCP/ICB Finance Lead

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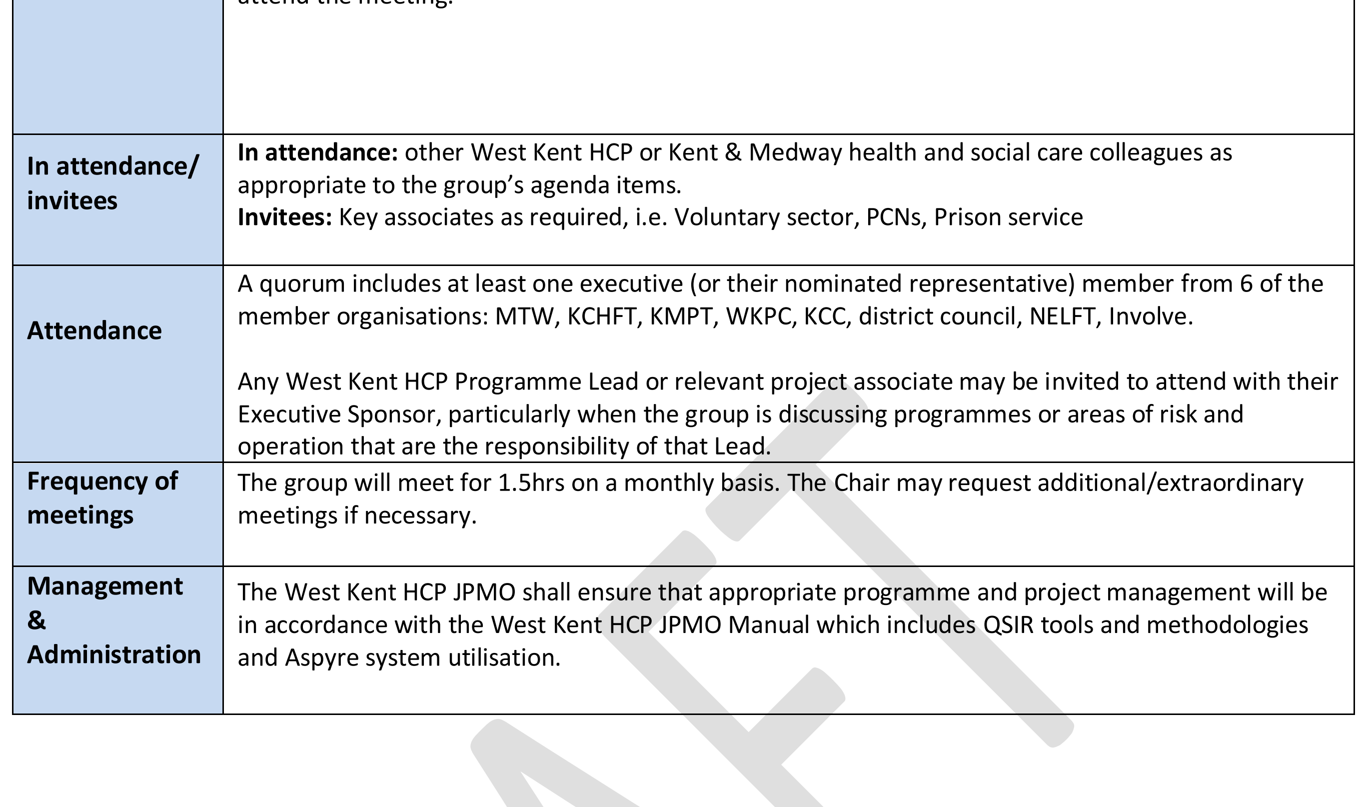

	Each member of the group will have a nominated peer substitute for any occasions that they cannot attend the meeting.
In attendance/ invitees	**In attendance:** other West Kent HCP or Kent & Medway health and social care colleagues as appropriate to the group's agenda items. **Invitees:** Key associates as required, i.e. Voluntary sector, PCNs, Prison service
Attendance	A quorum includes at least one executive (or their nominated representative) member from 6 of the member organisations: MTW, KCHFT, KMPT, WKPC, KCC, district council, NELFT, Involve. Any West Kent HCP Programme Lead or relevant project associate may be invited to attend with their Executive Sponsor, particularly when the group is discussing programmes or areas of risk and operation that are the responsibility of that Lead.
Frequency of meetings	The group will meet for 1.5hrs on a monthly basis. The Chair may request additional/extraordinary meetings if necessary.
Management & Administration	The West Kent HCP JPMO shall ensure that appropriate programme and project management will be in accordance with the West Kent HCP JPMO Manual which includes QSIR tools and methodologies and Aspyre system utilisation.

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Schedule 7

NHS KENT AND MEDWAY INTEGRATED CARE BOARD

SCHEME OF RESERVATION AND DELEGATION

DRAFT

Version: 03 Effective Date: March 023

Version	Notes	Date
01	Original Version	July 2022
02	Updated following Board review	July 2022
03	Revision to primary care committees and delegation to clinical decision-making areas	Mar 2023
04	West Kent Health and Care Partnership delegation information added	July 2023

SCHEME OF RESERVATION & DELEGATION

1. SCHEDULE OF MATTERS RESERVED TO THE INTEGRATED CARE BOARD AND SCHEME OF RESERVATION AND DELEGATION

1.1. The arrangements made by the Integrated Care Board (the Board) as set out in this scheme of reservation and delegation shall have effect as if incorporated in the Board's Constitution.

1.2. The Board remains accountable for all of its functions, including those that it has delegated.

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
REGULATION AND CONTROL	Exercise of those functions of the Board which have not been retained by the Board or delegated to a Committee, other decision making forum or an employee (subject to any statutory regulations or mandated requirements)		✓		
REGULATION AND CONTROL	Preparation of the Boards Constitution and Standing Orders				**Exec Director of Corporate Governance**
REGULATION AND CONTROL	Consideration of any proposed change to the Board's Constitution and Standing Orders		✓		**and Chairman**
REGULATION AND CONTROL	Approval of proposed applications to NHS England on any proposed change to the Board's Constitution and Standing Orders	✓			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
REGULATION AND CONTROL	Prepare and approve the ICB Scheme of Reservation and Delegation, which sets out those decisions delegated to the Board and its Partners, Committees and employees	✓ (Approve)			**Exec Director of Corporate Governance** (Prepare)
REGULATION AND CONTROL	Prepare and approve the ICB's Scheme of Delegated Financial Limits, which sets out those key operational decisions delegated to individual employees, Committees and other decision-making forum	✓ (Approve)			**Chief Finance Officer** (Prepare)
REGULATION AND CONTROL	Prepare and approve the Board's Prime Financial Policies, Standing Financial Instructions and Schedule of Matters Delegated to Officers	✓ (Approve)			**Chief Finance Officer** (Prepare)
REGULATION AND CONTROL	Seek assurance on behalf of the Board on the robustness of all financial policies, strategies, systems, processes and governance arrangements relating to financial and other corporate controls			**Audit and Risk Committee**	
REGULATION AND CONTROL	Approval of the arrangements for discharging the ICB statutory financial duties.	✓			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
REGULATION AND CONTROL	Approve the arrangements for managing exceptional funding requests outside of any delegated limits	✓			
REGULATION AND CONTROL	Approve any changes to the provision or delivery of assurance services to the Board				**Exec Director of Corporate Governance, Chief Finance Officer or Chief of Staff**
REGULATION AND CONTROL	On-going review of the ICB's governance arrangements to ensure that the organisation continues to reflect the principles of good governance	✓			
REGULATION AND CONTROL	Exercise the powers that the Board has reserved to itself in an emergency or for an urgent decision				**Chief Executive and Chairman** (To be formally reported to next Board meeting)
PARTNER REPRESENTATIVES AND EXEC MEMBERS OF BOARD	Approve the appointment of Ordinary Members of the Board including Partner Members				**Chairman**

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
PARTNER REPRESENTATIVES AND EXEC MEMBERS OF BOARD	Approve the process for appointing and removing Members to the Board as detailed in the ICB Constitution (subject to any regulatory req'ts)	✓			
PARTNER REPRESENTATIVES AND EXEC MEMBERS OF BOARD	Propose and approve arrangements for identifying the Board's Chief Executive	✓ (Approve)		**Remuneration Committee** (Propose)	
STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the Board	✓			
STRATEGY AND PLANNING	Preparation and approval of the local Integrated Care Strategy, Health and Care Strategy, the Annual Operating Plan and other strategies and plans as determined by the Board. Includes, determination and oversight of associated outcome measures	✓ (Approval)		**Kent and Medway Integrated Care Partnership Joint Committee** **Inequalities, Prevention and Population Health Committee** (Preparation and post-approval oversight as per terms of reference)	**Chief Strategy Officer and Chief Delivery Officer** (ICB Senior Responsible Officers)

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
STRATEGY AND PLANNING	Preparation and approval of annual ICB budget and financial operating plans to meet the financial duties as set out in the Constitution	✓ (Approval)		**Productivity and Investment Committee** (Assurance pre-Board approval)	**Chief Finance Officer** (Preparation)
ANNUAL REPORTS AND ACCOUNTS	Preparation and approval of the ICB annual report and annual accounts	✓ (Approval)		**Audit and Risk Committee** (Review)	**Exec Director of Corporate Governance and Chief Finance Officer** (Preparation)
ANNUAL REPORTS AND ACCOUNTS	Approving local timetable for producing the annual report and accounts, in line with mandated requirements			**Audit and Risk Committee**	
HUMAN RESOURCES	Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive members			**Remuneration Committee**	

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
HUMAN RESOURCES	For the Chief Executive, Directors and other Very Senior Managers employed by ICB: - Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars; - Determine arrangements for termination of employment and other contractual terms and non-contractual terms			**Remuneration Committee**	
HUMAN RESOURCES	For all staff employed or contracted by the ICB: - Determine the ICB pay policy - Oversee contractual arrangements - Determine the arrangements for termination payments and any special payments			**Remuneration Committee**	
HUMAN RESOURCES	Approve any other terms and conditions of services for ICB employees		✓		

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Chief Executive and for other persons working on behalf of the ICB	✓			
HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the ICB	✓ (Critical Policies as defined at Schedule 1)	✓ (All other policies)		
QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes	✓ (Critical Policies as defined at Schedule 1)	✓ (All other policies and arrangements)		**Chief Medical Officer and Chief Nursing Officer** (Preparation of policies)
QUALITY AND SAFETY	Approve and oversee arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of all services, including delegated services		✓ (Approve)	**System Quality Group** (Oversee)	**Chief Medical Officer and Chief Nursing Officer** (Preparation of arrangements)
QUALITY AND SAFETY	Approve the ICB's arrangements for handling complaints	✓			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
OPERATIONAL AND RISK MANAGEMENT	Ensure that there is an effective internal audit function that is adequately resourced and meets the Public Sector Internal Audit Standards. Includes approving the arrangements and annual budget for the internal audit function			**Audit and Risk Committee**	
OPERATIONAL AND RISK MANAGEMENT	Ensure there is an effective external audit function that is adequately resourced. Includes approving the arrangements and annual budget for the external audit function			**Audit and Risk Committee**	
OPERATIONAL AND RISK MANAGEMENT	Approve the ICB counter fraud and security management arrangements, including approval and monitoring of counter-fraud work plans			**Audit and Risk Committee**	
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB risk management arrangements	✓			
OPERATIONAL AND RISK MANAGEMENT	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under S75 of the NHS Act 2006)	✓ (In line with SFI thresholds)	✓ (In line with SFI thresholds)		

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
OPERATIONAL AND RISK MANAGEMENT	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB		✓	**Audit and Risk Committee** (Assurance function)	
OPERATIONAL AND RISK MANAGEMENT	Determine arrangements for managing litigation against or on behalf of the ICB		✓		
OPERATIONAL AND RISK MANAGEMENT	Approve the ICB arrangements for business continuity and emergency planning				**ICB Accountable Emergency Officer**
OPERATIONAL AND RISK MANAGEMENT	Approve the ICB banking arrangements	✓			
OPERATIONAL AND RISK MANAGEMENT	Approve the level of all fees and charges other than those determined by NHS England or by statute				**Chief Finance Officer**
OPERATIONAL AND RISK MANAGEMENT	Responsibility for recording and overseeing conflicts of interest				**Exec Director of Corporate Governance**
INFORMATION GOVERNANCE	Approve and oversee the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of		✓ (Approval)		**Senior Information Risk Owner and Caldicott Guardian**

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
	information and data				(Oversight)
TENDERING AND CONTRACTING	Approval of the ICB's contracts for any commissioning support and corporate support services (for example finance provision)		✓		
TENDERING AND CONTRACTING	Approve arrangements for the negotiation of contracts on behalf of the ICB		✓		
TENDERING AND CONTRACTING	Approve arrangements for the oversight and management of individuals contracts on behalf of the ICB				**Chief Finance Officer**
ICS WORKING	Approve decisions that individual members or employees of the ICB participating in joint arrangements on behalf of the ICB can make. Such delegated decisions must be disclosed in this overarching Scheme of Reservation and Delegation, Standing Financial Instructions, or Scheme of Delegated Financial Limits as appropriate	✓ (In line with SFI thresholds)	✓ (In line with SFI thresholds)		

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
ICS WORKING	Approve the delegation of functions, responsibilities and decisions that ICB Committees, statutory organisations and other authorised forums can make on behalf of the ICB. Such delegated decisions must be disclosed in this overarching Scheme of Reservation and Delegation, Standing Financial Instructions or Scheme of Delegated Financial Limits as appropriate	✓ (In line with SFI thresholds)	✓ (In line with SFI thresholds)		
ICS WORKING	Assurance and oversight of any ICB delegated budget, including those delegated to Health and Care Partnerships, provider collaboratives, system programme boards and any other forum			**Productivity and Investment** (Assurance)	**Chief Finance Officer** (Oversight)
ICS WORKING	Quality, safety, safeguarding, patient experience and performance delivery assurance and oversight of any services delegated by the ICB, including those delegated to Health and Care Partnerships, provider collaboratives, system programme boards and any other forum. *(In addition to local arrangements put in place by any of the above partnerships or forums. Specific arrangements to be confirmed in*			**Improving Outcomes and Experience Committee** (Assurance)	**Chief Medical Officer, Chief Nursing Officer and Chief Delivery Officer** (Oversight)

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
	relevant MoU or Terms of Reference)				
ICS WORKING	Approval of the establishment of joint committees (outside of those described in legislation) and approval of terms of reference and level of delegated authority. Includes committees established under Section 75 of the NHS Act 2006	✓			
COMMISSIONING AND CONTRACTING FOR CLINICAL	Within delegated thresholds: - approve recommendations from the Kent and Medway Joint Prescribing			**Joint Prescribing Committee / Integrated Medicines**	**Chief Medical Officer**

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
SERVICES	Committee/Integrated Medicines Optimisation Committee, including prescribing pathways, formularies and Patient Group Directions - approve recommendations from the Kent and Medway Policy Recommendation and Guidance Committee - Make decisions on individual cases which fall outside the purview of the Individual Funding Request panel			**Optimisation Committee** **Executive Management Team** (in line with SFI thresholds)	
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties and functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation	✓			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Preparation and approval of the ICB's Annual Operating Plan for primary care services. Includes primary medical, dental, pharmacy and optometry services	✓ (Approval)		**Primary Care Strategic Oversight Committee** (Oversight of preparation	**Chief Delivery Officer** (Preparation)

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Overseeing delivery of the functions and duties relating to all primary care services for those functions delegated from NHS England Includes primary medical services; and pharmacy, dental and optometry (POD) services			**Primary Care Strategic Oversight Committee**	
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Making decisions for the management of primary care services delegated functions. Includes primary medical services; and pharmacy, dental and optometry (POD) services. Delegation of decisions is in accordance with the Committee's Terms of Reference which are approved by the ICB Board			**Primary Care Strategic Oversight Committee**	
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the ICB procurement strategy	✓			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Committee	Specified Individual

ICB functions and responsibilities delegated to other parties to facilitate decision making within local communities, for example health and care partnerships, provider collaboratives and system programme boards

Body or individual that will exercise the function	Decision, function and or responsibility delegated	Supporting documentation Reference
West Kent Health and Care Partnership (H&CP)	The Memorandum of Understanding (MoU) and Operating Model between NHS Kent and Medway ICB and West Kent H&CP, approved on 4 July 2023 by the ICB Board, details the responsibilities delegated by the ICB to the H&CP. This includes confirmation that levels of financial delegation are in accordance with ICB Standing Financial Instructions (Appendix A and Appendix B), through this ICB Scheme of Reservation and Delegation. The only limitation to this is for any decision to transfer funds (within budget) amongst service providers in order to improve pathways, and/or achieve financial efficiencies over £1 million. This will require ICB approval before proceeding. These decisions must also be made in the context of the overall system finance position	MoU between West Kent H&CP and NHS Kent and Medway ICB NHS Kent and Medway Standing Financial Instructions

Schedule 1 to NHS Kent and Medway ICB Scheme of Reservation and Delegation – Policies where approval is retained by the board.

Finance policies

- Standing Financial Instruction
- Scheme of Reservation and Delegation

People and Remuneration policies

- Change Management
- Disciplinary
- Freedom to Speak Up (Whistleblowing)
- Grievance

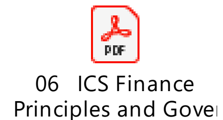
Quality policies

- Safeguarding

Corporate policies

- Emergency Planning
- Standards of Business Conduct
- Risk Management
- Information Governance
- Freedom of Information
- Health and Safety

Schedule 8 – Finance Principles and Governance Model



Schedule 9 – Measures of success

West Kent Metrics
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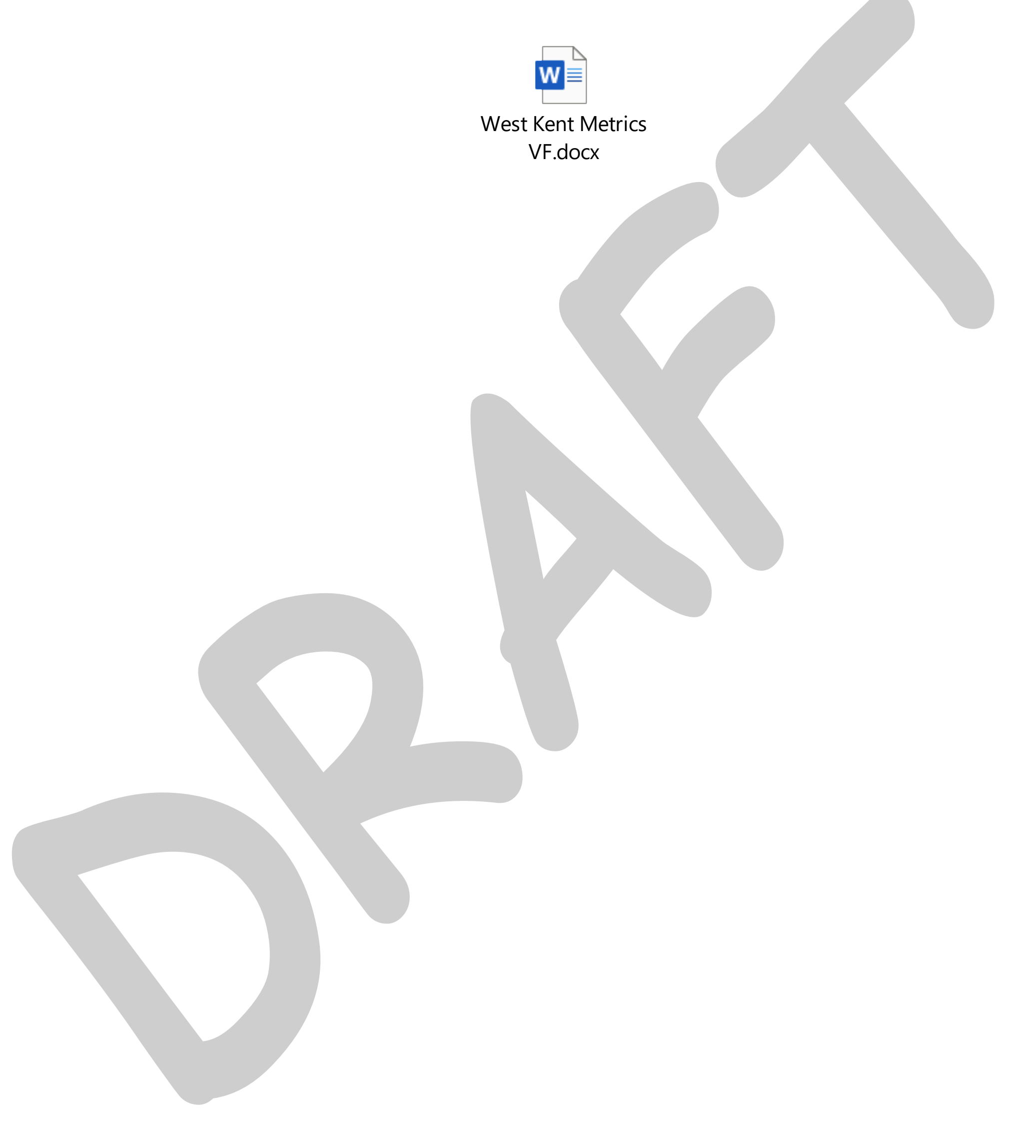


Trust Board meeting – 29th June 2023

To approve the corporate objectives for 2023/24	**Director of Strategy, Planning and Partnerships**

The enclosed report provides information on the current position and next steps for the corporate objectives as part of SDR.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 25/04/23
- Trust Board 'Away Day', 07/06/23

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

[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

Strategy Deployment Review 2022/23 Update

Rachel Jones
Executive Director Strategy, Planning & Partnerships

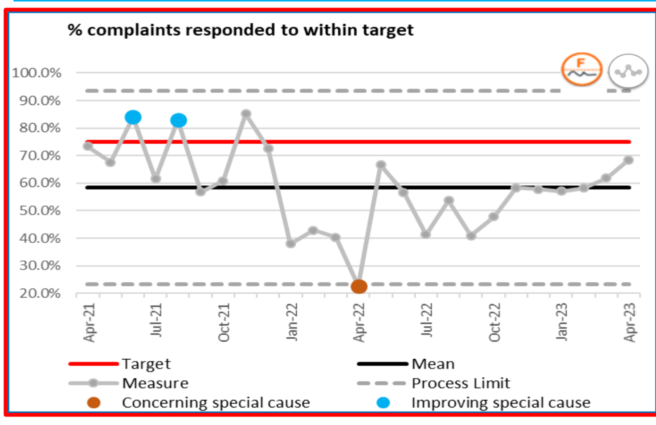
June 2023

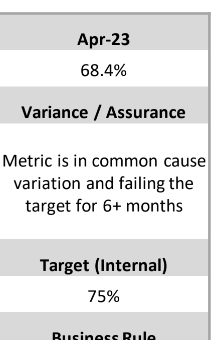
Mid year review

- We agreed the vision goals, targets and breakthrough objectives in June 2022 and the final corporate and divisional projects in October 2022.
- They were agreed for an 18 month period and we will commence the full refresh, aligned to business planning later this year.

- This is a mid year review to consider if we need to make any changes to vision goals, breakthrough objectives or corporate projects.
- The data presented is in the form of counter measure summaries which are required when a metric has with passed or failed the standard for 6 months or more

Patient Experience Breakthrough Objective: Counter Measure Summary





Apr-23

68.4%

Variance / Assurance

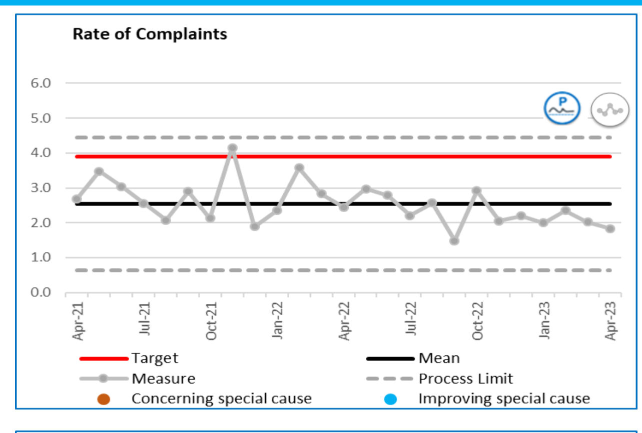
Metric is in common cause variation and failing the target for 6+ months

Target (Internal)

75%

Business Rule

Full Escalation failed the target 6+ months



Apr-23

1.8

Variance / Assurance

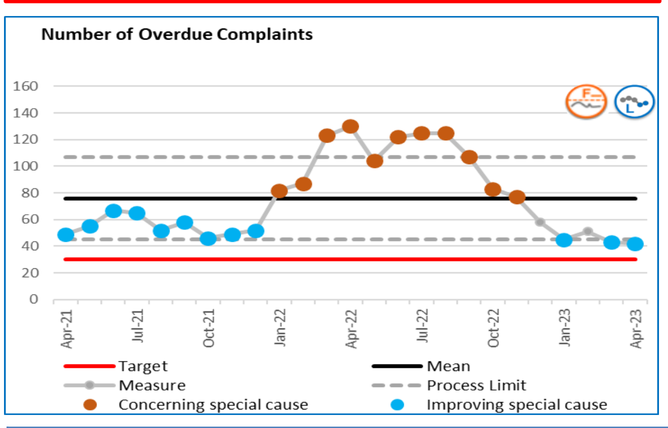
Metric is currently experiencing Common Cause Variation and has achieved the target for 6+ months

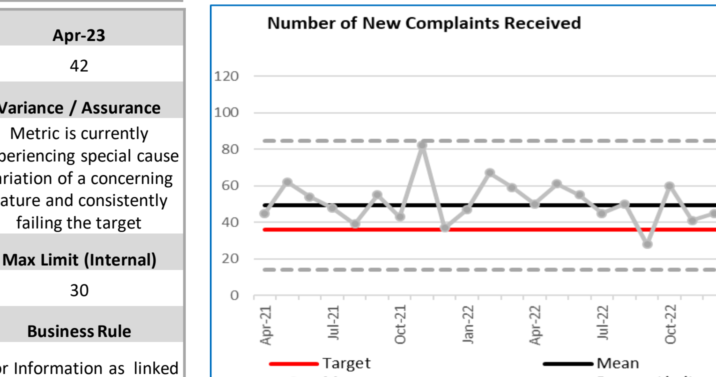
Max Limit (Internal)

3.9

Business Rule

For Information as linked to % Complaint Responded





Apr-23

42

Variance / Assurance

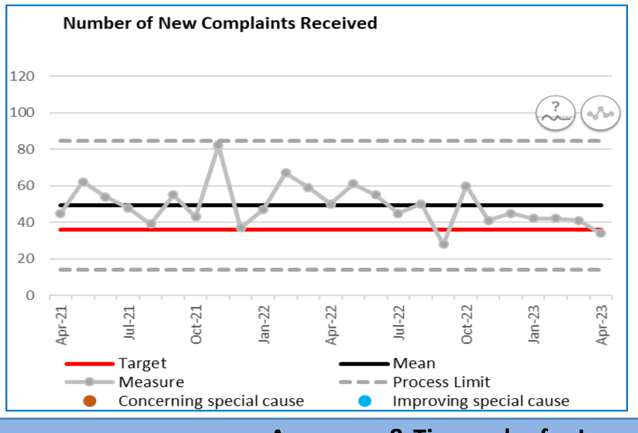
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target

Max Limit (Internal)

30

Business Rule

For Information as linked to % Complaint Responded



Apr-23

34

Variance / Assurance

Metric is currently experiencing common cause variation and variable achievement of the target

Max Limit (Internal)

36

Business Rule

For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within target: this indicator is experiencing common cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Over the last 5 months, complaints performance has stabilised and is currently averaging 59%. Performance for April was 68.4%.

Actions:

% Complaints responded to within Target:

Complaints performance recovery and stabilisation actions include;

- Interim performance monitoring reported weekly to CN
- Weekly oversight meetings led by CN and DQG
- Successful recruitment to x2 Complaint Lead posts
- Business case for revised complaints model (meeting new 2022 National framework) submitted
- Complaints QA now handed back to divisional leads
- Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times
- Introduction of new 40 day target to support more complex cases
- New head of complaints & PALS commenced in post 27 March '23

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- We expected to see an improvement in % compliance from November 2022 as a result of the introduction of a new 40-day timeframe for amber complaints and the recovery actions in place
- We are aiming to hit sustained delivery of the target response (75%) by September 2023
- We are aiming to increase our target response time % measure from 75% to 90% by December 2023

Patient Experience

Strategic Theme	Vision Goals	Strategic Theme Lead
Patient Experience Vision Goal	To provide outstanding care and experience where patients are at the centre of all that we do. Communicating in an effective and timely way. Keeping patients, families and their carers' fully informed and updated throughout each step of their journey	Joanna Haworth
Patient Experience Vision Target	To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month	Joanna Haworth
Patient Experience Breakthrough objective	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience	Richard Gatune

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
Outstanding Care	Establish a robust quality framework across the trust aligned to the KLOEs and EPOC	Joanna Haworth
PFIS	Implementation of training in Continuous Improvement to front line teams	Joanna Haworth

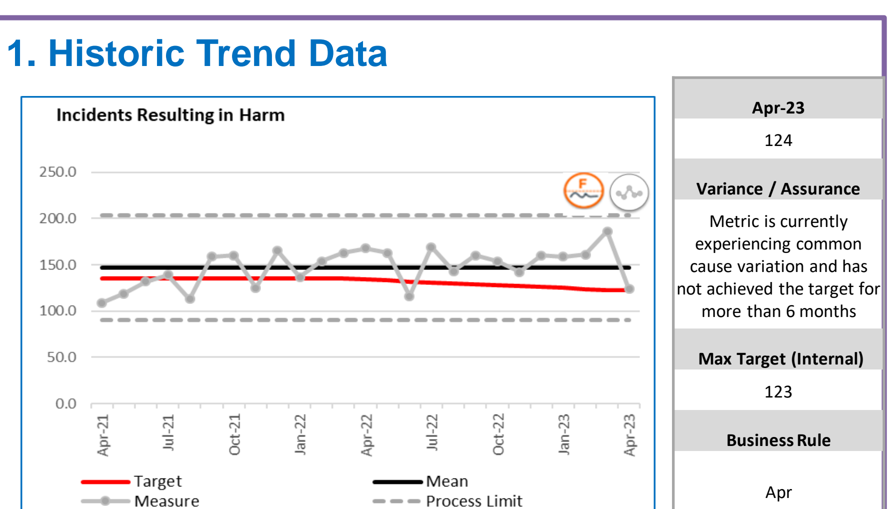
Proposal – to remain as is with the exception of the outstanding care corporate project which is to be become business as usual and to develop a corporate project on mental health which will go through the project filter.

Patient Safety and Clinical Effectiveness Vision: Counter Measure Summary

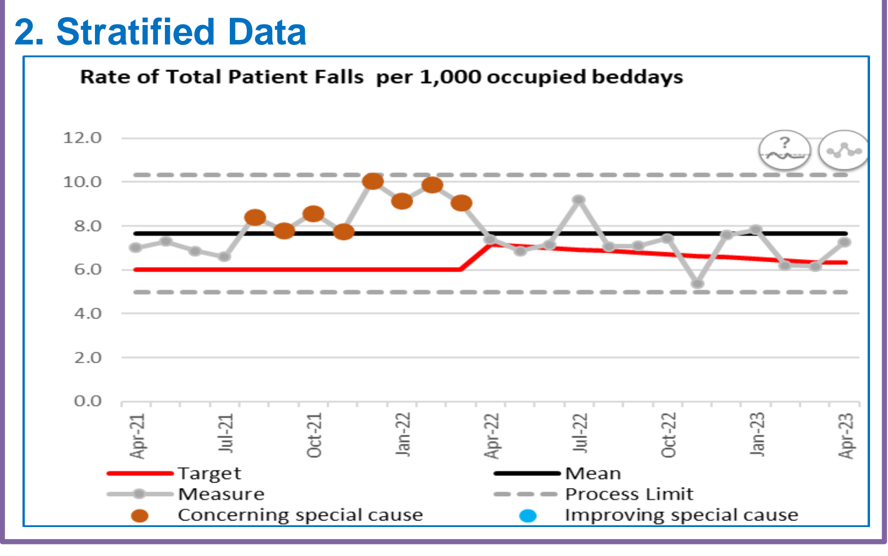
Project/Metric Name – Reduction in harm : Incidents resulting in harm

Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

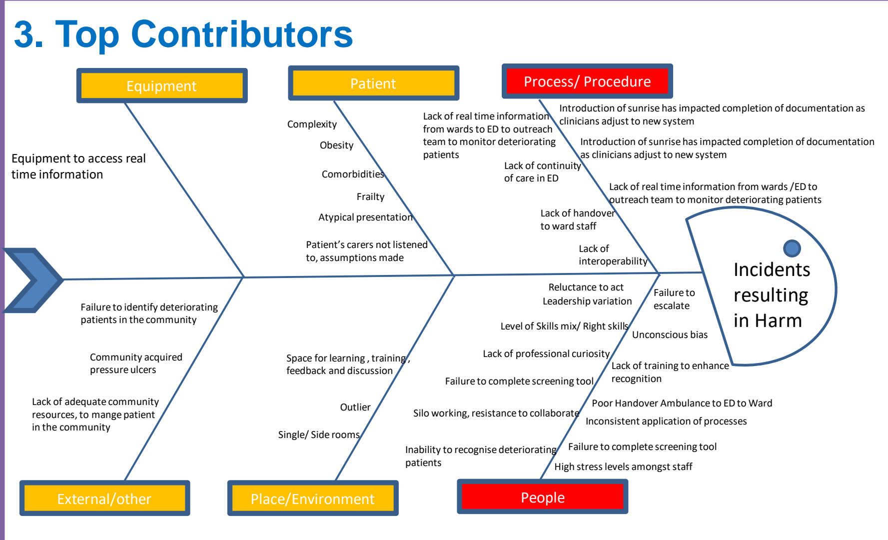
1. Historic Trend Data



2. Stratified Data



3. Top Contributors



4. Action Plan

Contributor	solution /countermeasure	Owner	Due By
Workforce	Safer staffing fill rate levels	CNO/CPO	Ongoing
Environment/ Equipment/ Process	**Focus on Slips, trips and falls,** as major contributing factor to incidents resulting in severe harm (30%). -Falls has increased slightly in April at 135 compared to March at 127 across the trust. Achieving 7.28 per 1000 bed days against the 6.36 per 1000 bed day target for falls A **Harm A3 Engagement Session** was held on the 17th of May 2023 with stakeholders from the divisions, patient safety and representatives from significant areas of harm impact including pressure ulcer, outreach, sunrise and resus. Analysis of the harm data indicates a large no of incidents relate to low harm. Increased validation and awareness of harm has impacted positively on levels of harms being reported. Falls – Fall will continue to be an ongoing initiative, returning to business as usual with a focus on monitoring and sustaining initiatives implemented. Some of the area of focus being developed include deteriorating patients, failure to escalate, sepsis, Acute Kidney Injury (AKI), missed diagnostics and pressure ulcers.	Medical Director	Ongoing - BAU

Patient Safety and Clinical Effectiveness

Patient Safety and Clinical Effectiveness Vision Goal	An organisation which has a blame free reporting and real time learning culture, delivering harm free hospital care.	Peter Maskell
Patient Safety and Clinical Effectiveness Vision Target	Reduction in incidents resulting in harm by 7.5% by June 2023	Peter Maskell
Patient Safety and Clinical Effectiveness Breakthrough objective	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023	Richard Gatune

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
EPMA	**Ensure the Trust has a robust system that delivers safe, high quality and cost-effective system to order prescriptions across MTW (excluding chemotherapy)** **This project will target all inpatient adult wards and the ED across MTW**	**Peter Maskell**

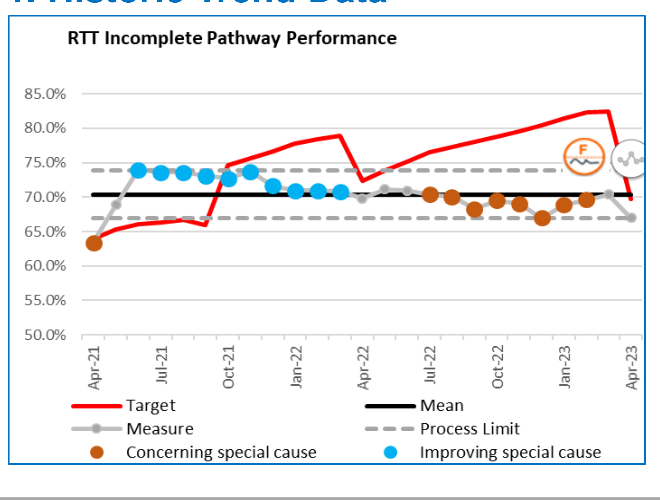
Proposal to amend the vision to delivering serious and moderate harm free hospital care and to develop the breakthrough objective that focuses on harm related to the late detection/failure to act arising from clinical deterioration and/or sepsis.

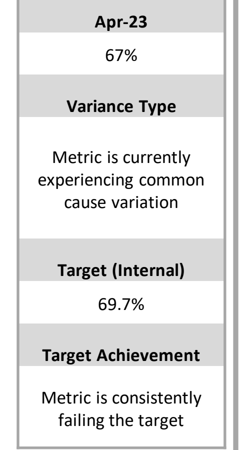
Patient Access Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

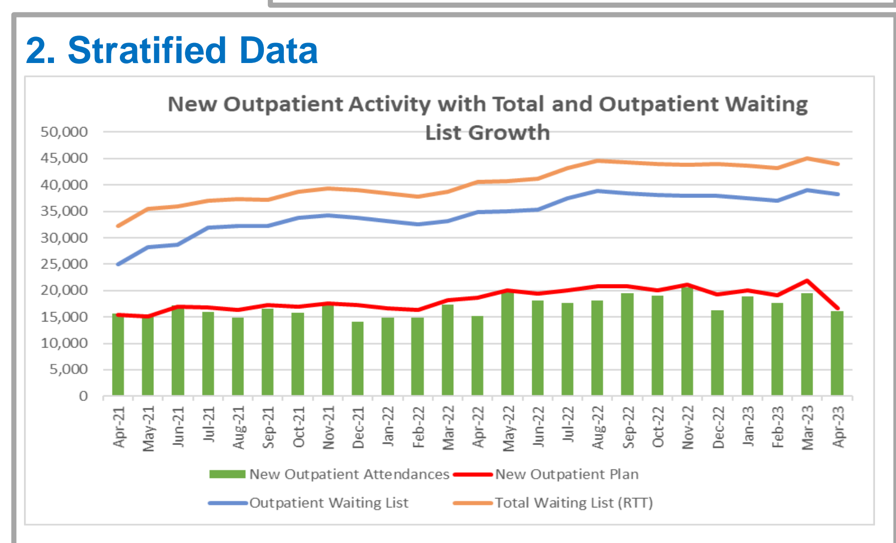
1. Historic Trend Data





Apr-23
67%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
69.7%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

New A3 being developed from updated RTT performance data to understand any changes to top contributors

BAU actions within action plan continue

4. Action Plan

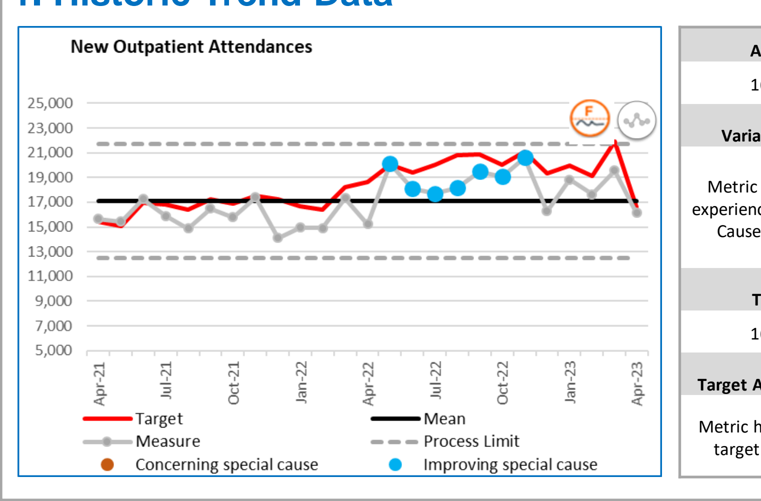
Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on the Breakthrough Objective to Increase New Outpatient Activity	SP	Ongoing
Additional PTL	Gynae team – focus on patients from 28 weeks to longest waiter	Specialty GM, Patient Access and Deputy COO	Ongoing
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting	RTT Lead and PAT team	Weekly and in progress
Update RTT top contributors	Develop new A3 with updated RTT data	SC/BI/PMO	End June 23

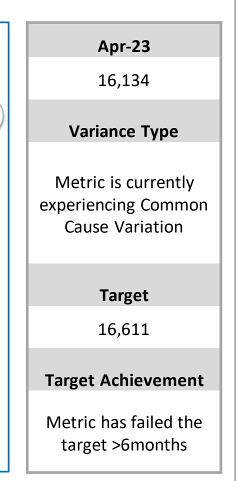
Patient Access Breakthrough Objective: Counter Measure Summary

Project/Metric Name – To achieve the planned levels of New Outpatient Activity

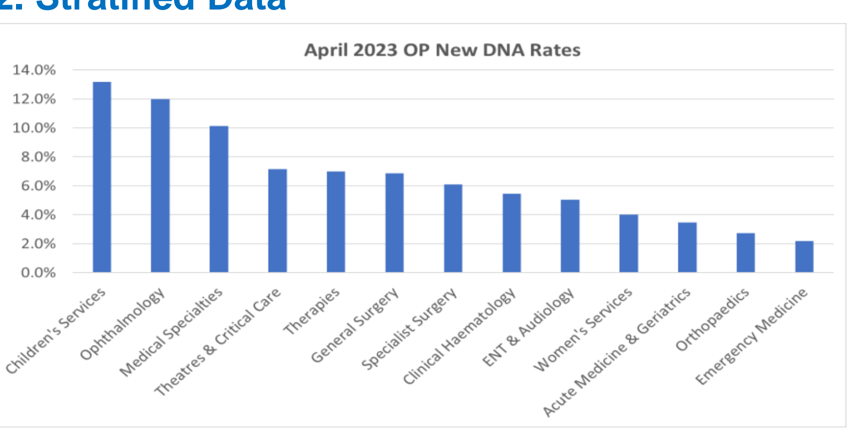
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



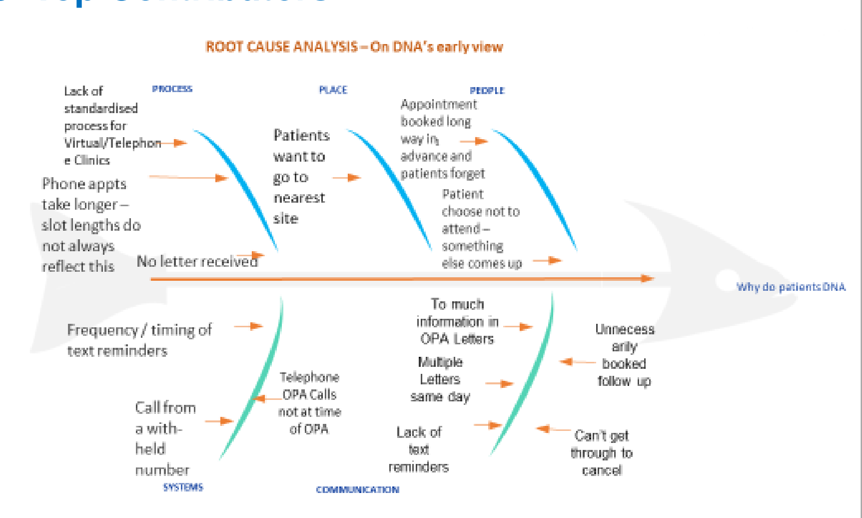


2. Stratified Data



Although the Trust is near its 5% target the specialties that are not achieving activity levels have a DNA rate of 9% or above

3. Top Contributors



4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Two way text	Implementation plan developed	Project Team	Complete
	Operational process flows for CAU to be agreed	Project team	Feb 23
	IT Load balancers installed	IT	Delayed TBC
	Go live	Project Team	TBC- IT work dependant
Switch on Paediatric Text under 13's reminders (agreed for Ophth)	SOP & Policy Document sign off by Governance and W&C directorate	SP/KS/JT	May 23
Telephone Clinics – review of letters & OPA flow	Monitor Telephone Clinic DNA's to see improvement. OP team auditing virtual clinics to identify areas of improvements	SC/LL/FS	In progress
Comms Plan	ICB Posters to be updated with MTW details and circulated to OP areas/intranet site	FJ/SC	In progress

Patient Access

Patient Access Vision Goal	All of our patients should be able to access the highest quality care and treatment when they need it, whether its as an emergency, waiting time for a cancer diagnosis or waiting for elective surgery.	Sean Briggs
Patient Access Vision Target	Achieve the Trust RTT Trajectory by March 2023	Sean Briggs
Patient Access Breakthrough objective	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Sarah Davis

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
Outpatient pathways and procedures	Improve patient-provider communication through secure messaging, and increased patient participation in healthcare decisions Embed consistent delivery of new standard operating procedures for OP across all OP services	Sean Briggs

No change is proposed

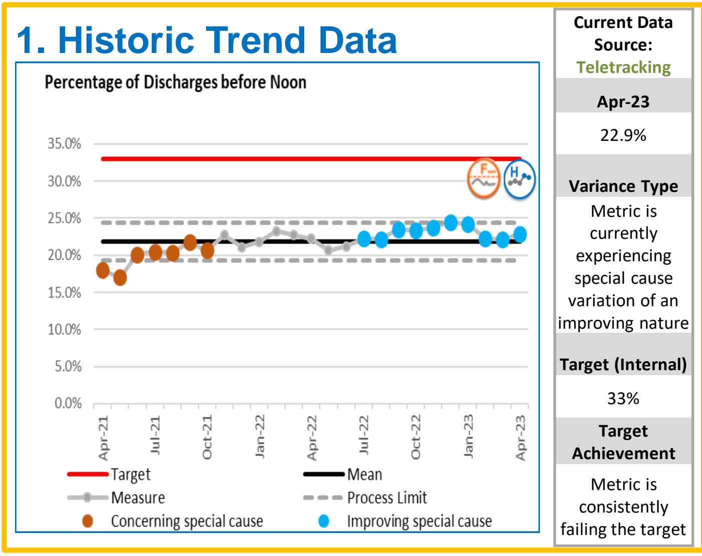
Exceptional people, outstanding care

Systems and Partnerships Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

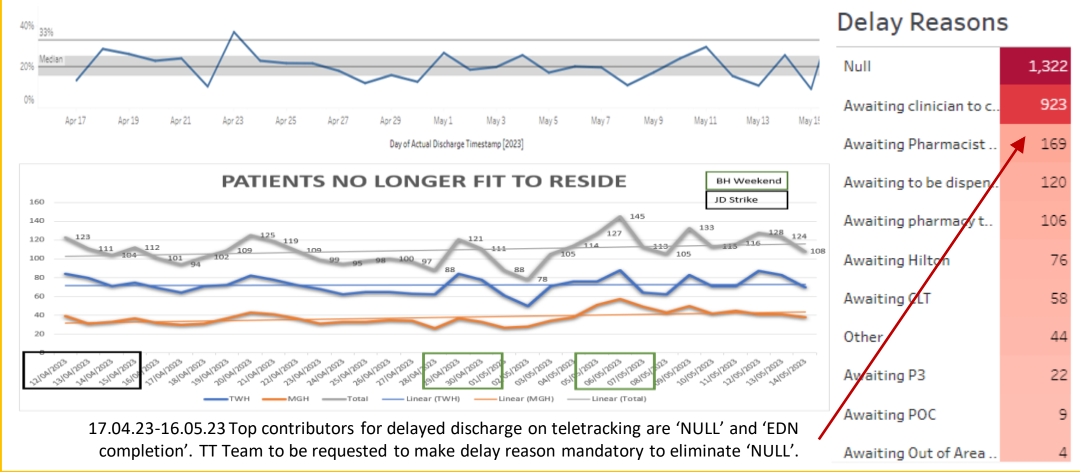
1. Historic Trend Data



Current Data Source:
Teletracking
Apr-23
22.9%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data

TT DBN Data: For context, the junior doctors strikes occurred on 11th to 15th April. The NCTR performance improved through the last two weeks of April however started to increase towards the May BH weekends with a drop off on the Tuesdays. The NCTR rates are higher throughout May overall compared to April. The DBN performance had improved for April, however as with NCTR the May performance has slightly dropped. It is hoped that the EDN programme rollout throughout will help to improve performance in June and July.



17.04.23-16.05.23 Top contributors for delayed discharge on teletracking are 'NULL' and 'EDN completion'. TT Team to be requested to make delay reason mandatory to eliminate 'NULL'.

3. Top Contributors

Area of Analysis	Considered a Top Contributor?
EDN Completion Times	EDNS are a top contributor in delays in discharge time. There is a clinically led EDN project group focussing on this including utilising Sunrise for a more integrated EDN: EPMA process.
Criteria Led Discharge	The data in Aug 2022 showed that Criteria Led Discharge was only utilised in 1.3% of all discharges, therefore there is an opportunity to increase DBN using this process.

4. Action Plan

CM	Action	Who	When	Complete
Hilton Pathway	• Hilton Stroke pathway improvements moved to BAU with daily meetings established.	Hilton/ MTW		Complete
Criteria Led Discharge	• Medical Director support received for CLD. • Video of the process being developed as part of communications. • CLD embedment into clinical pathways being developed i.e. board rounds/ handover sheets.	KC/ FR / NP	31.05.23	In Progress
EDN	• Pilot for EDN in sunrise commenced. Programme of works underway with expectation of TWH wards rollout throughout May / early June. • To undertake an assessment of the impact of the EDN project on orthopaedic wards.	RG / SF / JS	30.06.23	In Progress
NCTR	• Continued focus work being undertaken on data quality to deduce impact on BTO projects.	RS/ RG	31.07.23	In Progress

Systems and Partnerships

Systems and Partnerships Vision Goal	People receive timely care from the right care provider in the most appropriate setting and avoid unnecessary transfer of care delays	Rachel Jones
Systems and Partnerships Vision Target	Decrease the number of occupied bed days for patients identified as medically fit for discharge.	Rachel Jones
Systems and Partnerships Breakthrough objective	To increase the number of patients leaving our hospitals by noon on the day of discharge	Sarah Smith
Systems and Partnerships Breakthrough objective	No patient resides in an acute hospital bed who needs care that can be provided in another setting	Sarah Smith

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
Safer Better Sooner	**Ensure patient discharges are effective across 7 days, specifically focussing on weekend discharges**	**Sean Briggs**

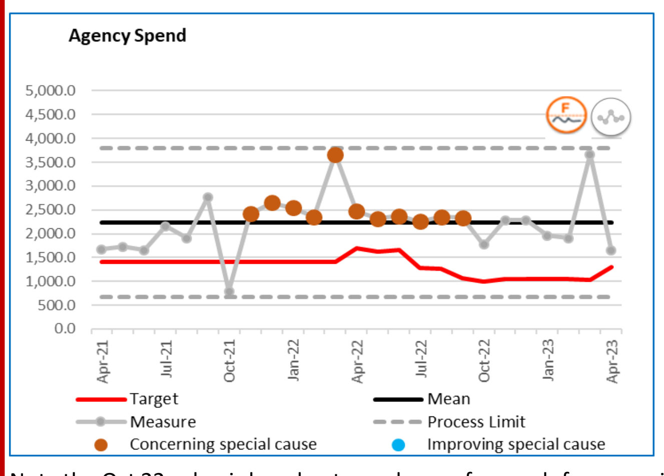
No change is proposed

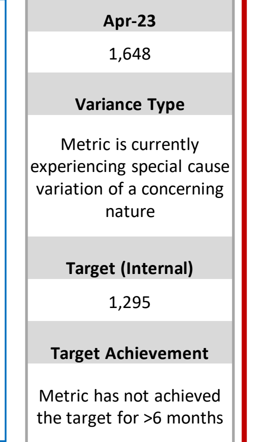
Sustainability Breakthrough: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000

Owner: Steve Orpin
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

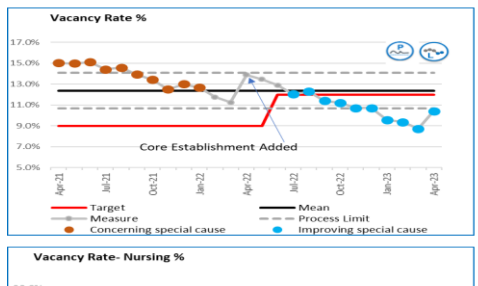
1. Historic Trend Data



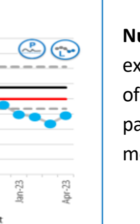


Note the Oct 22 value is low due to a release of accruals from previous months

2. Stratified Data



Vacancy Rate: Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.



Nursing Vacancy Rate: Metric is experiencing special cause variation of an improving nature and has passed the target for six months or more.

3. Top Contributors

Contributing factors to premium workforce spend have been narrowed down to:

- Healthroster usage and controls
- Training gaps particularly for new and junior managers
- Unfunded escalation areas
- Reduction in vacancies without a corresponding reduction in agency usage
- Enhanced control environment

4. Action Plan

Action	Status
Closure of escalation wards	MH closed in April and TW due to close imminently.
eRostering for non-medical staffing – controls and usage.	Weekly working group commenced **9/5/23** with all divisions represented. Specific focus on: authorisation rights, pay to grade, longest serving agency staff, rapid pool and areas with escalated rates.
Data and reporting	BI colleagues supporting to produce a weekly view of agency and bank spend as well as a monthly, detailed, payroll report. **Date TBC.**
Accountability and training	Reinvigorating confirm and support for top areas of temporary staffing spend in nursing – "core rosters". **Commence June 23.** Early discussions over managerial training programme for B7-B8c managers – getting the basics right.
Medical rostering	Decision to be made on most appropriate supplier **by end of May** – pilot implemented in time for next rotation in medicine (Aug 23).
Enhanced care business case	Ongoing. **Timescales TBC**

Sustainability

Sustainability Vision Goal	Continued delivery of our financial plan, allowing us to invest sustainably in high quality services and infrastructure, improving patient experience and outcomes, and providing staff the tools they need to do their job	Steve Orpin
Sustainability Vision Target	Delivery of financial plan, including operational delivery of capital investment plan	Steve Orpin
Sustainability Breakthrough Objective	To reduce the amount of money the Trusts spends on premium workforce spend	Katie Goodwin

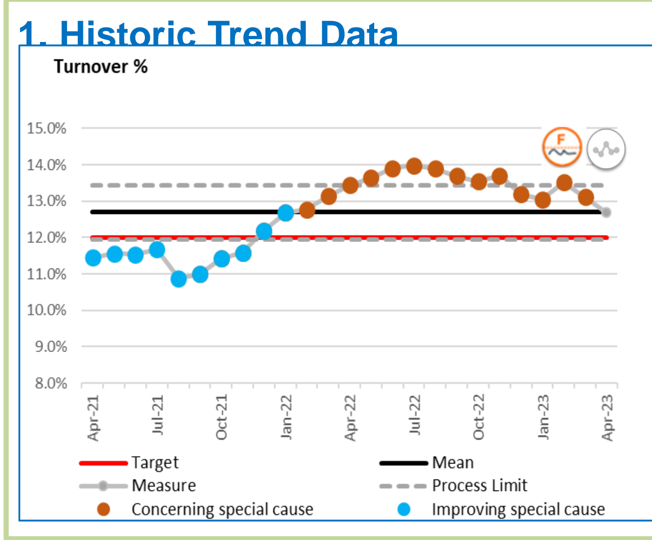
Proposal to remain as is with the additional development of a corporate project on workforce efficiency to be put through the project filter

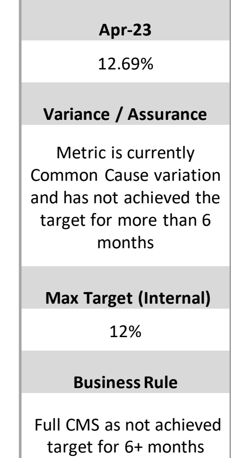
People Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

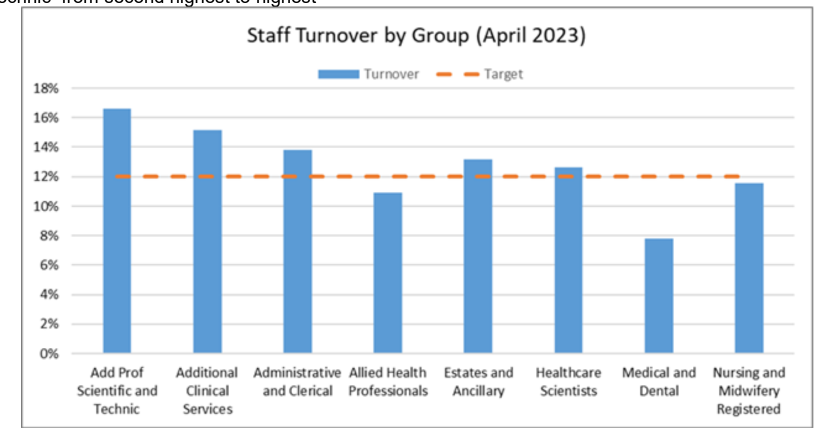




Apr-23
12.69%
Variance / Assurance
Metric is currently Common Cause variation and has not achieved the target for more than 6 months
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target for 6+ months

2. Stratified Data

NOTE: The theatre ODPs have been recoded from "Add Prof Scientific and Technic" to "Allied Health Professionals". This swing in staff has affected the turnover calculation, pushing "Add Prof Scientific and Technic" from second highest to highest



3. Top Contributors

These are some of the main contributors of focus for the working groups

Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership capability
	Not enough locally trained staff / Lack of staff development
Processes	**Retention**
Retire and return policy out of date, putting people off returning	Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action
TRAC process takes too long, leading to delays / lack of transparency in recruitment	No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere

4. Action Plan

A full action plan by the working groups has been developed; some of the key actions shown:

Countermeasures	Target Completion Date
Introduce localised trust-based incentives for both attraction and retention	May-23
Create talent pool/ list of names of people interested in promotion	Aug-23
Review Inequalities in relation to career progression for staff from ethnic minority backgrounds	Jun-23
Introduce virtual onboarding info pack	May-23
Introduce a clear and consistent Recruitment and Retention Premium approach (for hard to recruit roles)	End of April-23
Introduce stay interviews	May-23
Introduce staff voice box	End of April-23

People

People Vision Goal	Delivery of a robust workforce plan and pipeline supply that meets our operational plan so that our people are well supported and are able to provide high quality patient care. People leaders will support and coach people by setting clear objectives, encourage and support learning, communicate effectively and with compassion line with our leadership framework	Sue Steen
People Vision Target	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Sue Steen
People Breakthrough objective	Reduce turnover to 12% by March 2023	Rob Henderson

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
Workforce Supply	**Develop the organisational policy and change management approach to create an adaptable and agile workforce designed for the health care needs of the future** **Identify alternative routes into health care with less reliance on overseas recruitment**	**Sue Steen**
Leadership Development	Evolve the Exceptional Leadership programme to extend to all people leaders in the Trust (Band 3 upwards) Align all people development processes e.g. appraisals, training needs analysis, talent and succession planning Improve staff experience of being led and line managed	Sue Steen

Proposal to monitor the vision target and breakthrough objective through business as usual and to replace with a developing target and break through objective on equality, diversion and inclusion

Next Steps

1. To agree the amendment to the patient safety and clinical effectiveness vision goal.
2. To support the development of a new patient safety and clinical effectiveness breakthrough objective.
3. To support the development of a new people vision target and break through objective focussing on equality, diversity and inclusion.
4. To agree the development of 2 additional corporate projects round mental health and workforce efficiency to be put through the project filter.

Trust Board meeting – 29th June 2023

Nursing and Midwifery staffing review **Chief Nurse**

Executive Summary:

Nursing establishments are required to be reviewed bi-annually to provide assurance to the Trust Board that staffing levels and staff/patient ratios are appropriate to deliver safe and effective patient care (National Quality Board, 2016).

A full and comprehensive annual establishment review was completed in October 2022 to ensure that there are the right nursing and midwifery staffing and skill mix to meet the needs of patients. This review included all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services.

The recommendations from the annual establishment review were reported to the Trust Board in December 2022.

This report outlines the progress made in relation to the nursing and midwifery workforce, describing the current staffing position, recruitment pipeline and the monitoring of safe staffing, alongside the current view of the nursing establishments.

Which Committees have reviewed the information prior to Trust Board submission?
- Executive Team Meeting, 20/06/23

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

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

The purpose of this report is to present a six-monthly update of the nursing and midwifery (N&M) workforce and provide assurance to the board and public regarding N&M safe staffing levels.

1. Current Staffing position

Significant progress continues with recruitment with the current number of registered nurses in post increased to 1881.9 wte. Registered N&M vacancies have continued to drop with current vacancies of 269 wte (12.5% vacancy rate). There are currently 82.7 wte internationally educated nurses that are pending completion of their training (OSCE) and NMC pin. Once these internationally trained nurses achieve their NMC pin, the number of whole time equivalent vacancies drops further to 186.3 wte (8.6% vacancy rate).

Figure 1: Registered Nursing and Midwifery Vacancies (WTE)

2. Current Pipeline

Registered Nurse Recruitment

To date, there are currently 242.2 wte registered nurses being recruited to:

- 133.8 wte candidates currently going through checks for nursing and midwifery roles (band 5 or higher).

International recruitment

There are currently 27 wte internationally educated nurses with start dates confirmed, with divisional allocation as below:

Directorate	WTE
Acute & Geriatrics	5
Medical Specialities	5
Surgery	5
Critical Care	2
Trauma & Ortho	1
Cancer	1
Women's and Children	0
Kent and Medway Orthopaedic Centre	8
Total	**27**

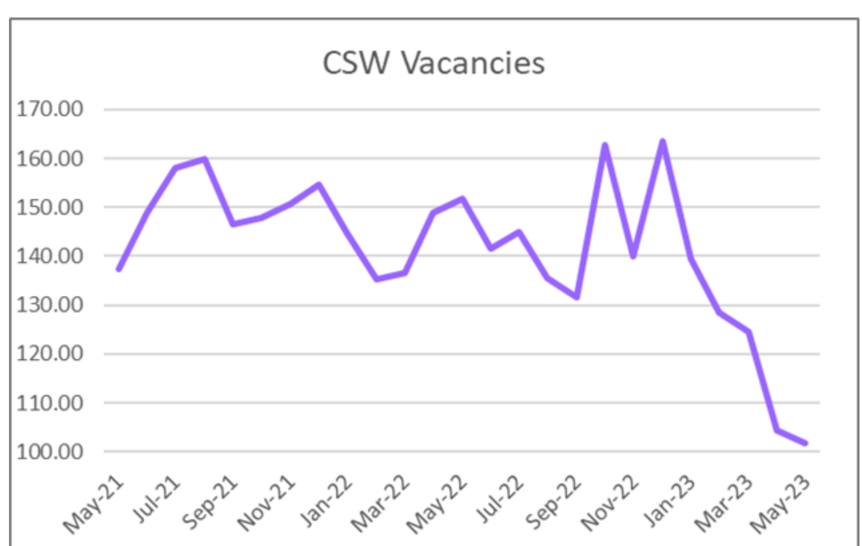
A further 78 WTE internationally educated nurses are currently going through pre-employment checks with the divisional allocation as below:

Directorate	WTE
Acute & Geriatrics	0
Medical Specialities	10
Surgery	0
Critical Care	1
Trauma & Ortho	0
Women's and Children	5
Cancer	0
Kent and Medway Orthopaedic Centre	19
Awaiting allocation	23
Total	**73**

Healthcare Support Worker Recruitment

Work has continued with the recruitment of Healthcare Clinical Support Workers (HCSW), with significant success achieved via open days and new routes into this role.

Figure 2: Healthcare Clinical Support Workers vacancies (WTE)



Currently we are reporting 103.7 wte (13.9% vacancy rate) HCSWs vacancies. Of these, 44.08 wte are currently going through pre-employment checks, with a further 13.32 wte candidates with start dates booked.

3. Nursing and Midwifery Workforce progress since previous report

Work continues with divisional and HR colleagues with further progress been made since the last report in December 2022. The table below outlines key achievements during this period.

Theme	Action
Recruitment	• Continuation of monthly Saturday recruitment open days for healthcare support workers; from June 2023 these will be every two months • Continuation of quarterly Saturday recruitment open days for registered nurses and midwives. • Continuation of ambitious international recruitment campaigns. • Progress with the implementation of divisional nursing workforce trackers with starters and leavers in real time to enable accurate recruitment to turnover. • Student nurse expression of interest forms have been sent to all third year students and we are currently mapping interest against vacancies
Retention	• Introduction of Retention Programme Board and associated working groups. • Launch of new preceptorship programme against national framework May 2023, initial feedback and evaluation extremely positive. • Successful recruitment of pastoral care nurse
Safe Staffing	• Embedding of daily recording of planned versus actuals RAG rated with distribution to senior nurses. • Continuation of daily huddles and development of daily staffing reporting. • Healthroster confirm and support framework written with monthly support meetings established to ensure rostering is effective, escalation meetings in place for areas who do not achieve three or more KPI's • Safe staffing policy live • Development of nursing establishment business case following October 2022 establishment review. • Safer Nursing Care Tool (SCNT) audit completed in February 2023, with the second audit commenced in June 2023 for an increased period of time of 30 days. • Introduction of escalation cards June 2023.
Training & Development	• Recruitment of 7x band 6 clinical skills facilitators to support newly recruited internationally educated nurses (IENs). Established within their roles. • Fully recruited into the RNDA/TNA courses due to commence September 23 • Review of the Learning Needs Analysis from 2022, work underway to develop Learning Needs Analysis for 2023, concentrating on professional development. • Continuation of career café and retention rounds with the recruitment matron and professional standards team. • Completion of the first cohort of ward manager/unit leader Band 7 leadership programme, with the second cohort commencing 12th June 2023.

Nursing and Midwifery Workforce Plan

The Nursing and Midwifery Workforce Plan has been developed and summarises the current N&M workforce position within the Trust and outlines our recruitment and retention plan for nursing and midwifery for the next 5 years (2023-2027). It describes the current establishment, the strengths and challenges related to the workforce and our ambitions to continue to develop this workforce to

support the Trust's vision; exceptional people, outstanding care. The overarching ambition for the N&M workforce is to achieve and maintain a vacancy rate of 10% and, importantly, maintain turnover below the 12% trust target.

The purpose of the nursing and midwifery workforce plan is to:

- Outline the current N&M position within the Trust
- Identify key strategic challenges and enablers that will influence our workforce plan
- Outline the plan to increase the number of nurses and midwives that are recruited locally and nationally, reducing the reliance on international recruitment
- Describe our current workforce demographics and the key challenges with recruitment and retention
- Establish a programme of work which will tackle the challenges identified and maximise the opportunities open to us as an organisation
- Ensure that we have sustainable safe staffing levels for our services for the future in a way that contributes to the ongoing development of an "outstanding" culture
- Outline how the Trust will deliver against this plan in conjunction with the business planning cycle and the impact that it will have

Governance:

4. Bi-Annual Establishment Review

The annual establishment review was undertaken in October 2022 where key recommendations were made. The review was undertaken using a triangulated approach using evidence-based tools, professional judgement and based on patients' needs, acuity, dependency and risks. The recommendations are now presented in a business case that is currently progressing through the trust internal systems and governance. The recommendations of the establishment changes can be found in Appendix 1.

This mid-year review provides oversight on the current vacancy, turnover and establishments. The recommendations to establishments in the annual review of December 2022 remain, with no further changes in head count required. In line with national guidance a full establishment review will be carried out in October 2023.

5. Monitoring of Safe Staffing

Ensuring safety within the clinical areas is of paramount importance therefore a number of key daily staffing reviews are in place to support this. The processes for monitoring safe staffing levels continues to be strengthened and staffing levels are closely monitored daily in real time at site meetings, daily staffing reports, daily staffing huddles and weekly recruitment activity meetings. The safe staffing policy has been ratified and is live on Qpulse. Operationalising of the policy is under way with the rolling out of the safe staffing escalation cards planned within June/July 2023.

A monthly report and publication return to NHSI/E indicating 'planned' and 'actual' nurse staffing by ward is submitted known as "staffing fill rates" (see figure 5). The safe staffing paper is published monthly and incorporated in the executive team workforce update, it is also shared with divisional nursing and midwifery leads and at the monthly N&M Recruitment and Retention Programme steering group.

In February 2023 the safe staffing team worked in conjunction with the divisional N&M teams to undertake an acuity and dependency data collection audit using the validated Safer Nursing Care Tool (SNCT). A second round of data collection has commenced in June 2023 and will run for 30 days. Both sets of data will contribute to the October 2023 Establishment reviews. This acuity and dependency data will help to inform future annual establishment reviews.

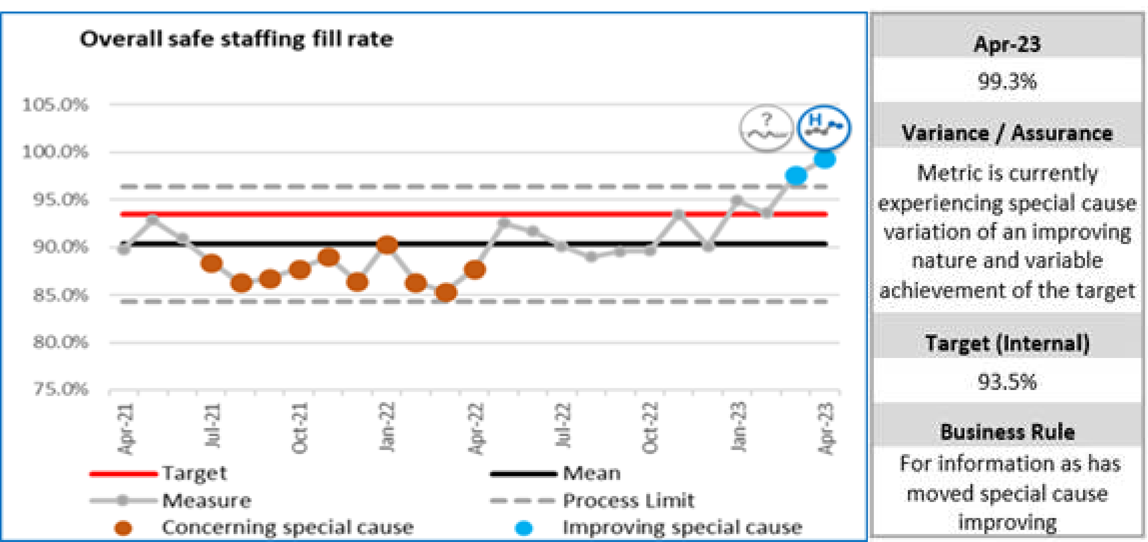
Safe Care®

Safe Care® is used across all adult and children inpatient areas to support the real time visibility of staffing levels across the Trust. The embedding of the 'Red Flag' function is ongoing and the triangulated process to manage daily staffing from a Trust wide perspective is to be piloted within MEC in June/July 2023. NICE (2014) developed the 'Red flag events' guidance which warn when nurses in charge of shifts must take action to ensure they have enough staff to meet the needs of patients on that ward.

Staffing Fill Rates

Planned Vs actual staffing fill rates are monitored monthly and submitted to NHSIE. Safe Staffing fill rate has increased to 99.3% which is 5.8% above target. This reflects the increase of staff in post within clinical areas and a reduction of vacancy.

Corrections are ongoing to Healthroster to ensure roster templates match the funded establishment. Following the October 2022 establishment review.



CONCLUSION

Significant work continues to maintain N&M safe staffing levels across the Trust, this includes maintaining recruitment pipelines, whilst shifting emphasis towards retention activity; with a particular focus on listening to staff and supporting professional development.

Appendix 1

Key Recommendations of Workforce Changes following Establishment Review presented to Board in December 2022.

The recommendations from the October 2022 annual establishment review are listed below as previously presented to the Trust Board in December 2022. These recommendations are now progressing through the business case process. Of note it is only the recommended changes that are progressing currently.

recommended change, consider change, divisional review and on hold. **Summary of totals:**

Cost	wte	Prioritisation notes
£2,957,094	67.71 wte	For progressing in 2023/2024
£593, 378	13.76 wte	Not for progressing this financial year
£1,739,531	40.7 wte	
£110,924	3.00 wte	
£5, 400,927	**125.17 wte**	

Surgical Division Recommendations

	Band	Recommend Change
Ward 30 (TW) - NG330	2	increase night by 1 HCSW
Ward 31 (TW) - NG331	2	increase night by 1 HCSW
Short Stay Surgical Unit (TW) - NE901	5	Additional RN at night weekends (currently 1)
Short Stay Surgical Unit (M) - NE751	2	Increase 1 HCSW at night due to lone working
Ward 10 (TW) - NG131	2	Extend HCSW early into LD - total 4 HCSW
Ward 10 (TW) - NG131	2	Increase HCSW by 2 at night
Total cost: £505, 962		**Total wte: 14.08 wte**

	Band	Consider Change
Ward 30 (TW) - NG330	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Ward 31 (TW) - NG331	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Vascular Access Service - NT401	6	Additional 2 B6 WTE.
Vascular Access Service - NT401	3	Additional 2 B3 WTE.
Total cost: £390, 816		**Total wte: 9.42 wte**

Medicine & Emergency Care Division Recommendations

	Band	Recommended Change
Whatman Ward - NK959	2	Additional 1 HCSW at night
Mercer Ward (M) - NJ251	2	Extend early into LD - Total of 4 HCSW on LD
Stroke Unit (M) - NK551	2	Additional 2 HCSW at night (Total of 6 HCSW)
Ward 2 (TW) - NG442	2	Additional 1 HCSW at night
Pye Oliver (Medical) - NA901	5	Additional RN
Ward 11 (TW) Winter Escalation 2019 - NG144	5	Increase nights by 1 RN to align with other TWH wards
Ward 21 (TW) - NG231	5	Extend RN early into LD - Total of 6 RN on LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 Night

John Day Respiratory Ward (M) - NT151	5	Additional 1 RN LD
John Day Respiratory Ward (M) - NT151	2	Increase HCSW by 2 Night
Total cost: £1,179,316		**Total wte: 30.49 wte**

	Band	Consider Change
A&E Paediatric Services Riverbank - NC370	5	Increase by 1 RCN
A&E Paediatric Services Riverbank - NC370	3	Increase by 1 NN to support 7-day service
Total cost £145,025		**Total wte: 3.34 wte**

Women Children & Sexual Health Division Recommendations

	Band	Recommendation
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Antenatal Ward - NF102	6	Additional RM LD
Midwifery Services - Antenatal Ward - NF102	6	Additional RM Night
Maternity Day Assessment Unit	3	1 Additional MSW
SCBU (TW) - NA102	7	Supernumerary for BAPM Standards (day)
SCBU (TW) - NA102	7	Supernumerary for BAPM Standards (night)
Total cost: £1,214, 279		**Total wte: 22.14 wte**

	Band	Consider Recommendation
Paediatrics Out Patients - LC451 & LC402	7	BCG Clinic paediatrics & maternity
Total cost: £57, 537		**Total wte: 1.00 wte**

Corporate Nursing* Recommendations

	Band	Consider Recommendation
Safeguarding Practitioner – AV851	7	1 Safeguarding Practitioner
Total cost: £57, 537		**Total wte: 1.00 wte**

*Excludes all other aspects of corporate nursing – safeguarding only.

Cancer Division Recommendations

Currently no recommendations in relation to establishment.

Expected Benefits

It is proposed that a phased approach to these workforce changes is planned focusing initially (within the first 6 months of financial year) on the recommended changes. The expected benefits are as follows:

1. Standardisation of nurse to patient ratios across all wards.
2. Reduction in temporary staffing spend in particular for RMNs and HCSW who provide enhanced care.
3. Improved patient and staff experience.
4. Improved patient flow with more time to focus on discharge planning.
5. Reduced redeployment of staff subsequently improving staff morale.
6. Improved retention rates.
7. Potential to increase placement capacity for Student Nurses.
8. Safer nursing & midwifery care delivery.

Appendix 2 – Safe Staffing Escalation Action Card – All Adult areas

Level	Action
BLUE	Do you have additional staff over your nursing establishment? **If Yes, inform Matron or Clinical Site Team to review the need to support other clinical areas.**
GREEN	Do you have the right staff with the right skills to provide patient care and ensure staff can take breaks? **If Yes, No action required.**
AMBER	Do you have the right staff with the right skills to provide patient care and ensure staff can take breaks? **If No, please follow actions below and complete a datix and document actions taken** In Corporate Working Hours • Nurse in Charge to ensure staff absence is reported on SafeCare or HealthRoster • Nurse in Charge to ensure Ward Manager and Matron are aware • Matron to escalate to Senior Matron. • Contact temporary staffing to actively recruit into shift. • Nurse in Charge /Ward Manager to work in numbers • Matron to move staff from other areas within the Division • Contact CCC to escalate impact on bed availability/patient boarding. • Ensure the use of the Discharge Lounge is maximised • Matron to seek mutual aid from other Divisions within the Trust • Prioritise patient care and adjust workload throughout shift • Ensure continual review of staffing during shift and at Safety Huddles • Review clinical staff on non-clinical shifts, such as non-mandatory study days. Out of Normal Working hours • Inform CCC to escalate impact on bed availability/patient boarding • CCC to move staff across Divisions. • Maternity Services – Inform on-call Senior Midwife • Nurse in Charge to ensure staff absence is reported on SafeCare or HealthRoster. • CCC to move staff from other areas • CCC to review rosters and authorisation for bank to go out to agency • Prioritise patient care and adjust workload throughout the shift
RED	**ENSURE ALL AMBER ACTION COMPLETE** Do you have the right staff with the right skills to provide patient care and ensure staff can take their breaks? **If No, please follow actions below and complete a datix and document actions taken** In Corporate Working Hours • Matron to inform DDNQ • DDNQ to seek mutual aid from other Divisions across sites • If no mutual aid from Divisions, Clinical site team to work with DDNQ to expedite discharges. • DDNQ to complete risk assessment for non-framework agency and send to temporary staffing • Redeploy off ward clinical staff (Clinical Nurse Specialists, Practice Development Nurses, Matrons and DDNQ's/HoN's) to work within clinical teams. • Huddle with CCC/ DDNQ's/HoN's/COO to determine if planned activity can be continued and make decision to cancel mandatory study days. • Inform Head of Nursing for Safe Staffing or Deputy Chief Nurse to review other staff groups in corporate teams to support. • Consider avoiding new admissions or boarding patients on the ward until resolved • In conjunction with the OPEL Escalation Triggers consider holding patients in the Emergency Department based on clinical risk • Liaise with Chief of Service/Clinical Director to consider a further ward round • Inform Chief Nurse/Chief Operating Officer Out of Normal Hours • Site Operations Team to inform Silver on call. • Silver on call to escalate to Executive on call.

Trust Board meeting – 29th June 2022

To approve the Kent and Medway Pathology Network Collaboration Agreement	Director of Strategy, Planning and Partnerships

Kent and Medway Pathology Network (KMPN) is a jointly owned programme with all K&M pathology providers represented at Board level as members of the Network Board. Whilst pathology is provided at acute Trust level, the majority users of the service, for blood sciences at least, are outside the acute sector and sit in primary and community care. The pathology network/programme is supported and partially funded (on a non-recurrent basis) by NHSE and the ICB and the funding currently held on behalf of providers by the Integrated Care Board (ICB). KMPN is one of over 20 similar networks across England who are all are seeking to future proof pathology services in the face of rising demand and increasingly scarce resources, staff in particular.

The ambition is that the single service will be stronger than the sum of its parts allowing KMPN providers to meet anticipated future demands in pathology safely and effectiveness. The move towards a single service provided by KMPN began with progression of enabling projects in the last few years: a single Laboratory Management System (LIMS) FBC currently being implemented, and Managed Equipment Service (MES) Outline Business Case currently out to tender to enable the production of the Full Business Case. The business cases for these projects have been approved by the KMPN Board, Trusts Boards and ICB. KMPN has proceeded to make two successful appointments into the roles of clinical director (CD) (Dr Supriya Joshi) and managing director (MD) (Ms Francesca Trundle). As executive leads, they will take forward the next steps to network maturity with changes needed over the coming years.

The Collaboration Agreement (CA) is a document prepared on behalf of the members of KMPN and sets out the basis for this approach, giving the CD and MD authority to take up single management responsibility for KMPN and make recommendations to the Network Board. The CA has been drawn up by solicitors (DAC Beachcroft LLP) appointed in agreement with, and acting in the joint interests, on behalf of all four provider Trusts to ensure their interests are equally protected and that appropriate mechanisms exist for governance generally and with respect to moving forward by way of agreement via use of the change control procedure. The CA includes the terms of reference for the pathology Network Board and pathology network executive committee in the schedules that explain the relationship between the groups mentioned above. Once the CA has been approved then KMPN can move forwards in fully defining the scope of the single service alongside the agreed changes already in motion, including agreeing the future model of governance of a single service.

Points to note:

- The pathology network team is funded on behalf of all K&M providers via the Trusts. The LIMS implementation team is mainly funded by a four-year non-recurrent contribution by the ICB. Each Trust has had finance team representation on the network governance and legal steering group, the CA does not commit additional funding to the programme.
- The CA requires the approval of all Trust Boards to give it authority, the NKPS Board effectively grants its approval via Trust Boards of Dartford and Gravesham NHS Trust and Medway Maritime NHS Foundation Trust.
- The CA does not change the responsibility of each organisation (in the case of DGT and MFT this is merged as NKPS) for the safe delivery of services as is currently the case, in other words, there are no changes to the service received by patients, how that is delivered by our staff and who manages issues if anything goes wrong.
- The engagement and management of staff across the network and the CA has been shared and agreed with HR business partners and Chief People Officers from each organisation and staff have been and will be briefed of the network intentions and changes

- As the programme progresses with its various phases of transformation such as LIMS, MES etc then the network Board will be responsible for ensuring changes are agreed, clinically led and conducted safely and effectively.
- The CA allows the KMPN Board to make decisions going forwards without the need to consultant individual Trust Boards on each detail.
- The programme draws on senior staff in each organisation and whilst backfill of the time required has been offered and taken up, individual services should note this does inevitably create some distraction from the day to day challenges of running a service.
- Each Trust SRO is responsible for bringing back the network intentions (such as this CA) from the KMPN Board to the Trust Board, and taking individual Trust approval and concerns from the Trust Board to the KMPN Board, at points when required.
- The data protection clauses in the Collaboration Agreement are relatively light-touch. This is because: (i) the Parties are independent Data Controllers, and are therefore separately responsible for discharging their own obligations under the UK GDPR; (ii) the Parties do not share liability under the UK GDPR as they otherwise would have if they were Joint Controllers or Controllers or they processed personal data on each other's behalf; and (iii) the personal data that may be shared under the Collaboration Agreement does not include patient-level data, and it will be limited to personal data that arises in the context of budgeting/ financial information. However, if there is a material change to either the nature or volume of personal data being shared under the Collaboration Agreement these clauses will need to be reviewed, and it may be that a Data Sharing Agreement will need to be drafted.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 06/06/23
- Finance and Performance Committee, 27/06/23

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

The Board is asked to approve the KMPN collaboration agreement.

[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

DAC BEACHCROFT

Dated 2023

(1) EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

(2) MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

(3) DARTFORD AND GRAVESHAM NHS TRUST

(4) MEDWAY NHS FOUNDATION TRUST

Kent and Medway Pathology Network Collaboration Agreement

DAC Beachcroft LLP
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Draft

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THIS AGREEMENT is made the .... day of 2023

BETWEEN:

(1) **EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST** of Kent and Canterbury Hospital, Canterbury, Kent, CT1 3NG (**"EKHUFT"**)

(2) **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST** of Maidstone Hospital, Hermitage Lane, Maidstone, Kent, ME16 9QQ ("**MTW**")

(3) **DARTFORD AND GRAVESHAM NHS TRUST** of Darent Valley Hospital, Darenth Wood Road, Dartford, Kent, DA2 8DA ("**DGT**"); and

(4) **MEDWAY NHS FOUNDATION TRUST of** Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY ("**MFT"**).

together, "the Trusts" or "Kent and Medway Pathology Network ("KMPN")"

BACKGROUND:

(A) The Kent and Medway Pathology Network ("**KMPN**") (also known as "**South 8**") is comprised of the four acute Trusts who are Parties to this Agreement and is one of 29 networks proposed by NHS England ("**NHSE**") to improve the efficiency and operational consistency of pathology services in England.

(B) KMPN operates as a collaborative partnership governed by the Kent and Medway Pathology Network Board with executive and clinical representation from each Trust. It currently collaborates pursuant to a Vision Document which details how the Parties work together in terms of procuring certain services, management and governance of KMPN, commercial principles, workforce and organisational development and was approved on 11 September 2020 ("**Vision Document**"). The KMPN Trusts have also entered into a legally binding LIMS Collaboration Agreement to specifically govern their collaboration with respect to the LIMS Contract.

(C) KMPN now wishes to further formalise its collaborative arrangements via this Agreement which will replace the Vision Document. The Parties recognise that NHSE's maturity roadmap for pathology networks provides a robust plan both for the immediate and long term future and this Agreement is intended to govern working together in the short to medium term and enable the introduction of any required changes for the long term requirements. At the date of this Agreement, it is recognised that the existing pathology services operate under their individual management structures and it is the intention of the Parties to move to a single management structure. All changes to this Agreement, including any in relation to the on-going establishment of a single management structure and move towards a single service will be agreed via the Change Control Procedure. In addition, the Parties recognise that they have collaboratively procured the LIMS Contract and it is recognised that KMPN will also undertake a collaborative procurement for a managed equipment service (MES), the detail of which will be agreed via the Change Control Procedure.

(D) This Agreement covers the start of the journey of the KMPN from "emerging" to "maturing". This will see the Network develop from a single management structure to single overall service provision. The detailed actions to become a mature network are identified in the KMPN maturity matrix however the key areas for development on this journey are:-

- accountability for clinical quality management, clinical governance, risk and Clinical Safety (i.e. the NHSE mandated role for introduction of new or revised electronic systems within the NHS).
- To fully implement the pathology single management structure under the CD and MD

- To finalise the services in Scope for KMPN particularly with how the mortuary, IT, phlebotomy and POCT is delivered and managed
- Implement workforce strategy to address recruitment and retention issues,
- Implement single quality strategy and monitoring process across the network
- Develop network five year clinical strategy
- To finalise the risk sharing profile in respect of any surplus/deficit in the annual pathology services budgets.

NOW IT IS HEREBY AGREED as follows:

1. **DEFINITIONS**

1.1 In this Agreement, the words and expressions defined in Schedule 1 shall have the meanings attached thereto.

1.2 This Agreement shall be interpreted in accordance with the following provisions unless the context requires a different meaning:

1.2.1 unless otherwise specified, references to Clauses and Schedules are to the Clauses of and Schedules to this Agreement;

1.2.2 the Schedules to this Agreement are an integral part of this Agreement and any reference to this Agreement includes a reference to the Schedules; and

1.2.3 where the context requires, words importing the singular shall be construed as importing the plural and vice versa and words importing the masculine shall be construed as importing the feminine or the neuter or vice versa.

1.3 In relation to any conflict and/or inconsistency relating to the provisions of this Agreement, the following shall apply:

1.3.1 for any conflict and/or inconsistency between the Clauses and the Schedules to this Agreement, the Clauses shall take precedence;

1.3.2 for any conflict and/or inconsistency between the Schedules, the following order of precedence shall apply:

(a) Schedule 1 (Definitions);

(b) Schedule 2 (Collaboration Requirements) and Schedule 3 (Network Costs); and

(c) any other Schedules and their Annexes.

2. **LEGAL STATUS AND PURPOSE OF THIS AGREEMENT**

2.1 This Agreement sets out the Parties' intentions to work together during the Term. The Parties agree there are a number of key objectives for KMPN:

2.1.1 continuing the delivery of clinically and financially sustainable Pathology Services whilst moving towards the creation of a single service under a single management structure for the Pathology Services (via the Change Control Procedure) based on strong, viable service provision that is clinically led, standardised, innovative and creative;

2.1.2 continuing the delivery of a high-quality diagnostic service for the local health economy across primary, secondary and tertiary providers that continually improves the patient experience and outcomes;

2.1.3 continuing the development of a valued and involved workforce;

2.1.4 continuing the transformation of service models to deliver technological change, increasing efficiency and maximising staff potential whilst meeting the needs of client trusts and commissioners;

2.1.5 continuing the management and development of KMPN in a creative and competent manner;

2.1.6 working together in a cooperative and constructive manner, with integrity, honesty and transparency to fulfil their individual and shared responsibilities to deliver the aims of KMPN;

2.1.7 sharing of data e.g. financial, workforce, performance, operational risks, activity and quality, on an open book basis to enable comparison and allow trends and areas for improvement to be identified;

2.1.8 devising strategies for quantifying and sharing benefit and risk which support financial sustainability and ensure that they are delivered to the satisfaction of all Parties;

2.1.9 adopting policies which build and sustain a stable, strong, and vibrant pathology workforce, identifying opportunity for development, training and specialization and providing mutual support;

2.1.10 identifying and implementing strategies for reconfiguration and consolidation of services as opportunity arises and where demonstrably supported by business modelling following assessment of local needs as a means of delivering improved stability, quality and efficiency;

2.1.11 where outsourcing of testing is necessary, prioritise clinically appropriate solutions using laboratory services within KMPN where possible as a means of supporting high quality, consistent patient care aligned with existing referral pathways;

2.1.12 working positively but non-competitively with each other and with regional healthcare organisations to maximise opportunities for collaboration in the development of local and regional diagnostic services such as community diagnostic centres;

2.1.13 ensure that inter Kent providers are not bidding against each other or offering services to other organisations that are already provided within the KMPN. Any bids for new markets or existing contracts coming to an end and new tenders going forwards will be discussed as part of the KMPN business and agree the best placed provider to bid and the best configuration to meet the needs of the tender.

2.1.14 collaborating on joint procurement initiatives, including coordinating bids for funding, managing awards made to KMPN and supporting business case development

2.1.15 identifying opportunities for pioneering new technologies for the benefit of patient care;

2.1.16 promoting the use of strategies which drive operational consistency and reduce unwarranted variation across all KMPN workstreams, aiming for

harmonization of laboratory processes and systems, unified adoption of national standards, and equitable service provision across the South 8 geography; and

2.1.17 aiming to reach consensus on key decisions of KMPN direction and strategy, seeking to resolve in good faith any disagreements in line with the principles and values described in this Agreement and, where this fails, to work within the dispute resolution framework to resolve any issues which cannot otherwise be settled

2.2 In addition to Clause 2.1, this Agreement clearly sets out the obligations of each Party to KMPN in relation to achieving the Key Deliverables, Governance and Management Structure, Network Costs, Risk and Benefit Sharing, types of Pathology Services and fulfilling any other commitments required in relation to the during the Term.

2.3 The Parties acknowledge that this Agreement is between NHS Foundation Trusts and NHS Trusts. It is not an NHS Contract for the purposes of section 9 of the National Health Service Act 2006 and is intended to be legally binding between the Parties.

2.4 The Parties confirm to each other that they have and will continue to have all relevant and necessary authority and permissions to enter into this Agreement and that each Party has obtained approval in accordance with its internal governance arrangements to enter into this Agreement.

3. TERM AND KEY DELIVERABLES

3.1 This Agreement will commence on the date of execution and shall continue for the Term unless terminated earlier in accordance with this Agreement.

3.2 The Parties may agree to extend the Term of this Agreement, and such extension must be agreed in writing and executed by the Parties' respective authorised signatories.

3.3 This Agreement will govern the achievement of certain Key Deliverables to be achieved during the course of 2023 and 2024 including:

3.3.1 the move towards a single, overall management structure for the three existing Pathology Services which shall be agreed via the Change Control Procedure to the extent not included at the date of signature of this Agreement;

3.3.2 the procurement and collaboration requirements in relation to the MES pursuant to the MES Procurement Strategy (as the same may be updated from time to time and incorporated into this Agreement via the Change Control Procedure as the MES procurement develops);

3.3.3 the management and implementation of the LIMS Contract to the extent not already covered by the LIMS Collaboration Agreement;

3.3.4 Specifically, but not limited to, during the first 6 (six) months from the date of this Agreement:

(a) Finalisation of terms and conditions relating to work force management;

(b) Finalising governance structure below the executive level;

(c) Confirmation as to whether Medical and Transfusion practitioners are to be treated as Network staff or remain with their provider Trusts;

(d) Agreeing a quality & governance process for KMPN. This will include a full review of accreditation status to ISO 15189 of laboratories, examination procedures and tests. For those not currently accredited to ISO15189 a governance strategy will be agreed.

(e) Confirming and/or agreeing financial apportionments and responsibilities in accordance with financial principles in Schedule 2 Part 3;

(f) Agreeing collaboration strategy for point of care testing (PoCT), transport, phlebotomy and mortuary requirements which are currently not in Scope of this Agreement; and

3.3.5 any other general collaboration provisions as detailed herein.

4. GOVERNANCE AND MANAGEMENT STRUCTURE

4.1 The Parties have established a Kent and Medway Pathology Network Board with representation from each Party. The Kent and Medway Pathology Network Board is responsible for formal decision making and making proposals to the individual Trusts' Boards when applicable.

4.2 The Kent and Medway Pathology Network Board is supported by the Kent and Medway Pathology Network Executive Team which is responsible for operational decisions with respect to LIMS, MES and any other KMPN projects as well as the operation of the KMPN. The Kent and Medway Pathology Network Executive Team will make recommendations to the Kent and Medway Pathology Network Board and meetings will be chaired by the KMPN Clinical Director.

4.3 The KMPN Clinical Director report to and is accountable to the Kent and Medway Pathology Network Board. The Managing Director reports to the KMPN Clinical Director and the two roles are responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Managing Director has line management responsibility for the Pathology Services senior leaders for the part of their role identified for activities of Kent and Medway Pathology Network. The KMPN Clinical Director has a dotted line relationship with the Trust pathology clinical directors and transitional network clinical and quality lead as detailed in Schedule 2.

4.4 The Kent and Medway Pathology Network Executive Team is supported by the LIMS Project Steering Group, MES Project Steering Group, Workforce Steering Group and Governance and Legal Steering Group.

4.5 The KMPN Clinical Director will coordinate the transformation programme on behalf of the Kent and Medway Pathology Network Board .

4.6 Each Party shall fully support the Kent and Medway Pathology Network Board and perform their respective roles in relation to the Governance structure which is set out in Part 2 Schedule 2 (Collaboration's Requirements) including:

4.6.1 participation in decision making process via each representative's delegated authority in a timely and appropriate manner in line with the Kent and Medway Pathology Network Board's and/or Kent and Medway Pathology Network Executive Team's and/or any Steering Group's requirements;

4.6.2 communications with the KMPN Clinical Director, the KMPN Managing Director, Kent and Medway Pathology Network Board's and/or KMPN Executive Team and/or any Steering Group and providing input to each Party's approval processes proactively (to the extent reasonably required) and as and when reasonably requested; and

4.6.3 use of reasonable endeavours to co-operate with and provide assistance to each Party as requested by the Kent and Medway Pathology Network Board and/or KMPN Executive and/or any Steering Group.

4.7 The Parties hereby agree that Kent and Medway Pathology Network Board brings together expertise from across the Parties, with executive, clinical, and operational representatives acting under the delegated authority of Trust Boards to make recommendations on all issues relating to KMPN activity.

4.8 Additional attendees for specific agenda items and leads of individual work-streams may also be invited but do not have decision making power.

4.9 The Kent and Medway Pathology Network Board will provide strategic oversight and guidance for the successful delivery of the individual projects within its programme, supporting solutions which are in the best interests of KMPN.

4.10 The Kent and Medway Pathology Network Board will assist with conflict resolution as requested and provides targeted intervention where needed should progress towards shared milestones fall outside agreed tolerances.

4.11 The Kent and Medway Pathology Network Board has delegated authority from Trust Boards for the direction and management of these projects and to make decisions on policies and work programmes aligned with the agreed principles of KMPN (including any KMPN reconfiguration), including the management of operational and financial risk within agreed tolerances pursuant to the terms of this Agreement. This includes direct budget responsibility for PMO/KMPN costs, the management of external infrastructure funding awarded for dedicated management posts and project resource, and the line management of staff appointed to any such positions. It also includes decisions on moving any location for the performance of any tests. Organisations should not independently develop pathology tests already being provided by another organisation within KMPN. Where there is considered to be a clinical requirement to do so (e.g. due to turnaround time demands), this should be given due consideration through a formal change control process under this Agreement.

4.12 The Kent and Medway Pathology Network Board will be responsible for decisions relating to pathology tests including but not limited to:

4.12.1 decisions on moving any location for the performance of any tests;

4.12.2 notwithstanding that the Parties to this Agreement agree that no individual Party should independently develop pathology tests that are already being provided by another organisation within KMPN, the Parties agree that where there is considered to be a clinical requirement to do so (e.g. due to turnaround time demands) this will be reviewed and assessed by the Kent and Medway Pathology Network Board with any agreement documented via the Change Control Procedure;

4.12.3 agreeing strategies for the on-going provision and/or provision of new services to private/non-NHS providers in good faith with respect to the overall objectives of KMPN.

4.13 Decisions which are (or are perceived to be) out-with the agreed principles of KMPN may be referred to Trust Boards by any Party.

4.14 All significant investment by an individual Party will require Trust Board approval through standard governance processes appropriate to the scale of the proposal.

4.15 In the event that a disagreement arises that cannot be resolved through informal discussion a description of the disagreement should be submitted in writing by the aggrieved Party to KMPN, clearly and concisely setting out the nature of the dispute.

Executive representatives of the Kent and Medway Pathology Network Board shall meet within ten (10) Working Days of notice of the dispute being submitted at a meeting convened for the purpose of attempting to resolve it. Failing resolution, the procedure set out in Clause 21 of this Agreement shall be followed.

4.16 The Kent and Medway Pathology Network Board will produce an annual report documenting achievements, key recommendations and plans for the year ahead. The report shall evaluate the financial benefit to all Parties and make a comparative assessment of quality data, including detail on how improvement will be supported.

4.17 The annual report will be submitted to the Trust Board of each Party for review and information.

4.18 An annual meeting will be held to share progress and future plans with pathology teams and other stakeholders across all Parties and associated organisations.

Host and Hosting Obligations

4.19 The Parties hereby agree to the appointment of Maidstone and Tunbridge Wells NHS Trust as the Host Trust for the purposes set out in this Agreement. The Parties may agree to change the Host Trust by agreement between themselves. Each Party agrees that the Staff identified in Schedule 10 shall be employed by the Host Trust in accordance with this Agreement (including any Changes agreed pursuant to it).

4.20 Not used.

4.21 Subject to 4.22, the Host Trust shall carry out the Hosting Obligations in accordance with the Hosting Standards.

4.22 The Host Trust shall not be obliged to carry out or perform any act (or omission) that it reasonably considers:

4.22.1 would conflict with the legislation, regulations, the Host Trust's constitutional documents, the standing orders and standing financial instructions governing the Host Trust from time to time; or

4.22.2 would put the Host Trust's business or assets or reputation at risk.

4.23 There are no costs to be recovered in fulfilling the Hosting Obligations:

4.24 The Host Trust shall remain in place until the expiry or early termination of this Agreement UNLESS:

4.24.1 it serves not less than six (6) months' written notice [(such notice not to be served within the first twenty-four (24) months of the initial Term)] to the Kent and Medway Pathology Network Board that it wishes to resign as Host Trust; or

4.24.2 it serves notice to exit its participation from this Agreement in accordance with Clause 9.1.

4.25 During the term of the Agreement and for a period of twenty-one (21) years thereafter, the Host Trust shall (at the cost of KMPN) maintain in force insurance (or membership of a NHS Resolution risk sharing scheme) in respect of:

4.25.1 employers' liability to cover such heads of liability as may arise under or in connection with the Agreement and the provision of the Pathology Services;

4.25.2 any other insurance as the Parties may agree to incorporate pursuant to the Change Control Procedure.

4.26 The Host Trust shall, on a Party's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium in respect of each insurance.

4.27 For the avoidance of doubt, KMPN, acting through the Host Trust, shall attempt to mitigate its liabilities. Where the Kent and Medway Pathology Network Board considers it appropriate, the Parties acknowledge and confirm that where liability arises for which KMPN has insurance, they shall procure that KMPN shall seek to recover any losses from the relevant insurances rather than utilising the indemnities contained in this Agreement as a first recourse.

5. RESOURCE PROVISION AND NETWORK COSTS

5.1 Each Party commits to funding its share of the Network Costs including providing the resources required to ensure that the Host Trust's obligations under this Agreement and any payment obligations (as defined in any formal contracts) are met.

5.2 The Host Trust shall bill the Network Costs in accordance with the provisions set out in Schedule 3.

5.3 Any other costs relating to this Agreement shall be borne by each Party as they are incurred unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Parties. For the avoidance of doubt, such costs may include, but not be limited to, attendance at meetings and costs with complying with and/or performing in any relevant contract as agreed by the Parties or any other responsibilities defined in any other document agreed by the Parties.

6. REVIEW AND AUDIT OF THE COLLABORATION AGREEMENT

6.1 This Agreement shall be reviewed periodically and at least annually by the Kent and Medway Pathology Network Board.

6.2 The purpose of each review undertaken pursuant to Clause 6.1 is to ensure that the arrangements detailed within this Agreement are operating as envisaged and that each Party can raise any issues through the Kent and Medway Pathology Network Executive Team .

6.3 The Parties recognise and agree that this Agreement will require updating and amendments during its Term to reflect any Services that KMPN procures and any further contracts that any of the Trusts enter into, for example, in connection with the MES. All Parties shall act reasonably and in good faith in relation to required updates and amendments to reflect such requirements. Changes will be documents via the Change Control Process detailed in schedule 4.

7. RESPONSIBILITIES AND RISK AND BENEFIT SHARE

7.1 Each Party covenants with the other Parties that, for so long as it remains a Party or until the termination of this Agreement, it will:

7.1.1 at all times act in good faith towards the other Parties;

7.1.2 act in a timely manner (including by paying any costs within thirty (30) days of production of a valid invoice);

7.1.3 generally do all things necessary, to give effect to the terms of this Agreement;

7.1.4 take all reasonable steps to ensure, so far as it is able, that any meeting of the Kent and Medway Pathology Network Executive Team has the necessary quorum throughout;

7.1.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs; and

7.1.6 adhere to statutory requirements and best practice.

7.2 Each Party shall:

7.2.1 maintain accurate and complete:

(a) accounting and other financial records for each year in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom in relation to this Agreement;

(b) statements and records of all transactions for this Agreement

and make these available on request to any Party (subject to the provision of reasonable notice);

7.2.2 promptly notify the Kent and Medway Pathology Network Executive Team and Kent and Medway Pathology Network Board of any liabilities which it considers it is entitled to seek indemnity protection or reimbursement from the other Parties under this Agreement such notice to include:

(a) the quantum and nature of such liability;

(b) details of the circumstances causing such liability;

(c) any steps it has taken to minimise such liability; and

(d) other details regarding the liability, including details of any litigation.

7.3 The Parties to this Agreement agree to adhere to the Risk and Benefit Share as set out in Schedule 2 Part 3.

8. LIABILITY

8.1 No Party limits its liability for:

8.1.1 death or personal injury caused by its negligence;

8.1.2 fraudulent misrepresentation; or

8.1.3 any other liability which cannot be excluded or limited by Applicable Law.

8.2 Subject to Clause 8.4, each Party to this Agreement is liable for their own acts and omissions in connection with their own Pathology Services, any breach of this Agreement and/or any negligent or deliberate act or omission in connection with their own Pathology Services and/or this Agreement. Accordingly, to the extent that one Party's breach and/or negligence and/or wilful act or omission, either, in relation to their own Pathology Services and/or this Agreement causes another Party under this Agreement to suffer any loss, that former Party shall fully indemnity the Party who has suffered such loss.

8.3 No Party shall be liable under Clause 8.2 to the extent that the costs are already covered in the Network Costs.

8.4 No Party shall be liable for any Indirect Losses unless otherwise agreed in writing by the Parties.

9. **TERMINATION**

9.1 This Agreement shall terminate when all Parties agree to its termination. In addition, a Party may serve notice to terminate its participation in this Agreement upon giving twelve (12) months' notice to the Kent and Medway Pathology Network Board, subject to such notice only being permissible to be exercised after the expiry of the Transformation Programme.

9.2 A Party shall cease to be a Party to this Agreement if:

9.2.1 they commit a material breach of this Agreement or any contract that the Parties have entered into and (if such breach is remediable) fails to remedy that breach within a period of thirty (30) days after being notified in writing to do so by the Kent and Medway Executive Team; or

9.2.2 they are expelled by a resolution of the Kent and Medway Pathology Network Board where:

(a) the Party in default commits an Prohibited Act which is relevant to or connected with this Agreement; or

(b) the Party in default causes significant reputational damage to any other Party due to a material breach (whether or not capable of remedy),

9.2.3 they cease to exist in the form in which they existed when they are admitted as a Party to this Agreement, provided that this Clause 9.2.3 shall not apply to the extent that a relevant procedure is entered into for the purpose of a statutory reorganisation (where applicable) where the amalgamated, reconstructed or merged party agrees to adhere to this Agreement,

then the other Parties shall be entitled to immediately terminate the relevant Party's participation in the Agreement by joint written notice.

9.3 If notice is served pursuant to Clauses 9.1 or in the event a Party is expelled in accordance with Clause 9.2, then the Party that is in default or that wishes to withdraw or otherwise leave the Agreement shall pay any outstanding proportion of the Network Costs and any other costs directly arising pursuant to Clause 8. The Parties recognise that the Network Costs may accrue throughout the entire Term as well as on termination or expiry of this Agreement and any Party liable to pay such costs shall be notified of any final outstanding payments upon completion of the Term or as soon as practical thereafter.

9.4 The Parties recognise their continuing responsibilities in relation the performance of functions and liabilities under this Agreement. This liability extends, insofar as is required beyond expiry or termination of this Agreement.

10. **CONSEQUENCES OF TERMINATION**

10.1 Upon expiry or earlier termination of this Agreement, the Parties shall co-operate fully in achieving an orderly and efficient conclusion of the arrangements under this Agreement.

10.2 On termination of this Agreement, the following Clauses shall continue in force: Clause 7 (Responsibilities), Clause 8 (Liability,) Clause 9 (Termination), Clause 10 (Consequence of Termination), Clause 11 (Confidentiality), Clause 12 (Information and Sharing of Data), Clause 13 (Data Protection), Clause 14 (Bribery and Corruption), Clause 21 (Dispute Resolution), Clause 23 (Status of Agreement), Schedule 1 (Definitions) and Schedule 3 (Network Costs).

10.3 Termination of this Agreement shall not affect any rights, remedies, obligations or liabilities of the Parties that have accrued up to the date of termination.

10.4 Each Party shall act reasonably and in good faith with regards to mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Party to do so.

11. **CONFIDENTIALITY**

11.1 Each Party:

11.1.1 shall treat all Confidential Information belonging to any other Party or this Agreement as confidential and safeguard it accordingly; and

11.1.2 shall not disclose any Confidential Information belonging to any other Party or this Agreement to any other person without the prior written consent of that Party, except to such persons and to such extent as may be necessary for the performance of this Agreement or except where disclosure is otherwise expressly permitted by the provisions of this Agreement including Applicable Law.

11.2 Each Party shall take all necessary precautions to ensure that all Confidential Information obtained from any other Party under or in connection with this Agreement:

11.2.1 is given only to such of the employees and professional advisers or consultants engaged to advise it in connection with this Agreement and as is strictly necessary for the performance of this Agreement;

11.2.2 is, if it is Special Category Data or Personal Data, kept secure in accordance with the requirements of the Data Protection Legislation and only used in accordance with the disclosing Party's instructions;

11.2.3 is treated as confidential and not disclosed (without written prior consent) or used by any employees or professional advisers or consultants otherwise than for the purposes of performing its obligations under this Agreement.

11.3 The provisions of Clauses 11.1 to 11.3 (inclusive) shall not apply to any Confidential Information received by one Party from the other which:

11.3.1 is or becomes public knowledge (otherwise than by breach of this Clause 11 or through act of default on the part of the receiving Party or the receiving Party's agents or employees);

11.3.2 the receiving Party lawfully obtained from a Third Party who:

(a) lawfully acquired it;

(b) did not derive it directly or indirectly from the disclosing Party; and

(c) is under no obligation restricting its disclosure;

11.3.3 must be disclosed pursuant to a statutory, legal or parliamentary obligation placed upon the Party making the disclosure, including any requirements for disclosure pursuant to Clause 12 (FOIA), or otherwise in accordance with a court order, or the recommendation, notice or decision of a competent authority.

11.4 On termination of this Agreement or the participation of a Party, each Party (or in the event that the Agreement is terminated in relation to one Party, that Party) shall:

11.4.1 destroy or return to the other Parties, as applicable, all documents and materials (and any copies) containing, reflecting, incorporating or based on the other Parties' Confidential Information;

11.4.2 erase all Confidential Information belonging to the other Parties from computer and communications systems and devices used by it, including such systems and data storage services provided by Third Parties (to the extent technically and legally practicable); and

11.4.3 certify in writing to the other Parties that it has complied with the requirements of this Clause provided that a recipient Party may retain documents and materials containing, reflecting, incorporating or based on the Confidential Information of the other Parties to the extent required by Applicable Laws or any applicable governmental or regulatory authority.

11.5 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information.

11.6 The Parties agree that the provisions of this Clause 11 shall continue following expiry or termination for any reason of this Agreement for a period of three (3) years.

12. **INFORMATION GOVERNANCE AND SHARING OF DATA**

12.1 The Parties acknowledge that they are subject to the requirements of the FOIA, the EIRs and the Data Protection Legislation and the Parties shall assist and co-operate with each other to enable them to comply with these requirements.

12.2 The Parties shall procure that any of their agreed sub-contractors shall:

12.2.1 transfer any Request for Information to the relevant Party which is the subject of the Request for Information (the "**Disclosing Party**") as the case may be as soon as practicable after receipt and in any event within two (2) Working Days of receiving that Request for Information;

12.2.2 provide the Disclosing Party with a copy of all Information in its possession or power in the form that the Disclosing Party requires soon as practicable and in any event within five (5) Working Days (or such other period as the Disclosing Party may specify) of the Disclosing Party requesting that Information; and

12.2.3 provide all necessary assistance as reasonably requested by the Disclosing Party to enable it to respond to a Request for Information within the time for compliance set out in the FOIA and regulation 5 of the EIRs.

12.3 Each Party shall maintain an adequate records management system to enable it to retrieve the Information within the time limits prescribed in the FOIA and/or EIRs as applicable.

12.4 In considering whether Information is exempt from disclosure, the Disclosing Party shall reasonably consider the nature of such Information and in particular whether any information has been identified by the other Party as being commercially sensitive; however, for the avoidance of doubt, the Disclosing Party shall be responsible for determining in its absolute discretion whether the Information should be disclosed in response to a Request for Information.

12.5 Each Party acknowledges that the other Parties may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the discharge of public authorities' functions under Part 1 of FOIA (issued under section 45 of the FOIA, November 2004), be obliged under the FOIA or the EIR to disclose Information:

12.5.1 without consulting with the other Parties, or

12.5.2 following consultation with the other Parties and having taken their views into account.

12.6 The Disclosing Party agrees to keep the other Party fully informed of any FOIA requests received and processed in relation to this Agreement.

12.7 The Parties shall ensure that all Information produced in the course of this Agreement or relating to this Agreement is retained for disclosure and each Party shall permit the other to inspect such Information and documents and records containing such Information as that other Party may reasonably request from time to time.

12.8 It is agreed that the Kent and Medway Network Executive Team minutes and/or any other relevant documentation may contain commercially sensitive information, and that the Disclosing Party shall, where reasonably practicable and appropriate, seek the other Parties' opinion on whether such information is exempt from disclosure in accordance with the provisions of the FOIA or the EIRs save that the decision on disclosure shall remain the sole responsibility of the Disclosing Party.

12.9 Any costs charged for FOIA requests will be split proportionately between the Parties.

13. DATA PROTECTION

13.1 The Parties acknowledge that for the purposes of Data Protection Legislation, they are each independent Data Controllers in relation to the Contract Data.

13.2 The Parties agree to share Contract Data with each other to the extent necessary and proportionate to fulfil the purpose of this Agreement as identified by clause 2.1, and to meet their respective obligations as described by clause 2.2 (together the "**Purpose**").

13.3 Each Party shall comply with the Data Protection Legislation. Without prejudice to the foregoing, the Parties acknowledge that when one Party (the "**Data Discloser**") shares Contract Data with one or more Parties (the "**Data Receiver**"):

13.3.1 the Data Discloser will ensure it has a lawful basis for sharing the Contract Data under Data Protection Legislation;

13.3.2 the Data Discloser shall ensure it has provided clear and sufficient information to the Data Subjects as required by Data Protection Legislation;

13.3.3 the Data Receiver shall not Process the Contract Data in any way which is unrelated to or incompatible with the Purpose; and

13.3.4 for the avoidance of doubt, each Party shall ensure that it has lawful basis for Processing Contract Data at all times throughout the Term of this Agreement.

13.4 The Parties agree not to transfer, share or otherwise Process Contract Data outside of the UK.

13.5 Upon termination or earlier expiry of the Agreement for whatever reason, at the election of the Data Discloser, the Data Receiver shall either securely delete or return all Contract Data to the Data Discloser. If required by law to retain a copy, the Data Receiver shall inform the Data Discloser what it is retaining and the legal reason why it needs to be retained.

13.6 The Parties agree to use all reasonable efforts to assist each other with complying with the Data Protection Legislation. This includes (but is not limited to) the Parties providing each other with such assistance as is reasonably required to enable each other to

comply with any Subject Rights Requests within the time limits imposed by Data Protection Legislation.

14. **BRIBERY AND CORRUPTION**

14.1 The Parties must not commit any Prohibited Act.

14.2 Each Party warrants that in entering into this Agreement it has not committed any Prohibited Act and further represents and warrants it will, during the term of this Agreement (and procure that its employees, agents and contractors) not commit a Prohibited Act and will, comply with the Bribery Act 2010 and associated guidance published by the Secretary of State for Justice under the Bribery Act 2010 and all other Applicable Law in relation to bribery or corruption (the "**Bribery Laws**"). For the avoidance of doubt, any obligation to comply with (or to avoid any breach or contravention of) the Bribery Laws shall be deemed to include an obligation to avoid any act or omission that would constitute an offence under the Bribery Act 2010 if done or made by a person with a close connection with the United Kingdom (as defined in that Act) or if done or made in the United Kingdom.

14.3 Each Party further warrants that it has in place adequate procedures to prevent bribery and corruption, as contemplated by section 7 of the Bribery Act 2010, including an anti-corruption and bribery policy.

14.4 Each Party shall:

14.4.1 if requested, provide the Host Trust with any reasonable assistance, at the relevant Party's cost, to enable the Host Trust to perform any activity required by any relevant government or agency in any relevant jurisdiction for the purpose of compliance with the Bribery Act 2010; and

14.4.2 within fourteen (14) Working Days of the Commencement Date, and annually thereafter, certify to MTW in writing (such certification to be signed by an officer of the relevant Party) compliance with this Clause 14 by the relevant Party and all persons associated with it or other persons who are supplying goods or services in connection with this Agreement. For the avoidance of doubt, each Party shall provide such supporting evidence of compliance as the Host Trust may reasonably request.

14.5 If any breach of this Clause 14 is suspected or known, the relevant Party must notify the Host Trust immediately.

14.6 The Host Trust may expel any Party who is found in breach of this Clause 14 provided the Party is question is provided with a termination notice stating:

14.6.1 the nature of the breach;

14.6.2 the identity of the party whom the Host Trust believes as committed the breach; and

14.6.3 the date on which this Agreement will terminate.

14.7 Any termination under this Clause 14 will be without prejudice to any right or remedy which has already accrued or subsequently accrues to the Host Trust.

15. **EQUALITY ACT**

15.1 Each Party shall not unlawfully discriminate within the meaning and scope of the provisions of the Equality Act 2010 or any statutory modification or re-enactment of that Act or analogous legislation which has been, or may be, enacted from time to time relating to discrimination in employment or discrimination in the delivery of public services.

15.2 Each Party shall take all reasonable steps to secure that all their servants, employees or agents do not unlawfully discriminate as set out in Clause 15.1.

16. **SUB-CONTRACTING AND ASSIGNMENT**

16.1 No Party shall be entitled to sub-contract or assign its rights or obligations under this Agreement without the consent of each of the other Parties, such consent not to be unreasonably withheld or delayed unless such assignment, sub-contracting, novation or transfer is to a statutory successor in which case no consent shall be required.

16.2 At their own expense, the Parties shall promptly execute and deliver such documents and perform such acts as may reasonably be required for the purpose of giving full effect to this Clause 16.

17. **INTELLECTUAL PROPERTY RIGHTS**

17.1 All existing Intellectual Property of each Party that is used by the Parties in connection with this Agreement shall remain the exclusive property of the Party that owned such Intellectual Property on the commencement of this Agreement. Each Party hereby grants to each other a non-exclusive, royalty free licence to use any such existing Intellectual Property solely for the purposes of participating in the Procurement Process.

17.2 Any Intellectual Property created by a Party as part of or arising out of the Procurement Process shall belong to the Party who created it (the "**Owning Party**"). The Owning Party hereby grants to the other Parties a non-exclusive, royalty free licence to use any such new Intellectual Property for the purposes of collaborating in the Procurement Process.

17.3 The Parties will jointly own any jointly developed Intellectual Property arising out of the Procurement Process and no Party will be entitled to independently use such Intellectual Property other than in conjunction with the Procurement Process without the written consent of the other Parties.

17.4 Any dispute as to the ownership of any Intellectual Property shall be determined in accordance with Clause 21 (Dispute Resolution Procedure).]

18. **ADHERENCE TO THIS AGREEMENT**

18.1 In the event that a New Party wishes to join this Agreement, the New Party shall enter into a deed of adherence in the form set out in Schedule 11;

18.2 In the event that a New Party wishes to join this Agreement without any relevant contract for LIMS, the Parties shall agree such provisions via the Change Control Procedure.

19. **VARIATIONS**

19.1 Variations to this Agreement may be initiated by any Party by issuing a Change Control Note to the Kent and Medway Pathology Network Board by using the procedure set out in Schedule 4.

19.2 The Parties to this Agreement agree and acknowledge at the date of its signature that a number of changes will be required during the term of this Agreement. Such changes may include (but are not limited to):

19.2.1 Financial arrangement including levels of base costs and contributions to indirect costs;

19.2.2 impact of service change and reconfigurations (for example due to national mandates and/or centralised procurements) and changes relating to space utilisation;

19.2.3 The ICS collaborative bank (when it is in place) will manage bank requests on behalf of the KMPN;

19.2.4 A standard placement agreement is signed by each Trust in the KMPN and a university avoiding the need for individual honorary contracts (by June 2023);

19.2.5 Organisations should work to ensure equivalence of pay and conditions for roles across KMPN. Whenever a post is advertised, or an internal restructuring of a role is being considered, assurance should be sought from the workforce lead that the job description and banding are commensurate with those in other network organisations. Where a need to deviate from this position is considered necessary, this should be the subject of a Change Control Process under this Agreement.

20. **NOTICES**

20.1 Any notice required to be given under this Agreement may be delivered personally or sent by first class post, courier or transmitted by email to the Chief Executive (or equivalent) of each other Party at the address given at the beginning of this Agreement, or such other addresses as may be notified in accordance with this Clause 20 from time to time.

20.2 Any notice so sent shall be deemed to have been duly given if sent by (i) personal delivery or courier - on delivery at the address of the relevant Party; or (ii) prepaid first class post – five (5) days after the date of posting when able to be read as received on recipient's email server.

20.3 This Clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

21. **DISPUTE RESOLUTION PROCEDURE**

21.1 In the event of any dispute arising in relation to this Agreement ("**Dispute**"), the matter shall first be considered by the Kent and Medway Pathology Network Executive Team. In the event that the Kent and Medway Pathology Network Executive Team is not able to resolve the dispute within ten (10) Working Days of the matter arising, the Kent and Medway Pathology Network Executive Team . shall escalate the matter by referring it to the Kent and Medway Pathology Network Board

21.2 In the event that the Parties are unable to settle the dispute within ten (10) Working Days of referral to the Kent and Medway Pathology Network Board detailed in Clause 21.1, they shall within five (5) Working Days after the end of that negotiation period submit the dispute to an Expert in accordance with the process set out below.

21.3 An Expert is a person appointed in accordance with this Clause to resolve a dispute arising under this Agreement.

21.4 The Parties shall agree on the appointment of an independent Expert and shall agree with the Expert the terms of their appointment.

21.5 If the Parties are unable to agree on an Expert or the terms of their appointment within seven (7) days of either Party serving details of a suggested expert on the other, any Party shall then be entitled to request The Academy of Experts to appoint an Expert of repute with international experience in the subject matter of the dispute and for The Academy of Experts to agree with the Expert the terms of appointment.

21.6 The Expert is required to prepare a written decision including reasons and give notice (including a copy) of the decision to the Parties within a maximum of three months of the matter being referred to the Expert.

21.7 If the Expert dies or becomes unwilling or incapable of acting, or does not deliver the decision within the time required by this Clause then:

21.7.1 the Parties may agree or may apply to The Academy of Experts to discharge the Expert; and

21.7.2 the Parties may proceed to appoint a replacement Expert in accordance with this Clause 21 which shall apply to the replacement Expert as if they were the first Expert to be appointed.

21.8 All matters under this Clause must be conducted, and the Expert's decision shall be written, in the English language.

21.9 The Parties are entitled to make submissions to the Expert including oral submissions and will provide (or procure that others provide) the Expert with such assistance and documents as the Expert reasonably requires for the purpose of reaching a decision.

21.10 Each Party shall with reasonable promptness supply each other with all information and give each other access to all documentation and personnel and/or things as the other Party may reasonably require to make a submission under this Clause.

21.11 The Expert shall act as an expert and not as an arbitrator. The Expert shall determine the dispute arising under this Agreement which may include any issue involving the interpretation of any provision of this Agreement, their jurisdiction to determine the matters and issues referred to them and/or their terms of reference. The Expert may award interest as part of their decision. The Expert's written decision on the matters referred to them shall be final and binding on the Parties in the absence of manifest error or fraud.

21.12 The Expert may direct that any legal costs and expenses incurred by a Party in respect of the determination shall be paid by another Party to the determination on the general principle that costs should follow the event, except where it appears to the Expert that, in the circumstances, this is not appropriate in relation to the whole or part of such costs. The Expert's fees and any costs properly incurred by them in arriving at their determination (including any fees and costs of any advisers appointed by the Expert) shall be borne by the Parties in the proportions set out at Schedule 3 to this Agreement.

21.13 All matters concerning the process and result of the determination by the Expert shall be kept confidential among the Parties and the Expert.

21.14 Each Party shall act reasonably and co-operate to give effect to the provisions of this Clause and otherwise do nothing to hinder or prevent the Expert from reaching their determination.

21.15 The Expert shall have no liability to the Parties for an act or omission in relation to this appointment; save in the case of bad faith.

21.16 Nothing in this Agreement shall prevent a Party seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Party or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the process set out in this Clause 21.

22. GENERAL

22.1 No variation of this Agreement shall be effective unless it is in writing and signed by each Party.

22.2 Failure of any Party to enforce or exercise, at any time or for any period, any term of this Agreement does not constitute, and shall not be construed as, a waiver of any term and shall not affect the right to enforce such term, or any other term contained in this Agreement, at a later date.

22.3 Nothing in this Agreement shall constitute, or be deemed to constitute, a legal partnership between the Parties, or shall constitute any Party as the agent, employee or representative of the other(s).

22.4 The Parties hereby agree that this Agreement shall be binding on any successors in title.

22.5 No one other than a party to this Agreement, their successors and/or permitted assignees, shall have any right to enforce any of its terms whether by virtue of the Contracts (Rights of Third Parties) Act 1999 or otherwise.

22.6 If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and the Parties shall work together to agree a variation to this Agreement to ensure their continuation and achieve so far as possible their original intent. In the event that the Parties cannot agree an appropriate variation, any Party may terminate its participation from this Agreement with immediate effect.

22.7 No publicity or advertising regarding the relationship between the Parties concerning the Procurement Process, the LIMS Contract or this Agreement shall be released by any Party without the prior written approval of the other Party, which shall not be unreasonably withheld.

22.8 The Parties shall do and execute all such further acts and things as are reasonably required to give full effect to the rights given and the matters contemplated by this Agreement.

22.9 This Agreement may be executed and delivered in any number of counterparts, each of which is an original and which, together, have the same effect as if each Party had signed the same document.

22.10 This Agreement constitutes the entire agreement and understanding between the Parties with respect to the subject matter of this Agreement and supersedes any prior agreement, understanding or arrangement between the Parties with respect to the subject matter of this Agreement, whether oral or in writing.

23. STATUS OF AGREEMENT

This Agreement is governed in accordance with this Clause 23.

23.1 This Agreement and any dispute or claim arising out of, or in connection with, it, its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the laws of England.

23.2 The Parties irrevocably agree that the Courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

Definitions

Agreement	means this agreement, including its Schedules;
Applicable Laws	all laws, rules, regulations, codes of practice, research governance or ethical guidelines or other requirements of regulatory authorities, as amended from time to time;
Board(s)	means the executive board of any of the Trusts as the context so requires;
Bribery Laws	has the meaning set out in Clause 14;
Business Plan	means the annual business plan for KMPN prepared by Kent and Medway Pathology Network Executive Team and approved by the Kent and Medway Pathology Network Board in accordance with Schedule 9;
Change	means an amendment to any term or Schedule under this Agreement or any other contract entered into by the Parties (and agreed to be governed by this Agreement) pursuant to Schedule 4;
Change Control Note or "CCN"	means the written record of any Change agreed or to be agreed by the Parties pursuant to the Change Control Procedure as set out in Schedule 4;
Change Control Procedure	
Commissioner	the Information Commissioner (see Article 4(A3), UK GDPR and section 114, DPA 2018);
Confidential Information	means information, the disclosure of which would constitute an actionable breach of confidence, which has either been designated as confidential by a Party in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored), including commercially sensitive information, information which relates to the finances, business, affairs, properties, assets, trading practices, goods/services, developments, trade secrets, Intellectual Property rights, know-how, employees and other workers, customers and suppliers of a Party and all Personal Data and Sensitive Personal Data.;
Contract Data	means the management, performance and administrative data that may be collected, Processed and shared by the Parties under or in connection with this Agreement, which the Parties acknowledge includes Personal Data;
Data Controller	has the meaning given in the Data Protection Legislation;
Data Processor	has the meaning given in the Data Protection Legislation;
Data Protection Legislation	all applicable data protection and privacy legislation in force from time to time in the UK including without limitation the UK GDPR; the Data

	Protection Act 2018 (and regulations made thereunder) (**DPA 2018**); the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended; all other legislation and regulatory requirements in force from time to time which apply to a Party relating to the use of Personal Data (including, without limitation, the privacy of electronic communications); and the guidance and codes of practice issued by the Commissioner or other relevant regulatory authority and which are applicable to a Party
Data Subject	has the meaning given in the Data Protection Legislation;
Direct Losses	means amounts recoverable under Clause 8.3 or any Network Costs, excluding Indirect Losses;
Dispute Resolution Procedure	means the procedure set out in Clause 21 of this Agreement;
EIRs	means the Environmental Information Regulations 2004 together with any code of practice made pursuant to those Regulations and any related guidance issued by the Secretary of State for the Department for Environment, Food and Rural Affairs, the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Financial Year	means a financial accounting period of twelve (12) months ending on 31 March but, in the first year in which this Agreement is signed means the period starting on the date of signature and ending on 31 March;
FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in the Interpretation Act 1978), but excluding the EIRs, as amended modified or re-enacted from time to time, together with all codes of practice made pursuant to that Act or pursuant to that subordinate legislation from time to time, and together with any related guidance issued by the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Governance and Legal Group	means the group of that name reporting into the Kent and Medway Pathology Network Executive Team ;
Governance and Management Structure	means the KMPN governance and management structure set out in Part 2 of Schedule 2 (Collaboration's Requirements) as the same may be amended and updated from time to time pursuant to this Agreement;
Host Trust	means Maidstone and Tunbridge Wells NHS Trust as the contracting party under this Agreement on behalf of the KMPN;
Hosting Obligations	means those obligations set out in Schedule 5;
Hosting Standards	means those standards set out in Schedule 5;
Indirect Losses	means any loss of profits, loss of business or loss of business opportunity (whether such losses arise directly or indirectly) and any other consequential or indirect loss of any nature, but excluding Direct Losses;
Information	shall have the meaning given under section 84 of the Freedom of Information Act 2000 including but not limited to environmental information as defined in regulation 2 of the EIRs and Personal Data

	and data as defined in the Data Protection Legislation;
Intellectual Property	means any patents, rights to inventions, registered designs, copyright and related rights, database rights, design rights, topography rights, trademarks, service marks, trade names and domain names, trade secrets, rights in unpatented know-how, rights of confidence and any other intellectual or industrial property rights of any nature, including all applications (or rights to apply) for and renewals or extensions of such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world;
Kent and Medway Pathology Network Board	means the Kent and Medway pathology network's board or such other group that replaces it from time to time.
Kent and Medway Pathology Network Executive Team	means the Kent and Medway pathology network's management team or such other group that replaces it from time to time.
Key Deliverables	means the deliverables set out in Clause 3 and as more particularly described in Part 1 of Schedule 2 (Collaboration's Requirements);
KMPN	means the Kent and Medway Pathology Network;
LIMS Collaboration Agreement	means the collaboration agreement entered into by the Parties for the LIMS Contract;
LIMS Contract	means the contract for the provision of a pathology laboratory information management system entered into by EKHUFT with CliniSys ;
MES Contract	means the managed services contract to be procured by KMPN pursuant to the MES Procurement Strategy for the standardisation of analysers to improve quality and commercial outcomes of KMPN and for which further agreed provisions shall be included in this Agreement via the Change Control Procedure;
MES Procurement Strategy	means the MES Procurement Strategy v1.1 approved by the MES Steering Group on 21st September 2022 along with the paper called "September 2022 MES Project and Pathology Programme Delays noted at the meeting of the PNCOC and Transformation Board on 6th October 2022 and 13th October 2022 respectively;
MES Provider	means the supplier that enters into the MES Contract;
MES Steering Group	means the group of that name set up for the MES and reporting into the Kent and Medway Pathology Network Board;
Network Costs	means the KMPN management costs payable under or in connection with this Agreement, as apportioned between the parties as set out in more detail in Schedule 3 or as determined in accordance with Clause 8 of this Agreement and any other costs that are agreed to be incorporated via the Change Control Procedure;
NKPS	means the North Kent Pathology Service which is formed by DGT and MFT;
New Party	means a party who joins this Agreement pursuant to Clause 18;

Party(ies)	means each and any or all (as the context so requires) of the Parties listed at the start of this Agreement and any additional entities that become a party to this Agreement;
Personal Data	has the meaning given in the Data Protection Legislation;
Processing	has the meaning given in the Data Protection Legislation;
Personal Data	has the meaning given in the Data Protection Legislation;
Pathology Services	means the three independent pathology services that are provided by (1) NKPS at Darent Valley Hospital and Medway Maritime Hospital; (2) EKUHFT at William Harvey, Queen Elizabeth Queen Mother and Kent and Canterbury Hospital; and (3) MTW at Maidstone Hospital and Pembury Hospital;
Pathology Services senior leader (s) and Clinical Director(s)	means the relevant role of lead manager at any of the three Pathology Services;
Request for Information	shall have the meaning set out in FOIA;
Risk and Benefit Share	means the provisions relating to the same set out in Part 3 of Schedule 2 (Collaboration's Requirements);
Special Category Data	has the meaning given in the Data Protection Legislation;
Staff	means the staff that are employed by the Host Trust;
Steering Group(s)	means any or all of the transformation programme steering groups; LIMS Steering Group, MES Steering Group. Workforce Steering group, digital diagnostic steering group and Governance and Legal Steering Group as the context so requires;
Term	31st March 2038 unless terminated earlier in accordance with Clause 9 (Termination), or extended in accordance with Clause 3.2 (Term);
Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the Kent and Medway Pathology Network Board and the Kent and Medway Pathology Network Executive Team (as updated from time to time), copies of which (as at the date of this Agreement) are set out in Part 2 of Schedule 2 (Collaboration's Requirements);
Transformation Programme	means the programme detailing the planned transformation activities that KMPN shall implement via this Agreement, a copy of which is set out in Schedule 2 (Collaboration's Requirements);
UK GDPR	has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the DPA 2018;
Working Day	means any day other than a Saturday, a Sunday, Christmas Day, Good Friday or a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in any part of the United Kingdom and "**Working Days**" shall be construed accordingly.

SCHEDULE 2

Collaboration's Requirement

Part 1

KEY DELIVERABLES

The MES procurement phase of the project will conclude with an identical contract that all pathology services in the network (or individual Trusts) will enter into with a single MES Provider. The MES Provider will supply pathology services across all of the Trusts' sites and all specialities, for example a centralised inventory management solution, a specimen management and tracking solution and an Internal Quality Control solution. The MES Provider will also supply the biochemistry solution including tracked automation but it will sub-contract key elements of the MES Contract to third-party providers following a series of mini competitions, run by the MES Provider. Subject matter experts from the various disciplines will be directly involved in the assessment of bids as part of these mini competitions. The estimated launch date for the initial tender to select the MES Provider is early March 2023 and the total MES procurement phase of the MES project is expected to last around 12 months, with the initial stage taking around 7 months. Following the completion of the MES procurement phase, the MES Full Business Case (FBC) will be finalised and submitted for approval to the various governance Trust groups and NHSE, following which the MES Contract with the MES Provider will be finalised and signed.

A network SLA has been put in place with the main provider of outsources testing. When the needs arises the remaining small contracts will be held at Trust level will be procured/renewed on a network basis.

The LIMS Collaboration Agreement is separate to this Agreement. It covers the LIMS Contract and includes the following deliverables; -

- It provides legal protection for EKHUFT as they have entered into a legally binding commercial contract with CliniSys and are hosting the service on behalf of all Trusts in the KMPN;
- It is a legally binding agreement between all Trusts in the KMPN. All Trusts are bound by the agreement to pay an agreed share of the annual service costs and all other costs as they arise, e.g. delay payment penalties;
- It provides protection to all remaining Trusts should one or more Trust wish to stop using the LIMS system;
- It includes a provision for new Trusts joining at a future date; and
- It describes how the LIMS Contract will be governed.

COLLABORATIVE APPROACH AND CONFLICTS MANAGEMENT

1. The Trusts shall work collaboratively and in good faith during the Term in accordance with the provisions of this Agreement. The Trusts expressly recognise that the MES is intended to confer mutual benefits on all Trusts, and the Procurement Process and MES Contract(s) shall reflect this intention, in particular (but not limited to):

    1.1 standardising specifications across Trusts;

    1.2 rationalising and reducing supply-base for similar products/services, leveraging spend wherever possible;

    1.3 ensuring robust clinical evaluations that support the principles at Paragraphs 1.1 and 1.2;

    1.4 influencing behavioural change throughout the supply chain, reducing cost and removing process variation;

1.5 applying category management;

1.6 identifying and mitigating supply chain risk;

1.7 ensuring evidence based decision making;

1.8 procuring leaner requisition to pay processes;

1.9 ensuring focus on execution and project delivery; and

1.10 identifying strategic partners to achieve the outcomes listed at Paragraphs 1.1 to 1.10.

2. The Trusts have selected common Selected Suppliers for all Trusts by virtue of the application of the Contract Award Criteria. Each Trust has and shall continue to participate in the Evaluation Process as required by the Kent and Medway Pathology Network Board . The Procurement Process has and shall continue to be constructed so as to protect the Trusts from an outcome that puts any Trust in a worse position to its current contract(s).

3. Decisions made by the Kent and Medway Pathology Network Board in line with the application of the Terms of Reference shall be ratified by each individual Trust in accordance with Schedule 2 Part 2.

4. The Trusts shall keep each other fully informed of any issues and/or conflicts (or potential issues and/or conflicts) arising from, in relation to or connected to this Agreement and/or the Procurement Process and/or their Contracts that may have any material adverse impact on any Trust or a material adverse effect on the ability of the Trust to comply with the provisions of this Agreement and/or the provisions of their Contracts and/or participate in the Procurement Process. Each Trust shall act reasonably and in good faith with regards to escalating and mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Trust to do so.

5. The Trusts recognise that mutual benefit will be derived from a collaborative approach to management of their Contracts with respect to (but not limited to) the following:

5.1 system efficiency and resilience;

5.2 benchmark and performance data review;

5.3 cross-organisational operational delivery;

5.4 shared learning and cross organisational responsibilities;

5.5 escalation of issues and disputes with Selected Supplier;

5.6 cross organisational implementation and transition;

5.7 benefits realisation assessment;

5.8 innovation and technology assessments;

5.9 continuous improvement initiatives;

5.10 collaborative contract management;

5.11 business continuity;

5.12 management of adverse impacts on individual Contracts and subsequent cross organisational impacts (e.g. delays); and

5.13 price changes, extensions and change control.

6. Each Trust shall immediately give written notice to the other Trusts and the Network Board of any actual, threatened or suspected procurement challenge and/or other legal action in connection with a Contract of which it becomes aware.

7. The Parties will co-operate with each other in good faith and will take all reasonable action as is necessary for the efficient transmission of information and instructions and to enable the Parties to derive the full benefit of this Agreement and Contracts.

8. Parties will not enter into unilateral contract negotiations with the single MES provider or any other pathology equipment provider, all contract negotiations must be undertaken via a unified KMPN process

Part 2

GOVERNANCE AND CONTRACT MANAGEMENT

A. Terms of Reference for the Kent and Medway Pathology Network Board and Kent and Medway Pathology Network Executive Team

TERMS OF REFERENCE

KENT AND MEDWAY PATHOLOGY NETWORK BOARD

1. **Constitution**

Kent and Medway Pathology Network Board has delegated authority from its partner organisations to develop and deliver the pathology network services as set out in the network collaboration agreement.

The network board aims to reach consensus on key decisions of KMPN direction and strategy, seeking to resolve in good faith any disagreements in line with the principles and values described in the network collaboration agreement and, where this fails, to work within the dispute resolution framework to resolve any issues which cannot otherwise be settled.

With respect to representatives on the Kent and Medway Pathology Network Board, it is recognised and agreed that only the Parties to this Agreement shall have voting rights and be able to ratify/veto decisions of the Board. Any non-provider representatives on the Board are non-voting members and are not able to ratify or veto Board decisions.

2. **Scope**

To provide leadership oversight of Kent & Medway Pathology Network direction, strategy and operations.

3. **Aims, Functions and Objectives**

The role of the network board is:-

- Holding the Pathology Network Clinical Director and their leadership team to account for development and delivery of pathology services including risk and issue management.
- Ensuring the vision for the pathology network and the goal, strategic objectives and key requirements are met in the development of the pathology network.
- Approval of business cases for recommendation to the partner organisations.
- The Kent and Medways Pathology Network Board will produce an annual report documenting achievements, key recommendations and plans for the year ahead. The report shall evaluate the financial benefit to all Parties and make a comparative assessment of quality data, including detail on how improvement will be supported.
- The annual report will be submitted to the Trust Board of each Party for review and information.
- An annual meeting will be held to share progress and future plans with pathology teams and other stakeholders across all Parties and associated organisations

- Engage and consult with key stakeholders, including patients, pathology staff, pathology service users, ICBs and NHSE .to ensure network delivery meets their needs.

4. **Membership**

Position	Role on the Network Board
Chair (Senior Responsible Officer)	• Ultimately responsible for the programme of network development and delivery • Ensures network is focused on achieving its objectives and forecast benefits. • Engages with acute Trust CEOs and ICB executive to ensure their collective views are represented. • Holds the KMPN Clinical Director to account to deliver their objectives. • Holds network board members to account for their role as outlined below. • Chairs network board meetings ensuring members are enabled to fulfil their role and that ways of working are supported.
Acute Trust Executive SROs	• Represent their Trust executive colleagues on the network board and make decisions/recommendations on their behalf • Engage with executive and other senior colleagues to ensure socialisation of draft business plans and business cases and feedback to the network board in advance of the formal approvals process • Present applicable documents to Trust Boards and pre-board committees for approval
Acute Trust clinical representatives	• Represent their Trust clinical colleagues on the Network board and make recommendations on their behalf • Engage with clinical colleagues to ensure network plans are in line with Trust needs and that Trust needs are met by the pathology network
Primary Care Clinical Representative	• Represent their primary clinical colleagues on the Programme Board and make recommendations on their behalf • Engage with primary care clinical colleagues to ensure network plans are in line with primary care needs and that primary care needs are met by the pathology network
ICB Representative	• Represent and engage with ICB executive colleagues • Ensure network direction and strategic objectives are aligned with the strategic objectives of the ICB.

Position	Role on the Network Board
	• Review business plans and business cases as part of the governance and approval processes
Pathology Network Clinical Director	• Accountable to the SRO and network board for delivery of the network transformation projects and services. • Holds the managing director and senior network leadership team to account for delivery of their objectives. • Ensures network development and delivery aligns with the requirements of the NHSE maturity matrix. • Ensures that the network is well managed and delivers value for money. • Ensures agenda and papers support the achievement of network objectives and are developed through steering group/s and network leadership team as appropriate. • Ensures network direction and strategic objectives meet patient safety and quality requirements • Represents discipline clinical leads • Ensures engagement of network board members and Clinical Advisory Group members outside of meetings in order to make the best use of meeting time. • Engages with other pathology network clinical directors and NHSE diagnostics leads
Network Managing Director	• Leads on the day to day delivery of network projects and the transition to full operational management single service. • Facilitates the flow of information to and from the network Board and network senior leadership team. • Escalates risks and issues as required to the network Clinical Director and the network board. • Ensures the network is appropriately resourced • Provides support to and deputises for the network Clinical Director
Pathology network senior leaders	• Represents pathology services from an operational leadership perspective. • Ensures documents for approval meet operational requirements • Engages with operational colleagues in other disciplines across the network • Reports regularly and by exception on operational activity, risks and issues

Position	Role on the Network Board
Pathology Network (interim) Finance Director	• Reporting financial risks and concerns to the network Board. • Link to ICB strategic and capital planning leads. • Supports the network Board in setting and monitoring annual and multi-year budgets. • Supporting the financial aspects of business plans and business case. • Supports the realisation of cash-releasing benefits.
Pathology Network (interim) Workforce, education & network development Director	• Reporting workforce risks and concerns to the network Board. • Supports the network Board in ways of working and board development. • Supporting the workforce, education and network development aspects of business plans and business cases. • Supports the realisation of non-cash-releasing and qualitative benefits.
Pathology Network (interim) Digital director	• Reporting risks and concerns relating to digital transformation to the network Board. • Supporting the digital aspects of business plans and business cases. • Supports the realisation of benefits associated with digital transformation.
Pathology Network (interim) procurement director	• Reporting procurement risks and concerns to the network Board. • Supports the network Board in ways of working and board development. • Supporting the procurement aspects of business plans and business cases. • Supports the realisation of benefits associated with procurement.
NHSE South of England Diagnostics lead	• Feeds in learning from other networks and guidance from regional and national NHSE • Critical friend ensuring documents meet NHSE requirements
Non-executive director	• Supports the chair in holding the network board to account • Brings own expertise and experience to the network board • Engages with relevant stakeholders to ensure their collective views are represented.

Position	Role on the Network Board
	• Deputises for the Chair at network board meetings, ensuring members are enabled to fulfil their role and that ways of working are supported.

Additional attendees for specific agenda items and leads of individual workstreams may also be invited but do not have decision making power.

5. **Quoracy**

The network Board will be quorate with the chair, and an executive lead, clinical representative or nominated deputy from each trust and ICB; and the network clinical director or managing director.

Members are asked to nominate a regular deputy and to ensure they can attend in their absence and are suitably prepared for the meeting.

Where a network board meeting is not quorate, any decision or recommendation to trust boards will be unable to be agreed and will be carried forward to the next meeting. Where carrying forward to the next meeting would impact on the critical path of a project or network delivery, SRO approval will be sought by email/telephone by the network clinical director or managing director.

6. **Frequency of meetings**

Meetings will be held monthly for 2 hours.

7. **Reporting**

The network Board will report into the ICB committee as directed by the ICB. Trust SROs are expected to keep their Trust board updated regularly and by exception.

8. **Admin Support**

Admin support for Programme Board meetings will be provided from the network team.

9. **Ways of Working**

Ways of Working in Meetings and in the workplace

- Respect for each board member; as it is one team delivering the network.
- If unable to attend a meeting, then advise the meeting co-ordinator in advance
- Be appreciative – focus on what's going well first.
- Honesty and transparency (NB exception for commercially sensitive information)
- Giving timely feedback, both positive and constructive, to individuals
- Asking for advice and help when you need it
- Open to all ideas, critique and challenge
- Escalate issues to project team rather than outside the programme governance
- Everything is a learning opportunity
- Involve teams at all stages

- Respect work/life balance
- Call rather than email more
- Value our diversity

10. **Meetings governance**

- Terms of reference agreed by members within first two months of meetings being held
- Agree meeting dates well in advance and avoid changing them
- Meetings should start at the planned time; it respects members who have arrived in a timely manner.
- Papers are sent out at least 3 working days in advance of the meeting
- Larger documents such as business cases should be sent out with a minimum of 5 days in advance
- Meeting notes are issued, within 3 working days after the meeting is held
- Respect for each team member and not interrupting the contributor
- Time to reflect on
- Summarise actions and agree escalation to project team and stakeholder communications - what is shared and how

TERMS OF REFERENCE

KENT AND MEDWAY PATHOLOGY NETWORK EXECUTIVE TEAM

1. **Constitution**

Kent and Medway Pathology Executive Team has delegated responsibility from the Kent and Medway Pathology Network Board to plan, develop, deliver and report on the pathology network projects as set out in the network collaboration agreement towards a maturing network by March 2025.

2. **Scope**

The Kent and Medway Pathology Executive Team will lead and manage the delivery of network programme and projects within an overall framework of the NHSE maturity matrix. It will provide a forum for structured discussions on the local and national issues facing the Pathology Network. It aims to support each of the Trusts covered in the collaboration agreement in meeting their objectives by discussing and agreeing the implementation of service improvements across the network and by ensuring the network services are clinically, operationally and financially effective and meets the needs of its users.

3. **Aims, Functions and Objectives**

3.1 To manage the delivery and monitoring of the NHSE maturity action plan towards a maturing network by March 2025.

3.2 To hold project steering groups to account for the delivery of project milestones, supporting across the programme where required.

3.3 To receive and discuss current data on activity, quality, performance and workforce.

3.4 To develop a strategy for future service provision aimed at meeting the needs of service users in an efficient and cost effective manner.

3.5 To receive communications from both within and outside the Trusts in order to inform members of developments both locally and nationally.

3.6 To discuss the financial position of Pathology in each Trust and across the network, highlight any areas of budget pressure, and discuss remedial action.

3.7 To keep an up to date risk and issue log to include those which may impact on service provision as well as on network project delivery.

3.8 To develop and discuss management of implementation of any agreed changes at an operational level.

3.9 To review research and development opportunities.

3.10 To discuss the strategic position of the Trusts and ICS and how this will impact on Pathology.

3.11 To ensure effective communications and engagement with internal and external stakeholders

3.12 To ensure network values and behaviours underpin all network activities

3.13 To receive minutes from steering groups and the clinical advisory committee

4. **Membership**

Position	Role on the Pathology Executive Team
Chair (Network Clinical Director)	• Ensures network development and delivery aligns with the requirements of the NHSE maturity matrix. • Ensures that the network is well managed and delivers value for money. • Ensures network direction and strategic objectives meet patient safety and quality requirements • Engages with transitional speciality leads to ensure their views are represented. • Holds the Managing Director to account to deliver their objectives. • Holds executive team members to account for their role as outlined below. • Chairs executive team meetings ensuring members are enabled to fulfil their role and that ways of working are supported.
Network Managing Director	• Leads on the day to day delivery of network services. • Facilitates the flow of information to and from the Pathology Executive Team, steering groups and CAC. • Escalates risks and issues as required • Ensures agenda and papers support the achievement of network objectives and are developed through steering group/s and CAC as appropriate. • Ensures the network is appropriately resourced • Provides support to and deputises for the network Clinical Director
Pathology Network (interim) Finance Director	• Reporting financial risks and concerns to the Executive Team. • Link to ICB strategic and capital planning leads. • Supports the Executive Team in setting and monitoring annual and multi-year budgets. • Supporting the financial aspects of business plans and business case. • Supports the realisation of cash-releasing benefits.
Pathology Network (interim) Workforce, education & network development Director	• Reporting workforce risks and concerns to the Executive Team • Supports the Executive Team in ways of working and team development.

Position	Role on the Pathology Executive Team
	• Supports the chair of the workforce, education and network development steering group to deliver the workforce strategy • Supports the workforce, education and network development aspects of business plans and business cases. • Supports the realisation of non-cash-releasing and qualitative benefits. • Provides people management expertise in matters relating to network development, resourcing, career development and talent management
Pathology Network (interim) Digital director	• Reporting risks and concerns relating to digital transformation to the executive team. • Supporting the digital aspects of business plans and business cases. • Supports the chair of the digital steering group to deliver agreed pathology digital projects • Supports the realisation of benefits associated with digital transformation.
Pathology Network (interim) procurement director	• Reporting procurement risks and concerns to the executive team. • Supporting the procurement aspects of business plans and business cases. • Supports the realisation of benefits associated with procurement.
Pathology Services senior leaders	• Leads on agreed network projects within their identified and protected network time • Represents pathology services within their Trust/s from an operational perspective • Engages with operational colleagues in own Trust/s and across the ICP system • Represents all pathology disciplines in their service. • Ensures documents for approval meet operational requirements
Pathology Clinical Directors	• Represents their pathology service on the Programme Board from a clinical leadership perspective. • Ensures documents for approval meet patient safety and quality requirements • Engages with clinical colleagues in own Trust/s and across the ICP system • Represents all pathology disciplines in their service.

Position	Role on the Pathology Executive Team
Project Directors (LIMS and MES)	• Responsible for day to day project delivery • Reporting risks and concerns to the Executive Team • Reports on business case development and presents for approval • Supports steering group chair for ensuring delivery of aspects of project delivery
Steering group chairs (may also hold another role as above)	• Accountable for project delivery • Holds steering group members to account for aspects of project delivery
Programme support manager	• Ensures meetings are scheduled and papers are presented professionally and timely • Ensures appropriate minute taking and minutes reviewed by chair before circulating

Additional attendees for specific agenda items and leads of individual workstreams may also be invited but do not have decision making power.

5. **Quoracy**

The Pathology Executive Team will be quorate with the chair, a clinical director or pathology service senior leader or nominated deputy from each trust; and one other network director.

Members are asked to nominate a regular deputy and to ensure they can attend in their absence and are suitably prepared for the meeting.

Where a executive team meeting is not quorate, any decision or recommendation to the network board will be unable to be agreed and will be carried forward to the next meeting. Where carrying forward to the next meeting would impact on the critical path of a project or network delivery, member approval will be sought by email/telephone by the network clinical director or managing director.

6. **Frequency of meetings**

Meetings will be held monthly for 2 hours.

7. **Reporting**

The Pathology Executive Team will report into the Pathology Network Board.

8. **Admin Support**

Admin support for executive team meetings will be provided from the network team.

9. **Ways of Working**

Ways of Working in Meetings and in the workplace

- Respect for each board member; as it is one team delivering the network.
- If unable to attend a meeting, then advise the meeting co-ordinator in advance

- Be appreciative – focus on what's going well first.
- Honesty and transparency (NB exception for commercially sensitive information)
- Giving timely feedback, both positive and constructive, to individuals
- Asking for advice and help when you need it
- Open to all ideas, critique and challenge
- Escalate issues to project team rather than outside the programme governance
- Everything is a learning opportunity
- Involve teams at all stages
- Respect work/life balance
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10. **Meetings governance**

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- Meeting notes are issued, within 3 working days after the meeting is held
- Respect for each team member and not interrupting the contributor
- Time to reflect on
- Summarise actions and agree escalation to project team and stakeholder communications - what is shared and how

B Job Descriptions for the Network Clinical Director and the Network Managing Director

JOB TITLE: Kent and Medway Pathology Network Clinical Director

BAND: Consultant plus Responsibility Allowance or Band 9 for clinical scientist

CARE GROUP: Kent and Medway Pathology Network (KMPN) hosted by Finance

DEPARTMENT: Kent and Medway Pathology Network

HOURS OF WORK: 0.6wte/6 PA

RESPONSIBLE TO: KMPN Board SRO

ACCOUNTABLE TO: KMPN Board SRO/Professionally accountable to employing Trust Chief Medical Officer

BASE: Clinical base with visits to other K&M hospital sites

Please note: The network Clinical Director role will be appointed for a period of 3 years subject to satisfactory performance and will be given a separate Contract of Employment in respect of the Clinical Director duties. The job description will be reviewed on an annual basis in line with the progression of the network. Subject to mutual agreement this Contract may be extended for a further period up to a maximum of six years.

Additional clinical PAs will be available for external candidates at one of more of the network sites.

JOB PURPOSE:

The post holder will be responsible for providing high-level strategic and clinical leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Clinical Director will be accountable to the Network Board SRO and clinically accountable to the Chief Medical Officer at their employing Trust.

KEY RESULT AREAS:

- The Clinical Director will be responsible for providing the necessary strategic direction, leadership and vision, to enable KMPN to meet its vision and objectives towards a maturing network by 2025 and will have a key role in the provision and development of services.
- The Clinical Director will be accountable to the Network Board for the clinical, scientific, operational and financial performance of KMPN, delegating aspects of these functions as appropriate.
- The Clinical Director will be supported by and work in close partnership with a Managing Director, accountable to the Clinical Director.
- The Clinical Director will be professionally accountable to the employing Trust CMO, who will provide support, where appropriate, to ensure that the Clinical Director delivers his/her responsibilities with regard to Clinical Governance.
- The Clinical Director will be responsible for ensuring that systems and processes are in place to effectively manage the Clinical Governance and Patient Safety within the Network.
- The Clinical Director ensures ensuring that systems and processes are in place to effectively manage network values and behaviours underpinning the strategic and operational development of the network including effective staff engagement and involvement of the KMPN Pathology workforce.

RESPONSIBILITY:

- Provide strategic direction for the development of service strategy, to enable the delivery of services within the network.
- Chair the Network Executive leadership team and Clinical Advisory Committee, making decisions according to delegated authority and recommending a course of action to the KMPN Board.
- Oversee the implementation of a comprehensive programme of quality improvement activity and patient safety by ensuring PQAD implementation and monitoring, a Clinical Audit programme in place, and that practice is based on evidence.
- Promote a culture of inquiry and research in the network,
- Ensure that risk is properly managed within the Network, ensuring a positive culture of learning from success and that serious incidents (SIs), adverse events and complaints are properly and comprehensively responded to in line with the Patient Safety Incident Reporting Framework.
- Ensure that clinical standards, GIRFT and NICE recommendations are implemented as appropriate by the Services
- Lead the development and implementation of Key Assurance Indicators
- In line with the network maturity matrix action plan, develop an agreed Business Plan which reflects quality and efficiency targets. agreed with the requesting services according to local pathways.
- Ensure the proper allocation and utilisation of resources necessary to meet the objectives and targets contained in the collaboration agreement once implemented, in relation to quality, volume and cost.
- Ensure equality of access to pathology services and maintain safety across Kent and Medway working with Trust medical directors.
- In collaboration with the Trust clinical directors, ensure that all Medical and Clinical Scientist staff within KMPN Pathology operate within clear lines of responsibility and accountability.
- Once appointed, agree with each transitional discipline lead within the Network, the arrangement of their network role within their annual job plans.
- Assurance that all staff have an annual appraisal in accordance with Trust policy and meets revalidation and professional registration requirements.
- Ensure that there is appropriate provision for Continuing Professional Development for all staff in the Network.
- Ensure that all targets set by external regulators are understood and met.
- Engage in succession planning, with particular reference to the identification and development of colleagues with an interest in clinical management.
- Develop and implement with the Trust clinical directors a transition from Trust clinical leadership to network clinical leadership ready for the next network phase.
- Agree with the network board annual objectives for KMPN and setting annual objectives for other staff as appropriate.
- To help define and implement a network way of working; support this and model its values and champion the evolution of the network

- Represent KMPN at relevant ICB forums and with external agencies.
- Ensure that a “Duty of Candour” is maintained with services users/carers at all time.
- Ensure services are able to be delivered safely and in accordance with the requirements of the Health and Social Care Act, including monitoring the quality and safety at each site of responsibility, identifying breaches, escalating them and acting on them as soon as possible.
- Be responsible for ensuring a regular process of review is in place to detect incidents that indicate adverse quality of care, and triangulate.
- The clinical director will act as the line manager for the network managing director and the transitional quality lead in the network part of their role
- The clinical director will operate a matrix management with dotted lines to and from the individual Trust pathology clinical directors and transitional discipline clinical leads and quality lead
- The programme management team (PMO) reports to the managing director and, as a team, support the clinical director through agreed delegated responsibilities.

The Clinical Director, Managing Director, pathology senior leaders and Finance Director for KMPN will agree an annual budget for the network PMO and projects with the network board and member organisations. They will be responsible for the effective and efficient use of that budget to deliver the agreed network projects.

ENVIRONMENT:

Working Conditions: Some working at home with some travel to other hospital laboratories and meeting venues.

Travel as required to meet the requirements of the role across Kent & Medway.

Physical Effort: Frequent screen and keyboard work with virtual meetings. Some driving to acute hospital sites.

Mental Effort: Significant concentration, problem-solving and project management.

Working under pressure to meet project key milestones - a flexible approach to work patterns is required.

Emotional Effort: Managing conflicting priorities and resistance to change. Manage multidisciplinary relationships across multiple organisations, regularly dealing with contentious issues.

JOB SUMMARY:

The post holder will be responsible for providing high-level strategic and clinical leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Clinical Director will be accountable to the Network Board SRO and clinically accountable to the Chief Medical Officer at their employing Trust.

COMMUNICATIONS AND WORKING RELATIONSHIPS:

Internal	Pathology clinical directors and leads across Kent and Medway Clinical chiefs and leads across disciplines across Kent and Medway Pathology staff Pathology Network PMO and board members Staff within multiple project workstreams

Other NHS	ICB Primary Care NHSE Other pathology networks Other staff in network Trusts
External to NHS	RCPath IBMS Patients and public

- To maintain credibility with all key players within the network, fostering a culture of collaboration for the delivery of equitable, high quality care. At times this will include acting as an 'honest broker' reconciling conflicting views and interests.
- To foster and promote a culture of clinical engagement and influence ensuring the network is clinically led
- To support and help maintain the network structures that supports widespread multidisciplinary involvement including medical, clinical scientists, biomedical scientists, support staff and managers
- Enabling patient and public involvement
- To act as a champion for patients and their interests and support the appropriate involvement of the public and patients in the development of network programmes and decision-making
- Promoting equality and reducing inequalities
- Establish and maintain collaborative working relationships with all partners and commissioners.
- To effectively engage with other clinical networks where synergies exist around the achievement of outcome ambitions and integrated care pathways
- To engage and develop collaborations for quality improvement across the network, for the realisation of equitable access to quality care and the achievement of outcome ambitions for patients
- To work with other structures, including Academic Health Science Networks aligning innovation, education, informatics, and quality improvement
- To work with national level bodies ensuring alignment of policy and service transformation for patients
- Regularly meet with clinical and non-clinical staff to ensure they remain engaged in the vision for delivering excellence in all we do.
- Establish and maintain effective internal and external communication
- Articulate strategic, clinical and professional issues, including KMPN vision and strategy, to meet the needs of a diverse audience.

STANDARDS OF BUSINESS CONDUCT:

The post holder will be required to comply with the Trust's Standing Orders and Standing Financial Instructions and at all times, deal honestly with the Trust, with colleagues and all those who have dealings with the Trust including patients, relatives and suppliers.

HEALTH AND SAFETY:

The post holder will be required to observe local Health and Safety arrangements and take reasonable care of him/herself and persons that may be affected by his/her work.

SAFEGUARDING:

All staff have a duty to identify, report and record incidents of potential or actual abuse. This statement applies whether the victim is an adult or child. All queries will be addressed by the Trust Safeguarding Team.

PERFORMANCE REVIEW:

This job description will be used as a basis for individual performance review between the post holder and the Manager.

The job description covers only the key result areas, and as such does not intend to provide a comprehensive list of objectives. Specific objectives will be reviewed each April, and may develop to meet the changing needs of the service.

The post holder will need to take due account, in the way they achieve the key result areas of Trust policies and procedures.

The Trust aims to maintain the goodwill and confidence of its own staff service and users and the general public. To assist in achieving the objective it is essential that at all times, employees carry out their duties in a courteous and sympathetic manner.

The post holder will carry out their duties in accordance with the Trust Equal Opportunities Policy respecting the differing backgrounds of colleagues and clients.

CONTINUOUS IMPROVEMENT:

The Kent and Medway NHS and Social Care Partnership Trust has adopted a strategy for Continuous Improvement and all members of staff employed by the Trust are expected to play an active role in development and improving services to the benefit of patients.

THE TRUST'S MISSION STATEMENT:

To put patients first by providing community based, high quality and responsive healthcare services, delivered by well trained and supported staff who work with relatives, carers and other agencies in the best interests of patients.

STATEMENT OF THE TRUST'S AIMS AND VALUES:

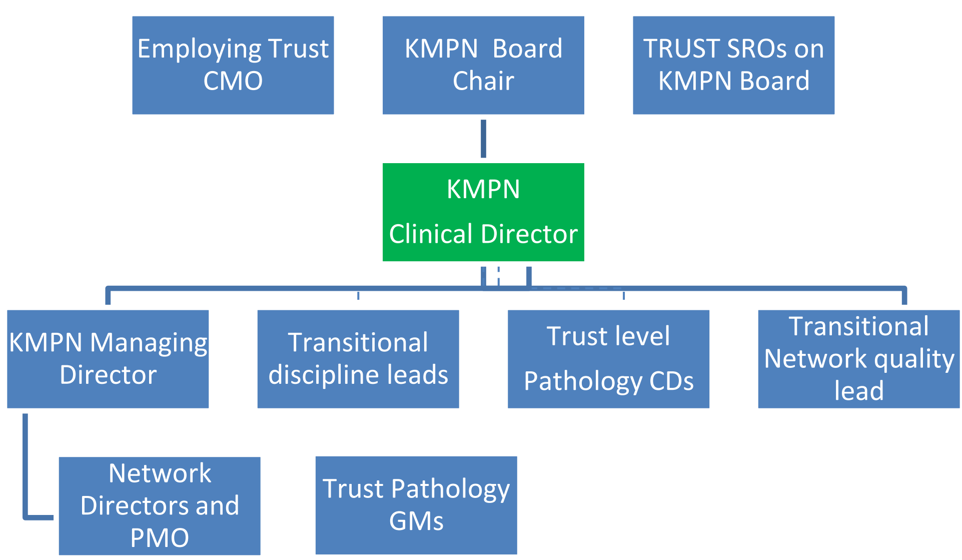
- To remain patient focused at all times by providing high quality and responsive healthcare services in hospitals and the community.
- To work closely with patients, their families, carer groups, local communities and other organisations ensuring care is co-ordinated.
- To respect and develop every member of staff by encouraging and supporting them in their personal and professional development and by valuing their input through recognition and individual reviews.

- To be innovative and proactive by encouraging staff to initiate new ideas in working practices and ensuring a process and continuous improvement in the way services are provided.
- To provide best practice and value-for-money by reviewing and evaluating services and sharing information internally and externally.

CONFIDENTIALITY:

The Kent and Medway NHS and Social Care Partnership Trust employees are required to ensure that information about patients is safeguarded to maintain confidentiality and is kept securely in accordance with NHS requirements of 1999. (The Caldicott Committee's Report on the review of patient-identifiable information 1997, & HSC/1999/012). This means that patient information can only be passed to someone else if it contributes to the provision of care or the effective management of health care services within the Trust.

ORGANISATION CHART:



Person Specification

Knowledge, Skills, Training and Experience

	Essential	**Desirable**
Training, Qualifications and Registration	▪ FRCPath ▪ Employed at consultant level ▪ Experience of Senior Management ▪ Evidence of continuous professional and leadership development ▪ GMC or HCPC registered	• Leadership qualification
Experience	▪ Clinical leadership roles in Pathology ▪ Credible to medical and other clinical and scientific colleagues	▪ Experience as clinical director or clinical lead

	Essential	Desirable
	▪ Experience of partnership working and amalgamating services across hospitals ▪ Experience working in acute hospital settings within Pathology services. ▪ Experience of leading complex change	
Knowledge and Skills	▪ Excellent leadership skills and the ability to build and motivate high performing teams ▪ Highly developed interpersonal skills, negotiation, conflict management, feedback, partnership working, and coaching skills ▪ Expert understanding of specialist healthcare science activities and management knowledge acquired through higher specialist training ▪ Strategic system-level thinker and ability to implement and embed system-level strategy successfully ▪ Implementation of different options on the effectiveness of the network as a whole ▪ Sensitive to clinical and political demands. ▪ Able to analyse and interpret highly complex information in a variety of formats ▪ Able to analyse situations and facilitate creative solutions using a collaborative team approach ▪ Knowledge of evidence-based policy making and NHS governance ▪ A good understanding of how to use data and financial incentives to improve quality and productivity ▪ To have a good understanding of integrated models of care across primary, secondary, tertiary and community care and appreciation of NHS contracting processes ▪ The ability to build excellent collaborative networks ▪ The ability to deal with ambiguity and complexity ▪ Able to assimilate complex and lengthy information and make decisions in an ambiguous and fast-moving environment ▪ Ability to communicate with stakeholders and the media, and convey complex messages to different recipient groups.	• Commercially focused within a healthcare setting • Proven ability in basic or translational clinical research

	Essential	Desirable
	▪ Able to develop effective and mutually supportive relationships with key partners within and without organisations ▪ Strong intellectual, strategic, and systemic thinking skills, with the ability to think creatively and laterally to achieve outcomes ▪ Able to make decisions confidently and consistently	

JOB DESCRIPTION

JOB TITLE: Managing Director

BAND: Agenda for Change Band 9

ACCOUNTABLE TO: KMPN Clinical Director

RESPONSIBLE TO: KMPN Clinical Director

TEAM NAME: Kent and Medway Pathology Network (KMPN)

BASE: Magnitude House as official base but work from Kent House and home with visits to other K&M hospital sites

CARE GROUP: KMPN hosted by Finance

SETTING (Inpatient, Community, etc.): Hospital laboratories

HOURS: 37.5h/week

The KMPN Managing Director is a new role developed to support the clinical director in leading through transformation to a maturing network and beyond.

KMPN is made up of seven laboratories across three pathology services in four acute Trusts – East Kent Hospitals University NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust and North Kent Pathology Services (hosted by Dartford and Gravesham NHS Trust and providing services to Medway Foundation Trust). The network provides services to a population of nearly 2 million in the Kent and Medway CCG/ICS area and into East Sussex, including direct access to all GP practices. There are nearly 800 staff working in pathology in Kent and Medway and the total pathology budget across all the services is over £50m.

Pathology services are currently structured as follows:

- Darent Valley Hospital at Dartford provided by Dartford and Gravesend NHS Trust operates a hub site for hot and cold work under North Kent Pathology Service (NKPS).
- Medway Maritime Hospital at Gillingham provided by NKPS operates as an Essential Service Laboratory (ESL) as well as Andrology and Foetal Medicine Unit screening.
- Queen Elizabeth Queen Mother Hospital at Margate provided by East Kent Hospitals University NHS Foundation Trust (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 haemophilia, haemostasis and thrombosis services.

- William Harvey Hospital at Ashford provided by EKHUFT provides hot and cold pathology services including full pathology support to the Kent Cancer Centre. East Kent also conducts the majority of immunology work for the region.
- Maidstone Hospital provided by Maidstone and Tunbridge Wells NHS Trust (MTW) operates a full hot and cold laboratory with Blood Sciences, Microbiology and Cellular Pathology. In addition, Cellular Pathology provides the Histology and 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.

JOB PURPOSE:

The post holder will be responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The job description will be reviewed for the next phase of the network journey. The Managing Director will be accountable to the Network Clinical Director.

KEY RESULT AREAS:

- The Managing Director will be responsible for providing the necessary strategic direction, leadership and vision, to enable KMPN to meet its vision and objectives towards a maturing network by 2025 and will have a key role in the provision and development of services.
- The Managing Director will be accountable to the Clinical Director for the operational and financial performance of KMPN.
- The Managing Director will be supported by and work in close partnership with network directors, project directors and Trust pathology general managers.
- The Managing Director will be responsible for delivery of operational performance and within the Network.
- The Managing Director ensures that network values and behaviours underpin the strategic and operational development of the network including effective staff engagement and involvement of the KMPN Pathology workforce.

Leadership Responsibility

- Provide strategic and operational leadership for the development of network strategy, to enable the delivery of services within the network.
- Responsible for delivery of the NHSE maturity matrix action plan towards a maturing network by March 2025.
- Lead the development and implementation of Key Performance Indicators
- Develop and deliver the single LIMS and procurement of the single set of MSC contracts.
- Ensure appropriate agreements, systems and processes are in place to enable the
- implementation of the network plans in the partner organisations following the terms of the collaboration agreement;
- Avoid the destabilisation of business as usual operations, including activity, quality, safety and accreditation;
- Oversight of the work with the steering group chairs, project leads and programme team and to ensure the network plans are integrated with the overall strategy; ensuring synergy between strategy milestones and objectives;

- In line with the network maturity matrix action plan, develop an agreed Business Plan which reflects quality and efficiency targets. agreed with the requesting services according to local pathways
- Act as the budget holder for the programme and delegated project and service budgets, ensuring the proper allocation and utilisation of resources necessary to meet objectives and targets, in relation to quality, volume and cost.
- Ensure equality of access to pathology services and maintain performance across Kent and Medway working with Trust pathology teams.
- Ensure that all targets set by external regulators are understood and met.
- Engage in succession planning, with particular reference to the identification and development of colleagues with an interest in leadership and management.
- Develop and implement with the Trust general managers a transition from Trust leadership to network leadership ready for the next network phase.
- Translate KMPN annual objectives into team and individual objectives.
- Lead the planning and design of the projects to meet the vision and strategic direction;
- Manage the activities necessary to ensure delivery of a transformational strategy;
- Responsibility for the overall planning of the strategy and for providing vision and strategic direction to the team;
- To help define and implement a network way of working; support this and model its values and champion the evolution of the network.
- Coaching and supporting the network team and steering group chairs.
- Represent KMPN at relevant ICB forums and with external agencies.

<u>Management Responsibility</u>

- The managing director will act as the line manager for the network directors and project directors and is the day to day lead for the PMO
- The Trust pathology general managers will report to the managing director for their network role as agreed by Trust boards
- Managing, monitoring and reporting on benefits realisation management, tracking the progress and ensuring that the intended benefits are achieved with outcomes maximised;
- Provide and receive highly complex, sensitive and contentious information, including presenting information about projects and dependencies to a wide range of internal and external stakeholders in formal settings.
- Defining and implementing business processes that support the functions of the network;
- Define and manage the governance processes of the network;
- Proposes changes to and making recommendations for the programme and projects as appropriate;
- Contribute to the review and development of existing programme and project information management systems and contribute to the development of an integrated approach to project management;
- Lead the implementation of the programme and projects outputs to achieve the desired benefits;
- Motivate, challenge and inspire staff throughout the network to role model leadership and network values
- Ensure plans are in place to develop the network support and wider project teams including

talent management and succession planning;

- Provide and receive highly complex, sensitive and contentious information, including presenting information about the programme and dependencies involving a wide range of stakeholders in formal settings: therefore, the post holder must have the ability to deal with resulting potentially challenging situations;
- Ensure the learning from research and development activities is effectively shared across the network.

Financial Responsibilities

- The Clinical Director, Managing Director, General Managers and Finance Director for KMPN will agree an annual budget for the network PMO and projects with the network board and member organisations. They will be responsible for the effective and efficient use of that budget to deliver the agreed network projects.
- Responsibility for providing guidance and management on the procurement of identified products, equipment, services and facilities for the network, to execute required services – from defining requirements, developing specification, developing bid evaluation methodology,
- Act in a way that is compliant with Standing Orders and Standing Financial Instructions of the relevant organisations in the discharge of budget management responsibilities;
- Constantly strive for value for money and greater efficiency in the use of these budgets and to ensure that they operate in recurrent financial balance year on year.

ENVIRONMENT:

- Working Conditions: Some working at home with some travel to other hospital laboratories and meeting venues.
- Travel as required to meet the requirements of the role across Kent & Medway.
- Physical Effort: Frequent screen and keyboard work with virtual meetings. Some driving to acute hospital sites.
- Mental Effort: Significant concentration, problem-solving and project management.
- Working under pressure to meet project key milestones - a flexible approach to work patterns is required.
- Emotional Effort: Managing conflicting priorities and resistance to change. Manage multidisciplinary relationships across multiple organisations, regularly dealing with contentious issues.

JOB SUMMARY:

The post holder will be responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The job description will be reviewed for the next phase of the network journey. The Managing Director will be accountable to the Network Clinical Director.

COMMUNICATIONS AND WORKING RELATIONSHIPS:

Internal	• Pathology leads across Kent and Medway • Service leads across disciplines across Kent and Medway • Leadership teams in partner organisations • Pathology staff • Pathology Network PMO and board members • Staff within multiple project workstreams
Other NHS	• ICB • Primary Care • NHSE • Other pathology networks
External to NHS	• RCPath • IBMS • Suppliers • Patients and public

- Operate effectively in a flexible and demanding environment and proactively engage with stakeholders.
- Communicate, proactively, build good working relationships and provide information and advice to a wide range of internal and external stakeholders on a range of business sensitive issues.
- Lead as an expert; integrating systems and managing effective working relationships with the appropriate stakeholders.
- Drive and challenge each key working relationship to innovate and drive reform to achieve agreed objectives.
- Provide and receive highly complex, sensitive and contentious information, including
- presenting information about projects and dependencies to a wide range of internal and
- external stakeholders in formal settings.
- Manage potentially aggressive and/or antagonistic situations with staff and stakeholders
- within change programmes for successful outcomes.
- Deal with complex and conflicting subject matter problems or in day today work load in workshops, meetings, one to one communications and other events, comprising various parts of the business.
- Nurtures key relationships with senior and high-profile individuals and responsible for the maintenance of networks.
- Employ effective communication, negotiation and influencing skills to enable stakeholder relationships to deliver objectives
- Internal leaders and staff to gain input to the development of systems, processes and

- activities.
- Represent the network in sensitive and political situations, delivering difficult messages where required to high-level audiences.

STANDARDS OF BUSINESS CONDUCT:

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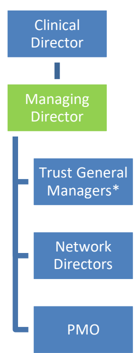

*the GMs will report to the MD for the part of their role identified for network activities

PERSON SPECIFICATION

JOB TITLE: KMPN Managing Director

KNOWLEDGE, SKILLS TRAINING AND EXPERIENCE:

	Essential	Desirable
Training and Qualifications	▪ Educated to master's level in relevant ▪ subject or equivalent level of experience of working at a similar level in specialist area ▪ Post graduate management/leadership ▪ qualification or relevant experience ▪ Evidence of Continued Professional Development	▪ Masters level understanding of Pathology Scientific Disciplines

	Essential	**Desirable**
Experience	▪ Proven and significant leadership ▪ experience ▪ Significant management experience at senior level in the NHS ▪ Experience of leading transformational change in clinical services ▪ Proven experience of leading and ▪ delivering complex change and strategy development programmes in a politically sensitive and complex environment ▪ Experience of 'leading when you're not in charge' across multiple organisations ▪ Significant experience and understanding of programme and project management methodologies ▪ Extensive experience of delivering presentations to large groups of stakeholders in often pressured and politically sensitive environments ▪ Experience of managing and prioritising a large budget ▪ Experience of creating a new team and motivating and inspiring staff to work together to achieve a common objective	▪ Experience of leading transformational change in pathology services
Knowledge and Skills	▪ Dynamic personality and the ability to build trusted stakeholder relationships and wide support networks in a political context like the NHS in Kent and Medway ▪ Leadership, vision, strategic thinking and planning with highly developed political skills ▪ Ability to make decisions autonomously, when required, on ▪ difficult issues ▪ Ability to diffuse volatile, emotive or ▪ antagonistic situations ▪ Ability to resolve complex problems ▪ through win/win approach ▪ Openness and championing new ways of working including digital innovations ▪ Ability to strategically plan, ensuring ▪ continuity between Strategy and ▪ operational delivery plans	

	Essential	Desirable
	▪ Ability to identify, evaluate and support continuous development of services ▪ Demonstrated capability in matrix ▪ management and leadership ▪ Ability to analyse highly complex issues where material is conflicting and drawn from multiple sources ▪ Demonstrated capability to act upon ▪ incomplete information, using experience to make inferences and decision making ▪ Ability to analyse numerical and written data, assess options and draw appropriate conclusions ▪ Ability to provide informative reporting on finances and impact to Boards ▪ Demonstrated capability to plan over short, medium and long-term timeframes and adjust plans and resource requirements accordingly ▪ Ability to manage own workload and ▪ make informed decisions in the absence of required information, working to tight and often changing timescales ▪ Ability to delegate effectively ▪ Ability to work effectively between ▪ strategic and operational activities where required ▪ Working knowledge of Microsoft Office with intermediate keyboard skills ▪ Ability to promote equality of opportunity and good working relationships in employment and service delivery.	
Approach to Values	▪ Ability to maintain and communicate optimism in a challenging environment ▪ Team worker ▪ Self-motivated, able to work proactively ▪ Able to demonstrate drive and commitment ▪ Clear focus on improved efficiency and service improvement ▪ Ability to prioritise conflicting demands ▪ Personal resilience and confidence ▪ Effective motivator with strong influencing skills and personal credibility	

	Essential	Desirable
	▪ Focused on delivering objectives and improvements to patient services ▪ Demonstrable commitment to and focus on quality, promotes high standards to consistently improve patient outcomes ▪ Values diversity and difference, operates with integrity and openness ▪ Uses evidence to make improvements, seeks out innovation ▪ Actively develops themselves and others	
Other	▪ Ability to travel across Kent and Medway	

PART 3

RISK AND BENEFIT SHARE

Financial principles

ISSUE	Commencement	To be revised during 2023/2024
Start Budget	Included 'as -is' Direct cost. Initial budget set as per Trust budget setting methodology. In year from 23/24 to be managed as a total so any under/overspend contained within the total. i.e., Trusts to match outturn to budget each month and KMPN Board will provide a report to Trusts for inclusion in forecasts	Budgets to be set on the same assumptions. All direct costs to be included for services within Scope
CIPs	3% p.a. Programme savings net of any required investment to support delivery of CIP. i.e., not additional Evidence efficiency via benchmarking to be used to identify the level of efficiency required. E.g., use of Model hospital and GIRFT. Annual planning to provide assurance of relevant level of efficiency against benchmarking and level of self-funded transformation costs.	Clause to enable agreement of some additional CIP if financial position of Trusts requires more than uplift CIP
Inter Trust billing	No change	Current process is slow and causes aged debt therefore whole process to be overhauled and simplified.
Transfer of tests between Trusts	Costs to be at marginal rate	Need to restart the repatriation work as part of the TOM review. Agree process for test transfer
Repatriation of tests	Tests repatriated between members approved by all members. Financial impact to be equitable between all affected members.	Formal change control process for all test changes to be agreed.
Financial Transactions	Full disclosure by members at transaction level to KMPN for spend and WTE	Single Staff and skill mix changes procedure to be agreed
Planning	Setting the baseline budget to be within the system planning timeline	Have agreed process on planning in a timely fashion to enable decision making

Risk Share

The Parties agree the risk sharing profile set out in the table below subject to any agreed changes via the Change Control Procedure. With respect to the MES Contract, any savings will be recovered by the relevant Trust benefitting from such savings and the MES Contract shall be procured in accordance with the MES Procurement Strategy.

	MTW	EKHFT	NKPS
Network Costs	25%	25%	50%
LIMS	33%	34%	33%
MES	As incurred	As incurred	As incurred
Outturn	The Parties will finalise the risk sharing profile in respect of any surplus/deficit in the budget as part of the arrangements for the establishment of a single management structure and move towards a single service (as described in Recital (C) and (D) of this Agreement).		

PART 4

WORKFORCE AND ORGANISATION DEVELOPMENT

- Development of a Network staff bank to enable - Network staff to work across the Network sites & to support /enable development opportunities using K&M staff seamless Pass-Porting scheme
- Kent &Medway Network combined procurement process for apprenticeship & University recruitment
- Freedom to develop and agree standard job descriptions and job banding – irrespective of, however observing and working within sovereign organisations
- Combined recruitment events for established roles, independent employing organisations to alternate responsibility for hosting the events whilst autonomous organisations maintain constitutional employment rights
- Network process for combined bids for education funding
- Collaborative approach for the process of developing & training Clinical Scientists within the sovereign organisations across the Network
- Collaborative approach to HEE pathways for STP/HSST training &funding (as a precursor to joint accreditation)
- Open, transparent and inclusive approach to network development and design in partnership with staff and staff representatives

Workforce Schedule

1. Development opportunities through shadowing or working on other sites will be agreed through individual staff appraisal and personal development plans.

   Staff will be enabled through the K&M staff passporting scheme to work on other sites when mutually agreed as a development opportunity or part of a training programme.
   In an exceptional circumstance, e.g. pandemic, when business continuity, staff may be required to work on another site in accordance with the current emergency planning guidance.

2. Apprenticeships

   The network education leads group in conjunction with operational leads from each Trust develops an annual apprenticeship plan to meet workforce needs and presents to the workforce steering group for oversight. One of the partner Trusts tenders and manages apprenticeship contracts on behalf of the network. The apprenticeship levy offsets the cost of the apprenticeships at a sum agreed by each Trust and the network.

3. University students

   The network education leads group develops an annual student placement plan to meet workforce needs and presents to the workforce steering group for approval. The network education and training team including Trust education leads develop and maintain relationships with university leads and negotiate a number of placements each year based on the needs of the network. Students are recruited through a joint selection process including all disciplines on all sites with all university partners.

   All new network role design and recruitment to use standard job descriptions, tailored to individual service or discipline requirements. The standard job descriptions will incorporate key requirements of each employing organisation relevant to the pay band.

4. New network role job descriptions requiring job evaluation will be drafted by relevant managers with HRBP support and evaluated once by a panel comprising HR reps and staff side reps from within each employing Trust.

   Where similar jobs are currently banded differently between organisations, the HRBPs will review the job descriptions and submit a standard job description for job evaluation to a panel comprising HR reps and staff side reps from each employing Trust. For this iteration of the agreement, roles undergoing such harmonisation will be limited to pathology-specific roles e.g. laboratory assistant, pathology quality lead, to avoid impact on other professions outside of pathology.

   Funding of new or re-evaluated posts will depend on Trust affordability.

5. Combined recruitment events for roles where there are aligned Job Descriptions in scientific and administration posts, that are challenging to recruit into across the independent employing organisations.

   The Pathology Services across the Network would agree to alternate responsibility for hosting the events in collaboration with their recruitment team whilst autonomous organisations maintain constitutional employment rights.

   Candidates will be asked to express a preference for work base at the event and the post-recruitment process will include matching candidates to Trusts.

6. Network goals and plans will be fed into the Trust workforce plans to ensure that Trust workforce plans align with network direction and projects.

   Trust goals and plans will be fed into the network workforce plans to ensure that network workforce plans align with Trust direction

   Recruitment at band 8b and above leadership roles and B7 and above non-scientific roles e.g. quality, education, to be considered and validated by the workforce steering group.

7. Talent management process aligned to workforce plan and succession planning managed by the pathology leadership and facilitated by the Workforce Project Director and Practice Educator.

   Career development workshops for individuals and managers facilitated by the PMO and education leads.

   Interactive career development resources on NHS Futures and/or network website.

   The talent management process will link to Trust career development and talent management where career ambitions extend beyond pathology.

8. A single education and training plan for the network to support workforce plans.

   The education and training plan is costed by the PMO and submitted to the ICB People and OD team/HEE for annual funding round and any ad-hoc in year funding.

   The education and training plan is updated mid-year.

   Internal Trust budgets for education and training are devolved to the network on a per capita basis.

9. The network values include principles of an open, transparent and inclusive approach. The network PMO is responsible for a robust communications strategy.

   Communications are two-way between the network leadership and network staff.

   All pathology staff are briefed on network developments via monthly bulletins and lab visits.

A network website and social media accounts are kept updated on a weekly basis.

Questions and ideas from pathology staff are logged and used to develop a frequently asked questions page.

Pathology staff are encouraged and enabled by their managers to take part and be involved in network developments including focus and working groups, act as change champions, education and training events and conferences.

A joint management and staff partnership group will meet quarterly or as required to consider proposed network developments and any impact on staff, in liaison with pathology staff and Trust HRBPs.

PART 5

TRANSFORMATION PROGRAMME

PROJECT	Milestone	v0.2 of the Procurement Strategy Document
Service Change business case		
	FBC complete	30/09/2027
MES (MSC) business case		
	Select MES Primary Provider (PP)	24/05/2023
	MES procurement against the specs	30/04/2024
	MES specifications x8 (run by PP)	27/06/2024
	FBC complete - pre check and challenge	01/09/2024
	Contract award (all contracts)	01/04/2025
Governance		
	MES (MSC) FBC approved by Programme Board	01/10/2024
	MSC FBC approved by Trust Boards	01/11/2024
	MSC FBC approved by NHSEI	01/03/2025
	SC FBC approved by Programme Board	15/09/2027
	SC FBC approved by Trust Boards	31/12/2027
Implementation		
	Go live site 1 LIMS	20/08/2024
	Go live sites 2 LIMS	13/11/2024
	Go live sites 3 LIMS	06/01/2025
	LIMS Project Closed	31/05/2025
	Commence MES (MSC) – MTW	12/09/2024
	Complete MES (MSC) MTW	15/12/2025
	Commence MES (MSC) – EKHUFT	16/12/2025
	Complete MES (MSC) EKHUFT	23/03/2027
	Commence MES (MSC) – NKPS	24/03/2027

PROJECT	Milestone	v0.2 of the Procurement Strategy Document
	Complete MES (MSC) NKPS	17/03/2028
	Commence service change	01/04/2028
	Commence transfer to new GP order comms	TBC
	Complete transfer to new GP Order Comms	TBC
	Commence transfer to new Community Order Comms	TBC
	Complete transfer to new Community Order Comms	TBC
	Programme Closed	30/10/2034

SCHEDULE 3

Network Costs

1. **Network Costs**

1.1 KMPN management posts

1.2 Education and work force post non recurring each Contract Year

1.3 Management Posts

POST	BAND	WTE	£'000
Managing Director	9	1.00	141
Clinical Director		0.60	84
Workforce and OD lead	8D	0.80	94
Finance Lead	8D	0.50	59
IT Lead	8D	1.00	102
Programme support	5	1.00	34
Procurement lead	8A	1.00	61
Non-pay			10
			583
Practice Educator	8B		36
Total			619

NB the functions of a number of these posts are covered by PMO staff. As the network develops from a 'developing' network to a 'mature' network, formal appointment will be made to these posts.

2. **Project costs**

	23/24	**24/25**
	£'000	**£'000**
MES - Project		
MES – project Director	94	94
MES legal fees	68	
MES - Estates lead	53	
MES - PM implementation	0	99
Contingency	10	10
	882	821
LIMS implementation costs	3,044	2,119
LIMS Contingency	73	61
Workforce strategy - HRBPs	16	0

	23/24	24/25
	£'000	£'000
Workforce strategy – Practice Educators	86	0

3. **Funding sources**

	21/22	22/23	23/24	24/25
	£'000	£'000	£'000	£'000
Funding source				
Roll over funding from Acute Trusts	289	695	695	695
Send away saving	57.5	115	115	115
MES extension savings	596	596	596	596
CCG/ICB contribution	569	1,229	1,642	1,150
MES savings		0	0	94
NHSEI non recurrent contribution		235	235	0
	1,512	**2,870**	**3,283**	**2,650**

The ICB approved the LIMS FBC in which it to invest in the Network for four years to deliver the projects.

NHSE has agreed to contribute to Network costs for two years.

4. **Summary hosted Network/PMO costs**

	23/24	24/25
FUNDING	**£'000**	**£'000**
STP Base funding	695	695
Send away saving	115	115
MES extension savings	596	596
MES single contract savings	-	94
ICB contribution	1,642	1,150
ICB rephasing	818	351
NHSEI non recurrent contribution	235	-
	4,101	**3,001**
EXPENDITURE		
PMO	657	619
MES Project	225	202
LIMS	3,117	2,180
Workforce Strategy	102	-
	4,101	**3,001**

5. The Trusts have baseline budgets to deliver the services provided by the KMPN

Baseline BUDGETS

The Parties acknowledge and agree that the baseline budgets set out in this section is for information purposes only, and will be revised and agreed in accordance with the financial principles set out in Part 3 of Schedule 2.

NKPS 18/19	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	960	4,299	318	2,336	524	8,437
NON PAY	13	4,142	3,809	852	9,115	17,931
GROSS COST	**973**	**8,441**	**4,127**	**3,188**	**9,639**	**26,368**
INCOME	0	(7,762)	0	0	(1,105)	(8,867)
NET COST	**973**	**679**	**4,127**	**3,188**	**8,534**	**17,501**

MTW 18/19	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000
PAY	4,636	5,194	1,683	303	11,817
NON PAY	6,968	1,760	1,549	3,944	14,222
GROSS COST	**11,604**	**6,955**	**3,232**	**4,247**	**26,039**
INCOME	(7,291)	(945)	(1,200)	(6,199)	(15,635)
NET COST	**4,313**	**6,010**	**2,032**	**(1,952)**	**10,404**

EKHUFT 18/19	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	1,222	4,580	4,715	2,220	330	13,067
NON PAY	2	7,943	1,175	1,958	3,232	14,311
GROSS COST	**1,224**	**12,523**	**5,891**	**4,178**	**3,562**	**27,377**
INCOME	0	(7,565)	(889)	(1,142)	(2,114)	(11,710)
NET COST	**1,224**	**4,958**	**5,002**	**3,036**	**1,448**	**15,667**

KMPN	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	2,182	13,515	10,227	6,239	1,157	33,320
NON PAY	15	19,053	6,745	4,359	16,291	46,463
GROSS COST	2,197	32,568	16,972	10,598	17,448	79,784
INCOME	0	(22,618)	(1,834)	(2,342)	(9,418)	(36,212)
NET COST	**2,197**	**9,950**	**15,138**	**8,256**	**8,030**	43,572

Baseline Activity -18/19

ACTIVITY - NKPS	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	4,226,654	77,948	314,276	4,618,878
Direct Access - tests	103,380	77,948		181,328
Acute- requests	5,499,741	0	626,868	6,126,609
Acute - tests	130,695	0	0	130,695
NB Excludes MFT blood transfusion				

ACTIVITY - MTW	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	919,669	83,039	162,468	1,165,176
Direct Access - tests	4,229,503	89,842	897,212	5,216,557
Acute- requests	745,768	68,030	414,662	1,228,460
Acute - tests	3,739,066	328,233	833,135	4,900,434

ACTIVITY - EKHUFT	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	1,207,533	39,516	167,450	1,414,499
Direct Access - tests	4,837,563	52,159	212,872	5,102,594
Acute- requests	1,439,177	52,368	367,972	1,859,517
Acute - tests	5,809,532	256,669	474,663	6,540,864

ACTIVITY - KMPN	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	6,353,856	200,503	644,194	7,198,553
Direct Access - tests	9,170,446	219,949	1,110,084	10,500,479
Acute- requests	7,684,686	120,398	1,409,502	9,214,586
Acute - tests	9,679,293	584,902	1,307,798	11,571,993

SCHEDULE 4
Contract Change Requests

1. **Purpose**

1.1 This Schedule sets out the procedure for dealing with Changes, including:

1.1.1 the rights of the Parties to request a Change;

1.1.2 the rights of the Parties to approve or reject a proposed Change;

1.1.3 the apportionment of costs incurred by the Parties in compliance with this Schedule; and

1.1.4 the form of any authorised Change.

1.2 Subject to Paragraph 1.1.4, a Change will not be effective until a relevant Change Control Note has been signed by the authorised representatives of Parties.

1.3 A Change Control Note will be in the form set out at the end of this Schedule.

2. **Requesting a Change**

A Party may submit a written request for Change to the other Parties via the Kent and Medway Pathology Network Executive Team .

2.1 Where a Party wishes to request for Change, it will prepare a Change Control Note and use all reasonable endeavors to provide as much information as possible to the Kent and Medway Pathology Network Executive Team in relation to the requested Change. The relevant Party will submit the Change Control Note to the Kent and Medway Pathology Executive Team .

2.2 If the Network Executive Team and/or Pathology Network Clinical and Operational Committee considers that it requires further information in order to consider the proposed Change, it will notify the relevant party within ten (10) Working Days of receipt of the request. Such notification must detail the further information required. The relevant Party will provide the further information and present it to the Kent and Medway Pathology Network Executive Team within ten (10) Working Days of receipt of the notification for further information.

3. **Consideration of requested Changes**

3.1 The Kent and Medway Pathology Network Executive Team will consider all requested Changes requested under Paragraph 2 of this Schedule and make recommendations to the Network Board .

3.2 The Kent and Medway Pathology Network's Executive Team's recommendation will include a risk score based on the following risk matrix:

Score	Description	Examples
5	Very high	Major impact on this Agreement, the collaboration/any relevant KMPN contracts and/or patients Major disruption to the collaboration/ KMPN contracts. Major financial impact

Score	Description	Examples
4	High	Significant impact on this Agreement, the collaboration/KMPN contracts and/or patients Extensive disruption to the collaboration/KMPN contracts Significant financial impact
3	Medium	Requested Change is unlikely to have any significant impact but Changes to be considered in relation to effect on patients and financial consequences
2	Low	Minor impact on this Agreement, the collaboration/KMPN contracts Minor or no disruption to the collaboration/KMPN contracts Minor or no financial impact
1	Very low	Insignificant impact on this Agreement, the collaboration/KMPN contracts No disruption to the collaboration/KMPN contracts No financial impact

4. **Approval of Changes by the Kent and Medway Pathology Network Board**

4.1 If the Change is approved by the Kent and Medway Pathology Network Board, the Change Control Note shall be signed by all Parties whereupon it shall become effective.

5. **Costs of Changes**

5.1 Each Party will bear its own costs in relation to compliance with this Change Control Procedure.

CHANGE CONTROL NOTE TEMPLATE

CR Number:	Title:	Type of Change: [Contract / Operational] Change
Contract:	Required by Date:	
Action:	Name:	Date:
Raised By:		
Area(s) Impacted (*Optional Field*):		
Assigned for Impact Assessment By:		
Assigned for Impact Assessment To:		
Supplier Reference Number:		
Full Description of Requested Contract Change:		
Details of any Proposed Alternative Scenarios:		
Reasons for and Benefits and Disadvantages of the Requested Contract Change:		
Signature of Requesting Change Owner:		
Date of Request:		

SCHEDULE 5

Hosting Obligations and Hosting Standards

Part 1 - General Obligations

Subject to the timeframes set out in the Transformation Programme the Host shall:

1. employ all the relevant staff of KMPN and provide the human resources and employment support as described in Schedule 10;

2. in all matters regarding legal personality act on behalf of the KMPN, including, without limitation, entering into all contracts, agreement and arrangements in relation to the KMPN if agreed by the Parties;

3. be responsible for all regulatory matters such as:

   3.1 registration with the Care Quality Commission (or its successor body);

   3.2 registration with the Medicines and Healthcare products Regulatory Agency (or its successor body);

   3.3 registration with the Human Tissue Authority and accreditation with the UK Accreditation Service (UKAS).

   3.4 meeting the requirements of NHSE and any relevant ICBs and any other commissioning organisations;

4. set up separate accounting records in relation to the KMPN;

5. prepare financial reports and account for the KMPN in accordance with the agreed accounting principles;

6. supply each Party with the financial and other information necessary to keep the party informed about how effectively the business of the KMPN is performing and in particular shall supply each Party with:

   6.1 a copy of each year's Business Plan for approval in accordance with Clause 8.4;

   6.2 monthly income and expenditure accounts of the KMPN to be supplied within fifteen (15) Working Days of the end of the month to which they relate (the first Working Day being the first Working Day of the following month) and the accounts shall include activity report, a surplus and loss account, a balance sheet and a cashflow statement;

7. provide and monitor the provision of the Pathology Services to the Customers and operate the KMPN as the legal host on behalf of the Parties in accordance with the decisions of and directions of the Kent and Medway Pathology Network Board; and

8. perform the Hosting Obligations to the Hosting Standards (as applicable).

Part 2 - Hosting Standards

1. In its performance of the Hosting Obligations, the Host Trust shall:

   1.1 comply with all instructions of the Kent and Medway Pathology Network Board in relation to the operation and management of KMPN;

   1.2 perform the Hosting Obligations with the best care, skill and diligence in accordance with best practice in the supplier's industry, profession or trade;

   1.3 use personnel who are suitably skilled and experienced to perform tasks assigned to them, and in sufficient number to ensure that the Hosting Obligations are fulfilled in accordance with this Agreement;

   1.4 ensure that the Hosting Obligations conform with all descriptions and specifications set out in any reasonable written specification provided by the Kent and Medway Pathology Network Board;

   1.5 provide all equipment, tools and vehicles and such other items as are required to perform the relevant Hosting Obligations;

   1.6 use the best value goods, materials, standards and techniques, and ensure that all goods and materials supplied and used will be free from defects in workmanship, installation and design;

   1.7 obtain and at all times maintain all necessary licences and consents, and comply with all applicable laws and regulations, in respect of the Hosting Obligations;

   1.8 observe all health and safety rules and regulations and any other security requirements that apply at any of the premises from which the Pathology Services or the Hosting Obligations are provided; and

   1.9 not do or omit to do anything which may cause any Party to lose any licence, authority, consent or permission on which it relies for the purposes of conducting its business.

2. With the prior written consent of the Kent and Medway Pathology Network Board, the Host may sub-contract the provision of the Hosting Obligations to a Third Party, provided that such sub-contract contains obligations upon the sub-contractor which require it to provide the relevant obligation to the same (or a higher) standard to that set out in this Agreement.

Part 3 - Payment for Hosting Obligations

At the date of this Agreement no charges are payable to the Host Trust for the Hosting Obligations unless the Parties otherwise agree pursuant to the Change Control Procedure.

SCHEDULE 6

NOT USED

SCHEDULE 7

Intellectual Property Agreement

Kent and Medway Pathology Network

Collaboration agreement

(Arrangements for intellectual property (IP) and relationships with Third Parties)

Status	Draft
Version	0.3
Author	John Stedman
Date	25/2/2021

Document Control

Review, Approval and Distribution

Group	Version	Date	Review	Approve	Distribute
Legal and Governance Steering Group.	0.2	25/2/21	X	X	
Pathology Programme Team	0.3	4/3/21	X	X	
Pathology Programme Board	0.4	11/3/21	X	X	X

Change history

Version	Date	Author/editor	Details of change
0.1	25/1/2021	J Stedman	First draft
0.2	29/1/2021	J Stedman	Updated after discussion with A Price and A Foreman
0.3	25/2/2021	J Stedman	Updated after Legal and Governance Steering Group review: title and clause 1.5 amended, new clauses 5.3 and 8.2 added
0.4	11/3/21	J Stedman	Updated after Programme Board to include new clause 7.11 to clarify disclosure of IP.

This Agreement is made on the day of 2021 between:

(A) East Kent Hospitals University NHS Foundation Trust;

(B) Maidstone and Tunbridge Wells NHS Trust;

(C) North Kent Pathology Service (i.e. the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust.)

1. **Background**

1.1 The Parties have agreed the Network Agreement (i.e. *Vison for the Kent and Medway Pathology Service* version 0.9, 6th October 2020) to enable them to work together across Kent and Medway.

1.2 The Parties have agreed to implement a single laboratory information system (LIMS) and managed services contract (MSC).

1.3 The Parties have agreed to appoint a Director of Pathology Transformation who will work with teams and services to design and implement service changes which benefit the whole network.

1.4 The Parties wish to establish an agreement to govern their respective rights and obligations in relation to activity that may generate intellectual property.

1.5 This agreement supports the collaborative working of the Parties and in particular how intellectual property is managed and relationships with Third Parties.

2. **Definitions and interpretation**

The following words and phrases shall have the meanings set out below unless the context requires otherwise:

Agreement	means this non-binding agreement.
Background IP	means intellectual property generated before the Commencement Date.
Commencement Date	means the date on which the Programme Board approve this Agreement.
Confidential Information	means a. information relating to the business affairs, finances or commercial interests of the disclosing Party or of a Third Party to which the disclosing Party has lawful access which is disclosed to the other Party pursuant to this Agreement in whatever form; and/or b. know-how which shall mean any and all technical and other information which is not in the public domain, including information comprising or relating to concepts, discoveries, data designs, formulae, ideas, information relating to material, inventions, methods, models, assays, research plans, procedures, designs for experiments and tests and results of experimentation and tests (including results of research or development), processes (including manufacturing processes, specifications and techniques), laboratory records/quality control data, case report forms, data analyses, reports or summaries and information

	containing submissions to and information from any ethics and regulatory authorities introduced to or made accessible by one Party to another; and/or c. such other written information whether provided in printed, hand-written, electronic or any other form of sensory recognition, that the disclosing Party deems confidential and which is provided to the other Party in writing and marked "Confidential" or which is the subject of oral discussions which will be summarised in any form and agreed by the Parties within thirty days after each discussion, such summaries also to be marked "Confidential" d. save that this definition shall not include any disclosed matter which: i. can be shown to have already been in the possession of the recipient by legitimate means other than under the operation of this Agreement, prior to disclosure; or ii. can be shown to have been independently developed or acquired by the recipient without any breach of confidence or any infringement of Third Party rights; or iii. is or becomes in the public domain other than through breach of this Agreement.
Costs	means any costs incurred by the Parties when Network IP may be generated and attributable to the subject matter of this Agreement.
Collaborative Activity	means any activity where two or more of the Parties work together on an activity that may be novel and has the potential to generate intellectual property.
IP (intellectual property)	means all inventions, improvements and/or discoveries including without limitation all utility models, registered and unregistered designs, registered and unregistered trademarks, topography, data including diagnostic results, diagnostic performance data, and patient related data, databases, computer software, know-how, technical and confidential information, trade and business names and goodwill, processes and methodology (whether or not all of the same are registered) and anything analogous to any of the foregoing in any part of the world.
IP Advisor	means NHS Innovations South East.
NHS Data Principles	means a) Guidance: A guide to good practice for digital and data-driven health technologies i) https://www.gov.uk/government/publications/code-of-conduct-for-data-driven-health-and-care-technology/initial-code-of-conduct-for-data-driven-health-and-care-technology#define-the-commercial-strategy b) Guidance: Creating the right framework to realise the benefits for patients and the NHS where data underpins

	innovation i) https://www.gov.uk/government/publications/creating-the-right-framework-to-realise-the-benefits-of-health-data/creating-the-right-framework-to-realise-the-benefits-for-patients-and-the-nhs-where-data-underpins-innovation
Network Agreement	means the *Vison for the Kent and Medway Pathology Service* document (version 0.9, 6th October 2020) that was agreed by the Parties on 15th October 2020.
Network IP	means all IP arising from Collaborative Activity and all IP arising from activity undertaken by a Party within the Scope of this Agreement.
Party	means either North Kent Pathology Service (i.e., the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust) or East Kent Hospitals University NHS Foundation Trust or Maidstone and Tunbridge Wells NHS Trust and 'Parties' shall mean North Kent Pathology Service (i.e., the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust) and East Kent Hospitals University NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust;
Programme Board	means the Programme Board defined by the Network Agreement
Revenue	Means revenue arising for the commercial exploitation of Network IP
Revenue Share	means the sum remaining when the Costs have been deducted from the Revenue in the relevant Accounting Period.
Scope	means pathology services undertaken within any of the Parties laboratories and includes biochemistry, haematology, blood transfusion, haemophilia and coagulation, microbiology, cellular pathology, immunology. Services provided outside of laboratories are point of care testing, phlebotomy (EKHUFT and MTW only) and mortuary (not MFT) performed by their employees or commissioned or contracted by the Parties to a Third Party or any activity in support of pathology services e.g. IT products and services.
Third Party	means any other organisation or individual not a Party to this agreement.

3. **Term**

This Agreement shall come into force on the Commencement Date and continue in perpetuity.

4. **Collaboration**

4.1 The Parties will collaborate on activities that benefit the Kent and Medway Pathology Network and are in accordance with the Network Agreement.

4.2 Examples of Collaborative Activity include improvement activity, benchmarking, clinical validation of a diagnostic using NHS samples for a Third Party, the development of a

new diagnostic, the application of a diagnostic to a new disease or condition, the provision of data from NHS samples to a Third Party, the development of new or improved methodologies or processes. This list is non-exhaustive and other Collaborative Activity may give rise to IP that needs to be evaluated for its potential to be disseminated or commercialised.

4.3 The Parties will agree on a lead Party to engage and contract with a Third Party for commissioned activity on behalf of the Network.

4.4 If a Third Party is funding the Collaborative Activity, for example clinical validation of a diagnostic, then the Parties will agree how the funding and activity is apportioned between them in accordance with the Network Agreement and seek guidance from the IP Advisor on IP management.

4.5 If the Third Party is a commercial organisation then the price of undertaking the activity will be determined in advance by the Parties and will be based on commercial pricing.

4.6 Alternative mechanisms to fund Collaborative Activity that benefits Third Parties can be agreed by the Parties and may require the IP Advisor to advise.

4.7 If additional funding is necessary to undertake Collaborative Activity, then this will be agreed by the Programme Board and the Costs shared in alignment with the Network Agreement.

5. **Intellectual Property**

5.1 Network IP will be jointly held by the Parties.

5.2 If formal legal protection is required for Network IP, then either a lead Party will take on the legal protection activity required or the legal owner of the IP will be identified and they will undertake the protection activity required on behalf of the Parties.

5.3 The benefits arising from any Network IP asset will be shared jointly by the Parties in accordance with the Network Agreement.

5.4 The Costs of legal protection of the Network IP will be borne by the Parties in accordance with the Network Agreement.

5.5 Each Party shall promptly disclose to the other(s) all arising Intellectual Property generated by it and each Party shall co-operate, where required, in relation to the preparation and prosecution of patent applications and any other formal legal protection relating to Network IP as appropriate.

5.6 Each Party hereby grants to each other Party an irrevocable, non-transferable, royalty-free right to use all Network IP for clinical and research purposes, including research projects funded or commissioned by a Third Party provided that the Third Party does not gain or claim any commercial or exploitable rights to such Network IP.

5.7 All Background IP remains the property of the Party that generated it. No Party will make any representation or do any act which may be taken to indicate that it has any right, title or interest in or to the ownership or use of any of the Background Intellectual Property of the other Parties except under the terms of this Agreement. Each Party acknowledges and confirms that nothing contained in this Agreement shall give it any right, title or interest in or to the Background Intellectual Property of any other Party save as granted by this Agreement.

5.8 Each Party grants the others a royalty-free, non-exclusive licence to use its Background Intellectual Property for the sole purpose of participating in the Network Agreement. No Party may grant any sub-licence over or in respect of the other's Background Intellectual Property.

6. Commercialisation

6.1 The Programme Board will review opportunities for the commercialisation of Network IP and agree whether pursued or not with advice from the IP Advisor.

6.2 The Revenue Share arising from commercialisation of Network IP shall be shared between the Parties based on the same proportion as the shares within the Network Agreement.

6.3 If the Parties generate Network IP that does not have the potential to be commercialised but which has value to the NHS and patients in producing one or more non-commercial benefits, then the Parties will seek advice from the IP Advisor on how best to disseminate and exploit the Network IP to achieve those benefits. The non-commercial benefits may include one or more of the following: efficiencies, cost savings, kudos for the Parties and or the Network, and improved patient outcomes.

6.4 The IP Advisor will provide advice on appropriateness and methods of IP protection and methods of IP exploitation or dissemination if the Network IP is not suitable to be commercialised.

6.5 The Parties will comply with the NHS Data Principles when commercialising Network IP or exploiting Network IP that is not commercialised.

7. Confidentiality

Each Party undertakes:

7.1 to maintain Confidential Information in strict confidence save where ordered to disclose same by a competent court of law or other empowered tribunal or authority; and

7.2 to inform the other Party promptly where disclosure has been ordered as envisaged in Clause 7.1 above; and

7.3 to keep securely Confidential Information such that only persons under the obligations of confidence similar to those contained in this Agreement have access to or custody of the Confidential Information and otherwise to protect the same with no less care than they apply to their own confidential information; and

7.4 to use the Confidential Information it receives from the other Party only for the purpose for which it was disclosed. Neither Party shall use such Confidential Information for any other purpose, either for itself or for any Third Party; and

7.5 not to copy or reproduce the Confidential Information or make any record or re-formatting of it save as is reasonably necessary for the performance of its obligations under this Agreement; and

7.6 to return or destroy all copies of the Confidential Information including but without limitation to copies in written or electronic form, either on the request of the disclosing Party or on the expiry or termination of this Agreement; and

7.7 to keep confidential the terms and conditions of this Agreement; and

7.8 to ensure that all its employees, contractors, consultants and advisors are aware of the confidential nature of the Confidential Information and the obligations under this Agreement and shall accept responsibility for each of them as if their activities in relation to the Confidential Information were carried out by that Party itself.

7.9 The Parties agree that any Confidential Information released prior to the execution of this Agreement shall be deemed to have been delivered hereunder and shall be subject to the terms of this Agreement.

7.10 The Parties agree that any Confidential Information disclosed pursuant to this Agreement shall remain confidential for a period of five years following the termination of this Agreement.

7.11 Each Parties organisational management processes and Intellectual Property Policy will govern its own staff's compliance to ensure intellectual property that has potential commercial value is not disclosed and value subsequently destroyed.

8. **Publications**

8.1 Each Party will use all reasonable endeavours to submit material intended for publication, that may relate to the collaboration or a pathology innovation, to the other Parties in writing not less than 30 (thirty) days in advance of the submission for publication. The publishing Party may be required to delay submission for publication if in any other Party's opinion such delay is necessary in order for that other Party to seek patent or similar protection for material in respect of which it is entitled to seek protection, or to modify the publication in order to protect Confidential Information. A delay imposed on submission for publication as a result of a requirement made by the other Party shall not last longer than is absolutely necessary to seek the required protection; and therefore shall not exceed 3 (three) months from the date of receipt of the material by such Party, although the publishing Party will not unreasonably refuse a request from the other Party for additional delay in the event that property rights would otherwise be lost. Notification of the requirement for delay in submission for publication must be received by the publishing Party within 30 (thirty) days after the receipt of the material by the other Party, failing which the publishing Party shall be free to assume that the other Party has no objection to the proposed publication.

8.2 Where one or more Parties, but not all Parties, are involved in a collaboration that gives rise to a publication or other non-financial benefit, then consideration will be given to recognising those Parties in the publication or other non-financial benefit not involved in the Collaborative Activity who may have had to forgo involvement for any reason. E.g. one or more Parties but not all Parties bid for a piece of collaborative work, and it is not possible for all Parties to bid and participate.

9. **Third Parties**

9.1 When a Third Party approaches a Party or the Parties with an opportunity to undertake an innovative activity or project within the Scope of this Agreement, then the opportunity will be disclosed to the other Parties and the Programme Board will review the opportunity and decide whether to pursue or not.

9.2 If the Third Party is a commercial organisation, then the opportunity will be costed on a commercial basis to generate a Revenue Share for the Parties. The IP Advisor will provide advice on the commercial costing and alternative approaches the Parties may adopt, particularly if IP may generated, to ensure Costs are recovered and that the arrangement is beneficial to the Parties.

9.3 If the Third Party is a non-commercial organisation, then the opportunity will be costed to ensure Costs are recovered and that there is a benefit to the Parties of undertaking the opportunity. The IP Advisor will advise on appropriate mechanisms for the Parties to realise benefits from the opportunity.

SCHEDULE 8

Business Plan

1. **BUSINESS PLAN**

1.1 The Business Plan is an annual business plan for KMPN prepared by the Kent and Medway Pathology Network Executive Team and approved by the Kent and Medway Pathology Network Board in accordance with this Schedule 9.

1.2 The Business Plan shall be:

(a) the investment plan presented to Parties' boards; and

(b) the investment update papers, headed as such and presented to the Parties' boards, prior to the Commencement Date. The investment update papers show:

(i) A plan showing proposed activity volumes, planned prices and outline income and expenditure for the forthcoming Financial Year;

(ii) A detailed operating budget for the coming twelve months including a monthly projected income and expenditure account;

(iii) an investment plan for the coming twelve months (including Capital Expenditure requirements); and

(iv) details of the surplus (if any) to be retained by KMPN,

and shall be deemed adopted by the Kent and Medway Pathology Network Board at the date of signature of this Agreement.

1.3 For each Business Plan, the Parties shall procure (though the Kent and Medway Pathology Network Board) that such Business Plan shall include (without limitation) in relation to the Financial Year to which it relates:

(a) a financial report including an analysis of the estimated results of KMPN for the previous Financial Year compared with the Business Plan for that year, identifying variations in sales revenues, costs and other material items;

(b) a management report including business objectives for the Financial Year;

(c) a brief strategic review for the forthcoming five (5) Financial Years (the first two (2) Financial Years in detail, the remaining three (3) in outline);

(d) A plan showing planned activity volumes, planned prices and outline income and expenditure for the forthcoming five (5) years (the first two (2) years in detail, the remaining three (3) in outline);

(e) A detailed operating budget for the coming twenty four (24) months including a monthly projected income and expenditure account;

(f) an investment plan for the coming twenty four (24) months (including Capital Expenditure requirements) and balance sheet forecast;

(g) a cashflow statement giving:

i. an estimate of the working capital requirements; and

ii. an indication of the amount (if any) that it is considered prudent to retain, for the purpose of meeting those working capital requirements, from the surplus of the previous Financial Year that is available for distribution to the Parties;

(h) details of the surplus (if any) to be retained by KMPN;

(i) details of any additional call on Parties for working capital funding required as a result of deficit;

(j) an appraisal of the feasibility of Incorporating KMPN; and

(k) an assessment of the potential impact (including any material adverse financial impact or consequences) that KMPN plans for Pathology Services may have on the business of the Parties in the Financial Year in question.

1.4 A Business Plan (other than for the first Financial Year) shall be prepared by Kent and Medway Pathology Network Executive Team so that:

(a) the draft is available at least twelve weeks before the first Working Day of the Financial Year to which the plan relates; and

(b) the final version is available at least four weeks before the first Working Day of the Financial Year to which the plan relates.

1.5 The Business Plan is to be approved and adopted by the Kent and Medway Pathology Network Board before 1 April of the Financial Year to which it applies.

1.6 To the extent that a Business Plan is not approved and adopted in any Financial Year, the Business Plan for the preceding Financial Year shall be rolled forward, subject to updating the costs detailed in such Business Plan to reflect indexation by reference to national NHS guidance.

SCHEDULE 9

Premises

Terms and Conditions relating to the Premises

The Parties agree and acknowledge that any Premises issues shall be addressed and agreed via the Change Control Procedure

SCHEDULE 10

Staff

Network Team

POST	BAND	WTE
KMPN Managing Director	9	1.00
KMPN Clinical lead		0.60
KMPN Workforce and OD lead	8D	0.80
KMPN Finance Lead	8D	0.50
KMPN IT Lead	8D	1.00
KMPN Programme support	5	1.00
KMPN Procurement lead	8A	1.00

PMO Team

MES Project

Project manager MES	8D	0.80

Any staff required for implementation as approved by the MES FBC

LIMS Project

Project Director	8d	1.00
Junior Project Manager	8b	1.00
Analyser & Integration PM	7	1.00
Pathology reporting PM	7	1.00
Data Migration PM	7	1.00
Integration specialist (Data Architect)	7	1.00
Business Change Manager	8a	1.00
Business Change analysts	6	4.6
APEX specialist	8b	0.40
MLA data migration	3	1.00
MLAs training	3	12.00
Test Manager	7	1.00
Testers	5	8.00
Training manager	7	1.00
Digital (LIMS) System Manager	8b	1.00
Project Support Office	5	1.00
All approved recharges for backfill	various	N/A

Workforce Team

HR BP	**8A**	**0.30**
Education and training co-ordinators	**8A**	**0.64**
Practice Educator	**8B**	**0.72**

N.B the education posts are funded non-recurrently by HEE and will be reassessed annually.

SCHEDULE 11
Deed of Adherence

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Dated…………………………………………..

(1) **[INSERT FULL LEGAL NAME OF NEW PARTY]**

- and -

(2) **Existing Parties**

DEED OF ADHERENCE TO THE PATHOLOGY COLLABORATION AGREEMENT

THIS DEED OF ADHERENCE is made on [*INSERT DATE OF FINAL SIGNATURE]*

PARTIES

(1) [*INSERT FULL LEGAL NAME OF NEW PARTY*] of [*INSERT REGISTERED OFFICE ADDRESS*] (**New Party**), and

(2) The parties whose names and addresses are set out in Schedule 1 (**Existing Parties**).

RECITALS:

A This deed is supplemental to, and is entered into in accordance with, the Collaboration Agreement.

B The New Party wishes to be admitted as a partner.

C The Existing Parties have resolved to admit the New Party as a partner with effect from the Admission Date on the terms of this deed.

THE PARTIES AGREE:

1. **Definitions and interpretation**

1.1 The definitions and rules of interpretation in the Collaboration Agreement shall apply in this deed except where expressly stated to the contrary and the following expressions shall have the following meanings:

Admission Date	[*INSERT DATE*];
Existing Parties	means the parties whose names and addresses are set out in Schedule 1;
Collaboration Agreement	Pathology Collaboration Agreement dated [INSERT DATE], and made between the Existing Parties, as amended from time to time.

2. **Admission of New Party**

2.1 The New Party shall become a partner as from the Admission Date.

2.2 The New Party hereby covenants with each Existing Party who is a party to the Collaboration Agreement from time to time to observe, perform and be bound by all of the terms of the Collaboration Agreement which are capable of applying to the New Party and which have not been performed at the date hereof.

2.3 The New Party shall agree to contribute £[INSERT AMOUNT IN FIGURES] ([INSERT AMOUNT IN WORDS]) on or before the Admission Date every year in respect of the Network Costs.

3. **General**

3.1 This agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this agreement.

3.2 This deed may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

3.3 This deed and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England.

3.4 Each party irrevocably agrees that the courts of England shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this deed or its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

The Existing Parties

Name	**Address**
[*insert*]	[*insert*]
[*insert*]	[*insert*]

EXECUTED AS A DEED by the parties on the date first set out on page 1.

Executed as a deed by
....
for and on behalf of **[INSERT NAME OF NEW PARTY]**

....
(Signature)

....
(Date)

In the presence of:

Signature ....

Name ....

Address
....
....
....
....

Occupation ....

Executed as a deed by
....
for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....
(Signature)

....
(Date)

In the presence of:

Signature ....

Name ....

Address
....
....
....
....

Occupation ....

Executed as a deed by
....

....
(Signature)

for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....

(Date)

In the presence of:

Signature ....

Name ....

Address

....

....

....

....

Occupation ....

Executed as a deed by

..

for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....

(Signature)

....

(Date)

In the presence of:

Signature ....

Name ....

Address

....

....

....

....

Occupation ....

SIGNATURE PAGE

SIGNED by ....

(Signature)

(Role) ……………………………………….. ....

for and on behalf of **EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST**

(Date)

SIGNED by ....

(Signature)

(Role) ……………………………………….. ....

for and on behalf of **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST**

(Date)

SIGNED by ....

(Signature)

(Role) ……………………………………….. ....

for and on behalf of **DARTFORD AND GRAVESHAM NHS TRUST**

(Date)

SIGNED by ....

(Signature)

(Role) ………………………………………..

for and on behalf of **MEDWAY NHS FOUNDATION TRUST** ....

(Date)

Trust Board meeting – 29th June 2023

To approve the Business Case for Virtual Wards | **Chief Operating Officer**

Business Case objectives:
Implement a hospital virtual ward to enable early clinically supported and technologically enabled discharge to:
Reduce/avoid the need for escalation bed capacity in the acute hospital with the development of Virtual Ward to support early discharge and admission avoidance
Improve flow through the hospital with commensurate improvement in access targets
Deliver value for money and evidence return on investment in the Virtual Ward
Improve patient experience and outcomes

Expected benefits:
Improved flow through acute beds reducing the need for escalation
Less pressure on ED
Improved patient experience

High-level risks and mitigations:
Clinical engagement with rapid implementation of a new concept
Ongoing cost of the service does not represent value for money

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 13/06/23

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

BUSINESS CASE

Title	Virtual Wards

Stage of plan	The development of this Full Business Case is to evidence robust use of central NHSE funding to deliver an operating virtual ward. This is a National initiative and part of the NHS plan to deliver more care at home and release bed savings in acute hospitals. The programme of work commenced in May 2022 and since then the Trust has developed and delivered a project plan, procured and implemented a monitoring system, develop governance arrangement and pathway development procedures and implemented a functioning Virtual Ward. This case seeks to support the ongoing development of the service with the appropriate resources and to confirm arrangements for continuing the service in 2024/25 once central funding is no longer available.
ID reference *mtw-tr.bcrp@nhs.net*	**ID881**
Division	Central Operations
Department/Site/ Directorate	Virtual Wards
Author	Jo Cutting, Programme Director Stephen Bundock, PMO Business Partner MTW Sam Roberts, General Manager, Virtual Ward Fay Johnstone – Virtual Ward Matron & Clinical Lead
Clinical lead/Project Manager	Clinical Lead: Dr. P Maskell Project Director: Jo Cutting

Prioritisation has been agreed at	Capital prioritisation group – in capital plan	Service development priority in divisional annual plan	Charitable funds group/s	**Other (Specify)** **Urgent and Emergency Care Funding from the ICB.**

Approved by	**Name**	**Date approved**
Virtual Ward General Manager/Service Lead	Samuel Roberts	Samuel Roberts
Head of Contracting and Income	Mark Pordage	[signature]
Clinical Director (or their clinical deputy)	Dr. Peter Maskell	[signature]
Executive sponsor	Dr. Peter Maskell	[signature]
Director of Operational Nursing and Flow	Sally Foy	[signature]

Approved by	Name	Date approved
Deputy Director of Operational Flow	Fiona Redman	Fiona Redman
Supported by	**Name**	**Date supported**
Deputy Site Director	Darren Palmer	All approved as per attached email
Patient Administration Lead - Sunrise	Di Peach	
Medicine Divisional Director	Tim Hubbard	
Pharmacy	Jonathan Bailey	
Procurement	Richard Cardy	
Human Resources (HR) Business Partner	Claire Cloude	
EME Services Manager	Michael Chalklin	
Head of Nursing – Central Operations	Kelly Cushman	
Finance Manager	John Coffey	
Virtual Ward Lead Matron	Fay Johnstone	

Executive Summary

Recommendation:

This business case seeks approval to invest £1,498,000 in the development of a virtual ward hub, enabled by a technological interface to allow patients to be monitored and treated against clinical approved pathways in their own home or the place they call home. This will improve patient experience, safety nets patients who would usually stay in hospital, release acute bed capacity and improve flow.

This total is the amount the ICB has invested in MTW for 2023/24 for the development of the Virtual Ward, and the Trust has committed to develop this service. The amount being invested does not include Trust overhead costs at £106,000 which will, over the course of the year be recovered by slippage from recruitment and staff turnover.

Recognising the challenges to developing and delivering this service there is a recommendation to review performance and costs after 6 months to consider the forward planning into 2024/25.

Strategic background context and need

In December 2021, NHS England announced that the establishment of virtual wards is now an integral part of its 2022/23 priorities and operational planning guidance, with a request that each integrated care system (ICS) responds to its ambition of extending or introducing virtual ward capacity equivalent to 40-50 virtual ward 'beds' per 100,000 population by December 2023. In doing so, additional acute 'bed' capacity is expected to be created as a result of the efficient use of resource and innovative ways of supporting patients at home.

With increased demand on NHS services and a growing elderly population with increased long-term conditions, NHS England's strategy is the development and implementation of Virtual Wards across NHS acute providers to support the management of acute hospital demand and reduce length of stay. The principle of Virtual Wards and telemonitoring have successfully been introduced nationally and internationally and the aim is to build on this experience to expand and improve local services.

Objectives

The key objectives of the programme are as follows:

1. Reduce/avoid the need for escalation bed capacity in the acute hospital with the development of Virtual Ward to support early discharge and admission avoidance
2. Improve flow through the hospital with commensurate improvement in access targets
3. Deliver value for money and evidence return on investment in the Virtual Ward
4. Improve patient experience and outcomes

The preferred option.

To use a dedicated App based system to support patients in their own home using an iPad and home monitoring to enable a link to a central clinical hub. The hub is supported by registered nursing staff who support patients against a speciality approved pathway. To provide a 24/7 service which provides monitoring and will be able to develop treatment pathways to open the Virtual Ward to a wider group of patients and clinical specialties.

The LUSCII system is the preferred provider which supports alongside the MTW Sunrise system. The ability to dynamically identify and manage patients.

To deliver this dynamic service will require 27.16 wte for a full year. Staff from grade 3 clerical support to grade 5-8a clinical grades and an 8b general manager to coordinate and drive the service forward.

Planned key benefits to come from the investment.

There are three planned key benefits to the implementation and deployment of the Virtual Ward at Maidstone and Tunbridge Wells NHS Trust:

1) Reduce impact on operational flow by either discharging patients early and preventing admission of patients who require ongoing monitoring and treatment, usually only provided in an acute inpatient setting
2) Evidence of financial efficiency and robust return on investment to reduce financial pressure
3) Improved patient experience as they recover in their own home with faster recovery due to patients at home naturally moving more and reduced exposure to infection

Measurable benefit Key Performance Indicator (KPI)	Baseline Position	Future Outcome
Bed days saved	New Service	Circa 10,000 bed days for the 23/24 year at 75% occupancy.
Admissions avoided	New Service	Reduction in demand for inpatient hospital beds.
Patient feedback	New Service	FFT for patients on the Virtual Ward compared with feedback from traditional wards
Hospital escalation capacity numbers	Currently utilising 1 ward per site during winter months	By Q4 23/24, reduce the demand on the escalation beds by providing capacity for up to 60 patients in the virtual ward at any one time.

Main risks associated with the investment

Risk of not doing it:

This is an NHS England funded initiative and progress and compliance will be monitored by the Integrated Care Board (ICB), the organisation will be accountable to the ICB for failure to deliver. Significant benefits in relation to improved flow and capacity have been identified in relation to successful deployment of Virtual Wards in other areas in the UK and Europe. Should the Virtual Ward not be deployed the organisation could miss out on significant wider benefits to operational flow, hospital length of stay and bed days saved.

Delivery risk:

The risks for consideration are:

1. Staff shortages are an NHS challenge and this is no different in relation to the Virtual Ward. Staff require specific training to be able to use the Virtual Ward monitoring system and therefore is impractical to cover a high number of shifts by bank or agency staff. To mitigate this risk a recruitment plan and phased approach has been drawn up by the project team responsible for delivering the Virtual Ward.
2. Delivery and maintenance of the anticipated capacity maybe a challenge. MTW has a number of well-established early discharge/admission avoidance initiatives which may impact on the ability to 'recruit' some specialties. Clinical scepticism and caution may also result in pathways not establishing rapidly. In mitigation MTW have broadened the communication to all specialties and are working to develop pathways outside of ARI and frailty to increase volume and impact.
3. Cost of the service is too great to sustain the service; The reduction in the funding will limit the amount of activity that the Trust will be able to deliver and will have a consequence as numbers increase on non-pay and the potential requirement for increased staffing. This will be assessed against acute bed days savings, however will remain a key risk on the risk register.

Residual Risk:

The residual risk relates to the continued momentum and maintenance of activity. In mitigation the service is looking to broaden the scope of the service to include treatment which will enable a wider group of specialties and patients to access and benefit from the service.
Funding from 24/25 is not resolved as this will have to come from internal Trust resources and will be based on the performance of the Virtual Ward and the impact on the Trust bed capacity and flow. This should be reviewed after 6 months to assess progress and consider the ongoing risk.

Financial impact of the preferred option Full year effect – include VAT unless recoverable			
Summary of financial impacts			
CAPITAL COSTS	**£0.00**	**FUNDING SOURCE**	**£1,498,000**
Estates	**£0.00**	Identified in the Trust capital plan	**No**
IT	**£0.00**	Identified in directorate revenue budget	**No**
Equipment	**£0.00**	Other: **Kent & Medway ICB**	**Yes**
Total Capital Cost	**£0.00**	**Additional Financial Information:** • The financial values for 2023/24 are based on limiting the nursing numbers to fit the available financial resources which will limit the number of patients that can go through the service. In 2023/24 the funding is from the HCP and will enable a capacity of up to 60 patients at any one time to access the Virtual Ward service based on the 1 nurse to 30 patient ratio.	
REVENUE COSTS			
Pay	**£1,303,546**		
Non- Pay	**£196,454**		
Capital Charges	**£0.00**		
Total Revenue Cost per annum	**£1,500,000**		

INCOME	£	• In 2024/25 the central funding ceases and the expectation is that this initiative will be funded from operational efficiencies by the Trust.
SLA	**£0.00**	
Other	**£0.00**	

The timetable below assumes the Hub activity of 1 nurse to 30 patients is realised. However, as the treatment/monitoring model progresses the Hub capacity may reduce BUT the activity will remain high due to the higher number of patients requiring treatment and monitoring and the impact this will have on length of stay. The bed days saved will over the course of the programme reflect the efficiency of the service and value for money, and providing treatment will increase virtual ward occupancy.

Timetable	
Based on Hub capacity for monitoring only	
Milestone	**Date**
Staffed 8am – 8pm seven days a week with capacity of 30	December 2022
Staffed 24/7	3rd April 2023.
Develop treatment pathways, a monitoring/treatment model of care and confirm capacity	April 2023.
Staffed 24/7 with a capacity of up to 60 (2 hub nurses 24/7)	July 2023.
Introduce treatment and monitoring pathways. Increase specialty pathways	July 2023.

Strategic Case

National context

The NHS Long Term Plan was published in January 2019 and sets out the overall NHS strategy to improve health and health outcomes. It describes five key changes to the NHS care model:

1. We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.
2. The NHS will redesign and reduce pressure on emergency hospital services.
3. People will get more control over their own health, and more personalised care when they need it.
4. Digitally enabled primary and outpatient care will go mainstream across the NHS.
5. Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

The NHS, local authorities and civic partners have recently made significant progress in developing more integrated community health and care models, many of which have been enabled by technology and innovative working practices.

During the UK's response to COVID-19, many localities deployed virtual wards as a step-down arrangement to support people's recovery from respiratory conditions at home, whilst still receiving acute-level care. While some of these models have existed for a long time, a great number were successfully set up during the pandemic – and Maidstone and Tunbridge Wells NHS Trust successfully set up and deployed a Covid-19 Virtual Ward to facilitate earlier discharge for patients with confirmed Covid-19 who's recovery could be monitored at home against a particular clinical criterion. This had multiple benefits for both the patient and organisation, the patient was able to return to their own home to recover in their own familiar surroundings. Whilst the organisation benefited from increased capacity and reduced risk of infection. There is now significant literature that has been produced evaluating Covid-19 Virtual Wards across the country with the majority all reporting success of the Virtual Ward with reduced length of stay, leading to positive 'bed days saved' along with minimal readmissions following discharge on the Virtual Ward.

In December 2021, NHS England announced that the establishment of virtual wards is now an integral part of its 2022/23 priorities and operational planning guidance, which aligns with the Long-Term Plan's objectives, and with current structural reforms and legislative proposals to develop more integrated community offerings across our footprint.

NHS England has since asked that each integrated care system (ICS) responds to its ambition of extending or introducing virtual ward capacity equivalent to 40-50 virtual ward 'beds' per 100,000 population by December 2023. In doing so, additional 'bed' capacity is expected to be created as a result of the efficient use of resource and innovative ways of supporting patients at home.

With increased demand on NHS services and a growing elderly population with increased long-term conditions, NHS England's strategy is the development and implementation of Virtual Wards across NHS acute providers to support the management of acute hospital demand and reduce length of stay. The principle of Virtual Wards and telemonitoring have successfully been introduced nationally and internationally and the aim is to build on this experience to expand and improve local services.

Definition

The national definition for a virtual ward is safe and efficient alternative to NHS bedded care that is enabled by technology. This technology enables patients to undertake and report regular observations to a clinically staffed hub. The hub provides the clinical and specialist management of the patients care. All care will be delivered via a robust and clinically approved pathway to ensure any deterioration is quickly

managed. The patient is provided with and trained to use the technology they need to undertake the necessary observations and to communicate effectively with the Virtual Ward Hub.

The virtual ward philosophy is that care is led by a specialist and provides acute clinical care at home which would otherwise be provided in a hospital for a short duration of up to 14 days. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or allied health professional (AHP) consultant) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition. Staffing for the virtual ward must be available for at least 12 hours a day 7 days a week with locally arranged provision for out of hours cover. For some pathways a wider group of professionals from community and primary care will support the patient.

By contrast, a virtual ward is not a mechanism for enhanced primary care programmes; long-term condition management; intermediate or day care; 'safety-netting'; or social care for people who are medically fit for discharge.

Local Context

Kent County Council estimates a total 6.8% increase in population over the next decade and a population increase in the over 65 age range of 18.9%. There will be further demand generated from the Government target for new homes in Kent and two large scale developments are planned in the Maidstone and Tunbridge Wells NHS Trust catchment. With an increasing, aging population with the Maidstone and Tunbridge Wells NHS Trust catchment area it will be vital that innovative processes are introduced to reduce the growing pressure that a growing population will bring to a health system.

As part of the agenda of 'Ageing Well' the Kent and Medway ICS plans to embed technology-enabled care such as wearable devices and home monitors as core tools to support long term health problems in new ways, and support people to remain at home safely where possible. The successful implementation of the Virtual Ward will support these initiatives and assist in the demand management of a growing populations use of secondary care services.

As a system West Kent, which includes MTW and KCHFT, will work closely to develop the pathways with KCHFT leading on the frailty Virtual Ward which builds on current home treatment capacity and MTW will focus on ARI and the development of other acute led virtual ward pathways. MTW hosts the Hub and have procured the system to support patients in their own homes. The organisations have a Memorandum of Agreement which determines they will work collaboratives but will be held to account for performance by the ICB.

As a minimum, there is an expectation that each system implements virtual ward models for the two pathways that have published guidance in place. The frailty Virtual Ward is led by KCHFT and the Acute Respiratory Infection (ARI) is led by MTW, with the opportunity and the flexibility to expand and develop other pathways and this is part of MTWs Virtual Ward strategy.

In 2022/23 funding was made available from NHSE to develop the virtual ward and in response to this MTW have invested in a system to run the Hub and staff to manage the development of the service and clinical staff to manage the patient pathways to ensure a smooth transition into Virtual Ward care.

Case for Change

The local development of our virtual wards is aligned with national strategy and policies. It responds directly to NHS England's explicit request for virtual wards to be prioritised in its 2022/23 priorities and operational planning guidance, and are also aligned with many of the Long-Term Plan's stated ambitions which we anticipate will deliver improvements as follows:

1. MTW has consistent bed pressures, particularly noticeable since the COVID pandemic. The demand on ED and subsequent demand on specialty beds is challenging the delivery of access

targets. During the course of the 22/23-year, MTW was unable to close the two escalation wards on either Maidstone and Tunbridge Wells sites (Cornwallis and Ward 11). The organisation was therefore consistently running with 49 escalations beds open above the funded bed base. It was also at times necessary to escalate into Same Day Emergency Care (SDEC) and Cardiac Catheter Lab recovery areas overnight which impacts on flow out of the Emergency Departments, and ongoing elective management the following day. Whilst the Trust has made strides to close escalation capacity there is recognition that this is brittle, and any initiative that supports patients early discharge or admission avoidance is worth exploring.

2. Developing a virtual ward to support early discharge and admission avoidance will contribute to the management of flow through both hospital sites.
3. Reduction in the requirement for escalation beds with the operational, staff and financial pressures they incur
4. Demonstratable value for money and return on investment
5. Improving patient and family/carer and staff experience

Link to Trust Values and Strategy

The development and delivery of the Virtual Ward strategy links directly to the Trust PRIDE values (Patient first, Respect, Innovation, Delivery, Excellence) and the Trust's 6 strategic themes:

Strategic Theme	Virtual Ward response
Patient experience – outstanding care for a positive patient experience of care and support	Patient given the right support with use of technology to enable anxiety free support with their care
Patient Safety and Clinical Effectiveness – achieving outstanding clinical outcomes with no avoidable harm	Robust pathway development to easily identify appropriate patients against clinically approved criteria
Patient access – to ensure our patients have access to the care they need to ensure they have the best chance of getting a good outcome	Accessible to all patients in the Virtual Ward pathways who fit the specialty pathway criteria
Systems and Partnerships – working with partners to provide the right care and support in the right place at the right time	Work with external system provider to ensure the system is fit for purpose, and work with health and care partners to provide support for patients in the Virtual Ward where required
Sustainability – long-term sustainable services providing high quality care through optimising the use of our resources	Development of pathways that deliver sufficient activity so they become business as usual
People – creating an inclusive, compassionate and high performing culture where our people can thrive and be their best self at work	Develop and support staff in the delivery of a Virtual Ward across all relevant disciplines. Keeps Trust and staff up to date with latest healthcare initatives

Table 1 Trust Values and Strategy

The case for change hinges on the ongoing robust assessment of the cost, risks and benefits to the Trust, to patients and staff in continuing with the Virtual Ward after 2023/24 when ICB funding is not available. The case will confirm the savings anticipated in continuation of the service to ensure that virtual wards represent a viable strategic opportunity for the Trust to provide innovative, high-quality care and to realise financial and operational efficiencies.

The case for change

The case for changes hinges on the delivery of the four key objectives outlined below: The key objectives of the programme are as follows:

1. Reduce/avoid the need for escalation bed capacity in the acute hospital with the development of Virtual Ward to support early discharge and admission avoidance
2. Improve flow through the hospital with commensurate improvement in access targets
3. Deliver value for money and evidence return on investment in the Virtual Ward.
4. Improve patient experience and outcomes

In considering the four key objectives the following have been explored:

- Supported by a robust IT system, the maximum potential opportunity in terms of patient volumes that we believe our virtual wards could address, adding value by giving people the opportunity to be supported out of hospital
- The net impact on the number of staffed beds as a result of implementing that number of virtual wards
- The specialties that could benefit from this initiative where the energy and enthusiasm is present to develop appropriate pathways
- The treatments available to each of the pathways and dynamic use of the hub staff to deliver treatment

The Luscii system was procured in October 2022 after a robust tender and evaluation process detailed in appendix 4, and enables 1 nurse in the Virtual Ward hub to manage 30 patients remotely.

Experience with the Respiratory pathway in the first whole month of running the pathway 17 patients accessed the Virtual Ward with an average length of stay of 5.29 days. This represents a utilisation which is lower than we anticipate going into 2023/24. Following feedback from the pilot, it is clear the critical success factor for other specialities is dedicated provision of medical staffing to the Virtual Ward. On this basis the service will be piloting 2 PA's of consultant time to the Virtual ward to support all pathways, within the clear criteria set by the speciality. The aim is to have the pilot starting in June 2023 and the Medical Director is actively working on this.

To enable the Virtual Ward to provide value for money to the Trust and the wider network, the volume of patients' needs to be increased. This will, by Q2 provide treatment on the monitoring pathways to capture more patients requiring support in the community. This will not be the same model as Hospital at Home and is not planned to include at this stage the requirement for Social Services.

As the service started to understand the patient cohort, an audit was undertaken over a 7-day period and it identified that if the Virtual Ward could provide home treatment, that an additional 133 patients would have been suitable for the Virtual Ward. See appendix 11. Active work with the Home Treatment service is underway to develop this alternative pathway.

The tables below outline the monthly capacity for 2023/24, the expected bed days provided for 2023/24.

On the basis that the capacity utilised is 75%, the virtual ward bed day cost will be £136.05. If this increased to 100% utilisation this reduces to £102.03.

	Daily Capacity, by month								
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Ja
Respiratory	2	6	6	6	6	6	10	10	10	
Acute medicine	0	7	7	7	10	10	20	30	30	
Haematology	0	0	1	1	1	1	1	1	1	

Gastro	0	0	2	2	2	2	5	5	5
Stroke	0	2	2	2	3	3	3	3	3
Orthopaedics	0	0	2	2	2	2	2	2	2
Surgery	0	0	2	2	2	2	2	2	2
Diabetes / Endo	0	0	0	2	2	2	5	5	5
Paediatrics	0	0	0	0	0	0	1	1	1
TOTAL	2	15	22	24	28	28	49	59	59

Specialty Pathway	Estimated Length of stay on Virtual Ward (Days)	Bed days available 23/24 @ 100% occupancy	Patient in 23/24 @ 100% occupancy	Average Patients per month	Bed days available 23/24 @ **75%** occupancy	Patient 23/24 @ **75%** occupancy	Pathway Start Date
Respiratory	5	2808	562	47	2106	421	Dec-22
Acute medicine	3	6889	2296	191	5167	1722	Jun-23
Haematology	10	305	31	3	229	23	Jun-23
Gastro	10	1159	116	10	869	87	Jun-23
Stroke	3	916	305	25	687	229	May-23
Orthopaedics	7	610	87	7	458	65	Jun-23
Surgery	5	610	122	10	458	92	Jun-23
Diabetes / Endo	7	1099	157	13	824	118	Jul-23
Paediatrics	3	305	102	8	229	76	Oct-23
Sub Total		**14701**	**3777**	**315**	**11026**	**2833**	

Table 2 Pathway Numbers

Note. The ‘bed days per year’ have been calculated by multiplying the daily capacity by 365 days and the ‘patients per year’ have been calculated by dividing the ‘bed days per year’ by the ‘estimated length of stay’

A full evaluation of the service will be conducted at the end of August 2023, including reviewing activity and potential pathways and to recast the plan for 2024/25.

Case for change re objective 1

Reduce/avoid escalation bed capacity with the development of Virtual Ward to support early discharge/admission avoidance

Currently across Maidstone and Tunbridge Wells NHS Trust we have three full time escalation wards open: Ward 11, Cornwallis and Chaucer, these are unfunded and therefore lead to a cost pressure for the organisation. Should the organisation see a reduction in length of stay for patients and improved operational flow, it is anticipated that this will lead to opportunities to begin to deescalate some of the escalation beds that are currently open across the organisation.

Should appropriate pathways be identified and imbedded on the Virtual Ward, literature suggests that we will see a number of bed days saved per patient enabling improved flow.

Case for change re objective 2

Improve flow through the hospital with commensurate improvement in access targets

Since the reduced attendances at the Emergency Departments during the height of the Covid-19 pandemic, Maidstone and Tunbridge Wells has seen a return to high numbers of attendances, exceeding the figures of 2019. During the month of January on more than one occasion the organisation saw the highest number of attendances that it had ever seen in a twenty-four-hour period. With increased attendances this no doubt leads to increased admissions and requirements for inpatient beds, therefore there is a need to explore alternative pathways to support in admission avoidance. Should appropriate pathways be agreed there is potential to refer patients direct from our Same Day Emergency Care (SDEC) settings and remotely monitor patients rather than admit them into an acute hospital bed.

Case for change re objective 3

Deliver value for money and evidence return on investment in the Virtual Ward

Increasing numbers of emergency admissions added to constraints with social care delaying patients discharge is putting continued pressure on hospital beds with frequent escalation capacity open. In 2022/23 period the Trust had between 50 and 116 escalation beds open during the winter months. With a cost of c£170,000 per month for the Cornwallis ward which has 19 beds, this equates to c£300 per day bed day cost. Bed day costs calculated in

	Daily Capacity, by month									
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Ja
Respiratory	2	6	6	6	6	6	10	10	10	
Acute medicine	0	7	7	7	10	10	20	30	30	
Haematology	0	0	1	1	1	1	1	1	1	
Gastro	0	0	2	2	2	2	5	5	5	
Stroke	0	2	2	2	3	3	3	3	3	
Orthopaedics	0	0	2	2	2	2	2	2	2	
Surgery	0	0	2	2	2	2	2	2	2	
Diabetes / Endo	0	0	0	2	2	2	5	5	5	
Paediatrics	0	0	0	0	0	0	1	1	1	
TOTAL	2	15	22	24	28	28	49	59	59	

Specialty Pathway	Estimated Length of stay on Virtual Ward (Days)	Bed days available 23/24 @ 100% occupancy	Patient in 23/24 @ 100% occupancy	Average Patients per month	Bed days available 23/24 @ **75%** occupancy	Patient 23/24 @ **75%** occupancy	Pathway Start Date
Respiratory	5	2808	562	47	2106	421	Dec-22
Acute medicine	3	6889	2296	191	5167	1722	Jun-23
Haematology	10	305	31	3	229	23	Jun-23
Gastro	10	1159	116	10	869	87	Jun-23
Stroke	3	916	305	25	687	229	May-23
Orthopaedics	7	610	87	7	458	65	Jun-23
Surgery	5	610	122	10	458	92	Jun-23
Diabetes / Endo	7	1099	157	13	824	118	Jul-23
Paediatrics	3	305	102	8	229	76	Oct-23
Sub Total		**14701**	**3777**	**315**	**11026**	**2833**	

Table 2 is c£68 per bed day.

Case for change re objective 4

Improve patient experience and outcomes
On the whole patients prefer not to be in an acute hospital and benefit from the comforts of their own environment without the disturbances and routines of a busy acute ward. Added to this reduced exposure to infection is a benefit to patients recovering from an acute episode of illness. Enabling patients to be an active part of their care with the use of resources and information further improves independence

Constraints and dependencies

Key constraints, dependencies and mitigation are detailed in the table below: -

Constraints and Dependencies	Mitigation and Management Actions
Recruitment and retention – insufficient staffing to cover the 24-hour Hub nursing will reduce capacity as the high volume of patients each nurse can support means that taking just one post out has a substantial impact	Robust and managed recruitment. Staged plan to deliver 24/7 capacity, training and development for staff, back up plans with other staff (Matrons, CCC) able to support gaps. Clinical supervision and staff support to maintain motivation and development
Money – the original allocation for the Virtual Ward was £2.7m per annum. This was a mixture of NHSE funding, matched by the ICB. The match funding is now not available and the HCP allocation has reduced from £2.7 to £1.5 for MTW, this will impact on capacity.	Effective use of the financial resources to provide a staged increase in activity to 60 patients at any time by June 2023. Discussion with ICB and plans to evidence the Trust can deliver a robust increase in activity. Discussion about further staging of activity increases in Q3 and Q4 2023/24
Support services ability to match demand should all capacity be filled, e.g. pharmacy. Whilst the Virtual Ward is intended to replace acute bed capacity rather than add out of hospital capacity in reality the risk of this becoming extra over and above escalation is not yet clear	Ensure support services are adequately resourced. Monitor Virtual Ward against the escalation capacity to determine impact, and plan accordingly.
Support from other partner, particularly the home treatment service, hospital at home or social services packages of care may limit the activity through the Virtual Ward	Work with home treatment and hospital at home to determine capacity for their intervention – e.g. IV antibiotics. Confirm with SS the maintenance of care packages for patients with short LoS or on admission avoidance pathways
Clinical buy in to the concept of accountability for patients on the Virtual Ward resulting in caution to develop pathways	Implement pathway and evidence success, develop pathways in specialties where there is clinical buy in, develop and deliver robust comms and a programme for meeting with each specialty

Table 3 Constraints and dependencies

Economic Case - The available options

There have been two options evaluated as part of our work to as follows:

1. Do nothing
2. Implement a Virtual Ward with step changes in capacity

In assessing the value offered by each of these options, we have also considered Professor Sir Muir Gray's 'triple value' model[1] in line with the Health Financial Management Association's approach (see table below). This articulate three types of value – personal value, technical value and population value – which have been considered alongside each option which are summarised in the table below and explained in the options appraisal.

Type	Option 1	Option 2	Description

[1] HFMA, *Measuring the Economic Value of Community Nursing* (p.8), February 2022 (https://www.hfma.org.uk/docs/default-source/publications/briefings/measuring-the-economic-value-of-community-nursing--briefing-jan-2022.pdf?sfvrsn=137f74e7_2)

Personal value	No improvement in patient experience from current position. Outcomes may be slower or worse than in a hospital environment	Improved patient experience as evidenced by the pilot with ARI. Reduced risks related to infection exposure, outcomes improvement from being at home and improved movement	Improving the outcomes that matter to an individual for a given amount of resources used not only by the health system but also by the individual and their family, recognising that the experience of care is a critical element.
Technical value	Technical improvement could be realised through existing processes	Improved use and exploration of technology enabled care to support patients safely in their own home	Optimising the use of resources to achieve the best possible outcomes for people being treated within a given pathway or process.
Population value	No outcome when specifically considering the Virtual Ward impact	Investing in Virtual Ward will use resources more effectively and create and manage capacity realising capacity for more patients and scope for future investment in the health and care system	Investing resources more wisely within a health system to optimise the outcomes for the population for which the health system is responsible.

Table 4 describing the 'triple value' model

Option 1 – Do nothing

The default option in this Strategic Case is to do nothing, which would see us carry on with business-as-usual. The perceived benefit of this option is to continue providing a familiar service to people and maintaining current ways of working. By contrast, the risks to this option are:

- Contravening national policy and regulation
- Continuing to expose older adults to stressful experiences, potentially increasing the risk of deconditioning associated with hospital admission
- Increasing the risk of infection
- Increasing use of escalation beds in the hospital which are difficult to staff, create risk and are expensive to resource.
- No cost benefits to the local and wider health and care population

This option does not address the continued growth in service demand and the consistent drive to reduce costs. There is also a broader risk that partners may miss the opportunity to affect change to service models during a unique period of significant reform; this could represent tacit acceptance that new ways of working do not support capacity challenges. This would also demonstrate Maidstone and Tunbridge Wells NHS Trust not adopting the NHSE and Integrated Care System Strategy.

Key activity and financial assumptions:

By 'do nothing' it is expected that there will be the continued or increasing demand for the use of escalation beds in the hospitals, which will further have a detrimental impact on the overall financial position of the Trust. The annual cost of running a 19 bedded ward is circa £2m, which can be negatively impacted both financially and qualitatively by the high use of bank and agency to staff to run it.

Strengths, Weaknesses, Opportunities and Threats (SWOT):

Strengths	Weaknesses
- no disruption or change to current service provision	- Do not gain potential benefits relating to 'bed days saved' and increased operational flow.

	- Not in line with national strategy - Not realising the possible opportunity cost savings. - Continued and increased use of escalation beds - Continued financial pressure from escalation wards. - Recruitment and retention challenges
Opportunities	**Threats**
- None	- Significant funding risk during contracting round with ICB - Reputational risk for future for not having delivered on a national strategy - Potential to miss out on further development funds and support

Table 5 SWOT Option 1

This option is rejected for the following reasons:

The growing population within the Maidstone and Tunbridge Wells NHS Trust catchment areas and already high and increasing demand on services particularly since the Covid-19 pandemic, along with the impact escalation brings to access targets (particularly inpatient waiting times and ED performance) the option to do nothing is not viable.

1. It is not in line with national strategy
2. There is no opportunity to support management of acute capacity
3. Reputational risk with ICB

Option 2 – Develop and Implement a Virtual Ward

This option continues to develop the virtual ward and increase capacity levels. Whilst the implementation of treatment pathways may change the dynamic of the service the utilisation of the Virtual Ward capacity is anticipated to increase as is the number of specialties

Due to experience with the pilot we are reviewing the model of care for the speciality pathways to include treatment. Our experience has shown that it is challenging to deliver to the full HUB capacity where the patients are too sick to be solely monitored and require in home treatments. This may impact on monitoring capacity however aims to maximise the use of the clinical staff out of hospital.

Due to the passage of time since the initiative was funded many of the initial steps have been taken to secure the technical solution, confirm the establishment and staffing and pilot the model of care. This consisted of the follows:

1. Tender for a technical partner
2. Shortlist
3. Procurement of the technological solution
4. Testing and implementation of the technology
5. Integration with trust systems
6. Development of a Virtual Ward hub staffed by registered nurses to monitor and manage patients on a specific clinical pathway
7. Recruitment of staff to manage and run the virtual ward
8. Implementation of two acute pathway pilots since December 2022

The preferred option adds personal, technical and population value through its use of innovative technologies and digital innovation as follows:

- it is anchored in redesigning and co-producing patient pathways with families and carers to provide a better experience, and likely at a lower resource cost than an alternative setting.
- in terms of technical value, this represents a more efficient use of resources without jeopardising the quality of care to an individual; in some cases, care outcomes have improved nationally through similar projects.
- from a population value perspective, this option represents challenge to current ways of working and investment into a system that is safe, preferable to patients and gives opportunity to maximise outcomes for the population and provide an opportunity to realise efficiency[2] through a technology-enabled service to enable resources to be diverted to other service provision.

In light of these benefits appraisals and independent evaluations, there is significant evidence to suggest that virtual wards drive material health and social benefits for individuals and their families; experiential benefits and efficiency for clinicians and their teams; and financial and operational benefits for care organisations and system partners.

Key activity and financial assumptions:

- Expectation that there will be clinical buy-in to provide sufficient volumes of patients, providing 'value for money' of the service.
- ICB will prioritise the initiative for funding as outlined in 2023/24
- Activity over the year 2023/24 will evidence release of capacity and revenue for the Trust to fund this ongoing in 2024/25 and beyond when central funding ceases
- Any shortfalls between the ICB funding and the costs will be funded by MTW by recruitment slippage
- The pay costs do not reflect any temporary staff outside of the financial envelop
- The pay cost has been updated to reflect the 2.1% national pay guidance in the 2023-24 Planning round, any changes to these will needs to be re-assessed.
- No Project Manager costs are included

Strengths, Weaknesses, Opportunities and Threats (SWOT)

Strengths	Weaknesses
- Remote monitoring technology that has proven successful and easy to use in the pilot - The potential benefits such as 'bed days saved' and improved operational flow. - Support more effective management of flow - Support reduction in escalation beds and more dynamic management of the acute bed stock	- It is new - Ability to deliver volume as this is unknown
Opportunities	**Threats**
- To support / supplement existing other home services and improve outcomes. - To increase admissions avoidance opportunities with an alternative pathway to offer. - Identify wider Trust financial and non-financial efficiencies. - Attractive employer	- New service and a risk to clinical buy in and achievement of trajectory - Ability to recruit - Culture change within the organisation required to truly embed Virtual Ward model. - Future funding for 24/25 and beyond is unconfirmed.

Table 6 SWOT option 2

This option is Preferred due to:

The growing population within the Maidstone and Tunbridge Wells NHS Trust catchment areas and already high and increasing demand on services, coupled with the impact of increasing demand on access targets (particularly inpatient waiting times and ED performance) the option to implement and develop capacity in a Virtual Ward is critical and:

[2] HFMA, *Making a difference with digital technologies: identifying and evaluating benefits,* April 2022 (https://www.hfma.org.uk/docs/default-source/publications/briefings/making-a-difference-with-digital-technologies-hfma-briefing-final.pdf?sfvrsn=f98e76e7_2)

1. It is in line with national strategy
2. Provides opportunity to support management of acute capacity
3. Provides an opportunity to develop innovative ways of working across many specialties to support overall population health
4. Ability to utilise central funding to start a new service.
5. Opportunities for financial efficiencies for ongoing funding as acute beds are released

The preferred option

Our preferred option is considered a commercially viable option within the parameters of the ICB/HCP funding that has been made available nationally to support virtual ward development.

The proposed development for virtual wards consists of the following key features:

- Remote monitoring of patients, using a technological solution 24 hours a day
- Provision of an iPad and Bluetooth enabled equipment for patients to use in their own home for monitoring and reporting purposes.
- A nurse to patient ration of 1:30, which is equivalent to three times a traditional hospital ward.
- Providing patients with choice, to remain in their own home or return home sooner or avoid admission
- Development of the service to provide care and point of care testing for patients which will increase clinical confidence and uptake

The requirements for the preferred option have been/will be implemented and are:

- Enter into contractual arrangements with third party suppliers who will provide the software and hardware.
- Access to the existing patient systems (eg PAS) for the Virtual Ward staff.
- Access of community staff to the hub supplier to be able to monitor patients on a community pathway

The expected outputs and outcomes as a result of our preferred option are:

- Delivery against the key objectives
- An increase in net staffed bed capacity at a system level over the next two years
- Improved patient experience
- Recurrent cost avoidance
- Improved quality of experience and care both on the Virtual Ward and in the hospital environment
- Improvement in care team experience and wellbeing as a produce of new ways of working and alternative career development opportunities
- More integrated working across the health and care system
- Support for surges in acute activity

Monitoring of the activity is supported by the BI and the technical virtual ward team, cross referencing activity data from the KCHFT and MTW PAS systems and the virtual ward activity profile. Real time occupancy monitoring is provided by a dedicated virtual ward on Tele Tracking.

Commercial Case

Services, assets and space required

Site and IT resources

During the development/pilot phase of the programme space was identified in the Care Coordination Centre on the Maidstone hospital site. This is appropriately located for support and partnership working with the rest of the care coordination team. The space makes provision for 5 Hub nursing staff at a time which will be our ambition moving into 2024/25. PC's have been supplied linked to the Trust clinical systems and the Luscii system, for ease of patient identification and pathway management. Patient going onto the Virtual Ward are not discharged from hospital but transferred from an inpatient ward to a newly set up Virtual Ward on our Trust system. The patients on the Virtual Ward remain the acute Trust activity until discharged from the Virtual Ward. The site and IT resources are in place and were supported within Trust resources

System Support

The Virtual Ward system support procured as part of a robust process, outlined below, is from Luscii. The system is widely used in Europe and is being introduced in Trusts around the UK. Luscii has the advantage of experience and pathways for specific conditions already set up, alternatively bespoke pathways can be identified. Luscii provide on line support for any issue/queries in support of the Trust implementation and ongoing management of the Virtual Ward.

Equipment Management

Luscii's partners with Academia Select, who offer a subscription model to provide hardware (including monitoring equipment), software and IT services. They manage cyber security to ensure users, data assets and infrastructure remains secure. They are able to offer unlimited repairs and supply Apple products, which meet with the Trusts encryption requirements.

Once a certain level of utilisation is reached, Academia Select are able to distribute the devices to the patient's homes on the same day, supporting tech turnaround, decontamination and aiding the swift transfer of patients from the Hospital to their home.

Until the required level of utilisation is reached, MTW will be responsible for providing the equipment to the patients, assisting with the set-up process and managing the collection and decontamination or the equipment. This responsibility will be shared between the Virtual Ward team and the ward-based teams. Stock will be securely held on both sites to minimise delays in the onboarding process.

Staffing plans

The virtual ward model represents a move away from historical ways of working, acknowledgement of the increasing acuity of patients while safely and effectively supporting them in community settings. In order for the integrated workforce to respond to this opportunity, the skills and capabilities required for virtual ward patient cohorts have been reviewed with consideration of training requirements for the current and the future workforce, including leadership, clinical and digital skills.

During the development and implementation of virtual wards, the programme also had support from JPMO and MTW PMO to develop the governance and reporting and in the case of JPMO be the conduit with the ICB and HCP. Transformation resource is an integral component to the delivery of this programme and will continue until the end of 2023/24.

The workforce required to mobilise, deliver and sustain the virtual ward is set out in the table below. The establishment is detailed in the table below and includes:

- Management support and direction from a general manager
- Clinical leadership from a senior matron
- Clinical management from a band 7 ward manager
- Site clinical leadership to 'pull' patients into the Virtual Ward
- Clinical support from clinical coding and pharmacy
- Training and IT support

Phasing of staffing (capacity for 60 patients):

Grade	Role	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2024-25 Full Year
8b	Band 8B General Manager	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
8a	Band 8a Clinical Lead / Matron	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
5	Band 5 IT Support	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
3	Band 3 VW Clerk	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
5	Band 5 Nursing (Days)	5.42	5.42	5.42	8.13	8.13	8.13	8.13	8.13	8.13	8.13	8.13	8.13	8.13
5	Band 5 Nursing (Nights)	2.48	2.48	4.97	4.97	4.97	4.97	4.97	4.97	4.97	7.45	7.45	7.45	7.45
7	Band 7 Virtual Ward Manager (Days)	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Consultants	Consultant	0.00	0.00	0.20	0.20	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
6	Band 6 Clinical Coder	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
6	Band 6 Nursing	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39	3.39
5	Band 5 Pharmacist	0.00	0.00	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69	1.69
Total Pay		**16.29**	**17.29**	**21.67**	**24.38**	**24.68**	**24.68**	**24.68**	**24.68**	**24.68**	**27.16**	**27.16**	**27.16**	**27.16**

Table 7 Staffing phasing

If the demand for capacity exceeds 60 patients, then there will be a requirement for additional funding, to provide the increased staffing for both monitoring and care and is detailed in appendix 5. This will only be considered if after review the service is financially viable and is positively impacting flow in the acute hospital.

Impacts on and interfaces with other services.

In addition to the workforce outlined above, there is a need to directly engage and collaborate with partners from health and social care and the VCSE sector to optimise service provision and improve care experiences. Internally interfaces with all specialities to develop the specialty pathways, clinical support services to ensure pathways are

supported, with the BI team to provide performance data and the IT service to enable the LUSCII system to interface with the Trust PAS system.

Activity, contractual and service level agreement implications. Commissioner involvement and input.

HCP has a split contract between MTW and KCHFT, with a MOU in place and a split of 70/30.

Procurement route

Procurement for the technology partner was sought from the open market in support of the digital enablement of virtual wards, with consideration to the Digital Technology Assessment Criteria (DTAC) set out by NHS Transformation to support vendor shortlisting. Further information on Guidance for Selecting and Procuring a Technology platform.

The digital system procurement for virtual ward was managed by the IT technical team who reviewed four systems, **Docabo, Current Health, Luscii** and **Docla**.

Additional information is included in appendix 4

Financial Case – Funding and affordability

Overall financial cost and projected financial benefits

Revenue Requirement:

The total cost of this proposal is £1,600,222 for 23/24. These costs are split out in the tables below, with table 8 highlighting the staffing costs (note this is not FYE as this is a phased increase until September 2023) with the phasing, and table 9 including the non-pay costs to give the total.

ICB funding for 2023/24 has been confirmed at £1,500,000 and there is a shortfall of £100,222 which will be needed to be funded by MTW by recruitment slippage, or increases in activity to reduce the pressure on acute beds. This will be monitored closely across the year.

Added to this, increasing the scope of the Virtual ward to included treatment (for example, IV antibiotics) will have a cost and confirmation of how this cost is accounted for will be confirmed, if and when, this cohort of patients come on to the Virtual Ward, this is not anticipated until Q2.

Staffing costs for the Virtual Ward – 2023/24

Grade	Role	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	PYE 23/24	2024-25 Full Year
8b	Band 8B General Manager	7,011	7,011	7,011	7,011	7,011	7,011	7,011	7,011	7,011	7,011	7,011	7,011	84,127	84,127
8a	Band 8a Clinical Lead / Matron	5,850	5,850	5,850	5,850	5,850	5,850	5,850	5,850	5,850	5,850	5,850	5,850	70,199	70,199
5	Band 5 IT Support	3,485	3,485	3,485	3,485	3,485	3,485	3,485	3,485	3,485	3,485	3,485	3,485	41,819	41,819
3	Band 3 VW Clerk	2,421	2,421	2,421	2,421	2,421	2,421	2,421	2,421	2,421	2,421	2,421	2,421	29,050	29,050
5	Band 5 Nursing (Days)	21,320	21,320	21,320	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	351,779	383,759
5	Band 5 Nursing (Nights)	11,627	11,627	23,254	23,254	23,254	23,254	23,254	23,254	23,254	34,881	34,881	34,881	290,676	418,573
7	Band 7 Virtual Ward Manager (Days)	0	5,092	5,081	5,081	5,081	5,081	5,081	5,081	5,081	5,081	5,081	5,081	55,907	60,977
Consultants	Consultant	0	0	2,310	2,310	5,775	5,775	5,775	5,775	5,775	5,775	5,775	5,775	50,824	69,305
6	Band 6 Clinical Coder	4,536	4,536	4,536	4,536	4,536	4,536	4,536	4,536	4,536	4,536	4,536	4,536	54,428	54,428
6	Band 6 Nursing	17,343	17,343	17,343	17,343	17,343	17,343	17,343	17,343	17,343	17,343	17,343	17,343	208,110	208,110
5	Band 5 Pharmacist	0	0	6,662	6,662	6,662	6,662	6,662	6,662	6,662	6,662	6,662	6,662	66,625	79,950
Total Pay		**73,591**	**78,684**	**99,273**	**109,933**	**113,398**	**113,398**	**113,398**	**113,398**	**113,398**	**125,025**	**125,025**	**125,025**	**1,303,546**	**1,500,298**

Table 8 Staffing costs phasing

TOTAL costs for the Virtual Ward **2023/24**

TOTALS	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	23/24 Total
Pay	73,591	78,684	99,273	109,933	113,398	113,398	113,398	113,398	113,398	125,025	125,025	125,025	1,303,546
Non-pay (excl overheads)	16,371	16,371	16,371	16,371	16,371	16,371	16,371	16,371	16,371	16,371	16,371	16,371	**196,454**

Total (excl overheads)	89,962	95,055	115,644	126,304	129,769	129,769	129,769	129,769	129,769	141,396	141,396	141,396	**1,500,000**
Total (excl overheads - cumulative)	89,962	185,017	300,662	426,966	556,735	686,504	816,273	946,042	1,075,812	1,217,208	1,358,604	1,500,000	

Table 9 Staffing costs totals

The projected financial benefits of this proposal are net positive. If 75% of the total capacity (detailed in table 2) is achieved then this proposal will provide over 10,000 virtual ward bed days for the 23/24 year. This will enable physical beds to be freed up within the hospital, therefore improving flow and contributing to the Trusts CIP target of releasing 20,000 bed days during 23/24.

Capital requirement

There is no capital requirement to the case

Affordability and sustainability

ICB funding for 2023/24 has been confirmed at £1,498,000. The overheads are excluded from this funding. There is expected recruitment slippage and staff turnover which will contribute to the overhead costs in year. Costs as well as activity and impact on acute beds will be monitored closely and will be the subject of a review mid-year to determine if this initiative is viable going into 2024/25. 2024/25 funding will then need to be reviewed for affordability going forward.

Added to this, increasing the scope of the Virtual ward to included treatment (for example, IV antibiotics) will have a cost and confirmation of how this cost is accounted for will be confirmed, if and when, this cohort of patients come on to the Virtual Ward, this is not anticipated until Q2.

This proposal is reliant on recurrent investment from FY24/25 onwards once national and regional funding expires, subject to an evaluation of the benefits realised by the proposal as it develops. To enable a smooth and sustainable financial transition, we have been working with local Finance teams to ensure that this investment will support the continued development and scaling of the model, including the potential for expanding into other pathways.

Breakdown of financial impacts *(State Financial Year)*	**Y1 (23/24)**	**Y2 (24/25)**
CAPITAL COSTS Estates	£0	£0
IT	£0	£0
Equipment	£0	£0
VAT	£0	£0
Total Capital Costs		
REVENUE COSTS Pay	£1,303,546	£1,500,298
Non-pay	£196,454	£196,454
Other ()		
Other (non- operating) expenditure		

Capital charges	£0	£0
Total Revenue Costs	£1,500,000*	1,696,752*
INCOME SLA	£1,498,000	£0
Efficiency gains	tbc	£0
Surplus/Loss	-£2,000	-£1,696,752

Funding source/ body
ICB Funding for 23/24, total of £1.498m 24/25 unfunded (currently) **Does not include overheads*

Table 10 summary of Virtual Ward costs 2023/24 (all costs assumed at 23/24 levels

Management Case - Arrangements for successful implementation

Governance arrangements

The delivery of this project will be owned and led locally by the ICB. West Kent have determined to split the programme between KCHFT and MTW, and the financial arrangements have been confirmed with a Memorandum of Understanding (MOU) in place for each organisation. The governance is supported by senior leadership and local clinicians, who will continue to remain involved through new governance arrangements. The operational delivery will be driven and owned by colleagues who will take on a project management office (PMO) role.

The funding received from the ICB and will be used to implement the proposal above and pump-prime the cost of the model described. Regular situation reports (sitreps) are being submitted regionally and nationally as part of ongoing reporting requirements for existing virtual wards, with regular contact with regional colleagues to provide support, guidance and resource where appropriate.

At this point there is no foreseeable need for third party advisors to support with local development, although if this becomes a requirement and is determined to add value, specialist advisors will be sought and procured through local processes.

Project team

Principle Project Team is made of up of:

Name	Role
Dr. Peter Maskell	Executive Sponsor
JoAnne Cutting	Programme Director
Sally Foy	Director of Operational Nursing
Darren Palmer	Deputy Site Director
Sam Roberts	Virtual Ward General Manager
Fay Johnstone	Virtual Ward Lead Matron
Mark Pordage	Head of Contracting and Income
John Coffey	Finance Manager
Jonathan Bailey	Pharmacy Lead
Kelly Cushman	Head of Nursing Central Operations
Richard Cardy	Procurement Manager
Sally Patching	Programme Manager (WK HCP)
Stephen Bundock	Programme Manager (MTW)

Table 11 Project team

The programme governance structure is outlined in the table below with details of terms of reference in Appendix 6 and the terms of reference in Appendix 7.

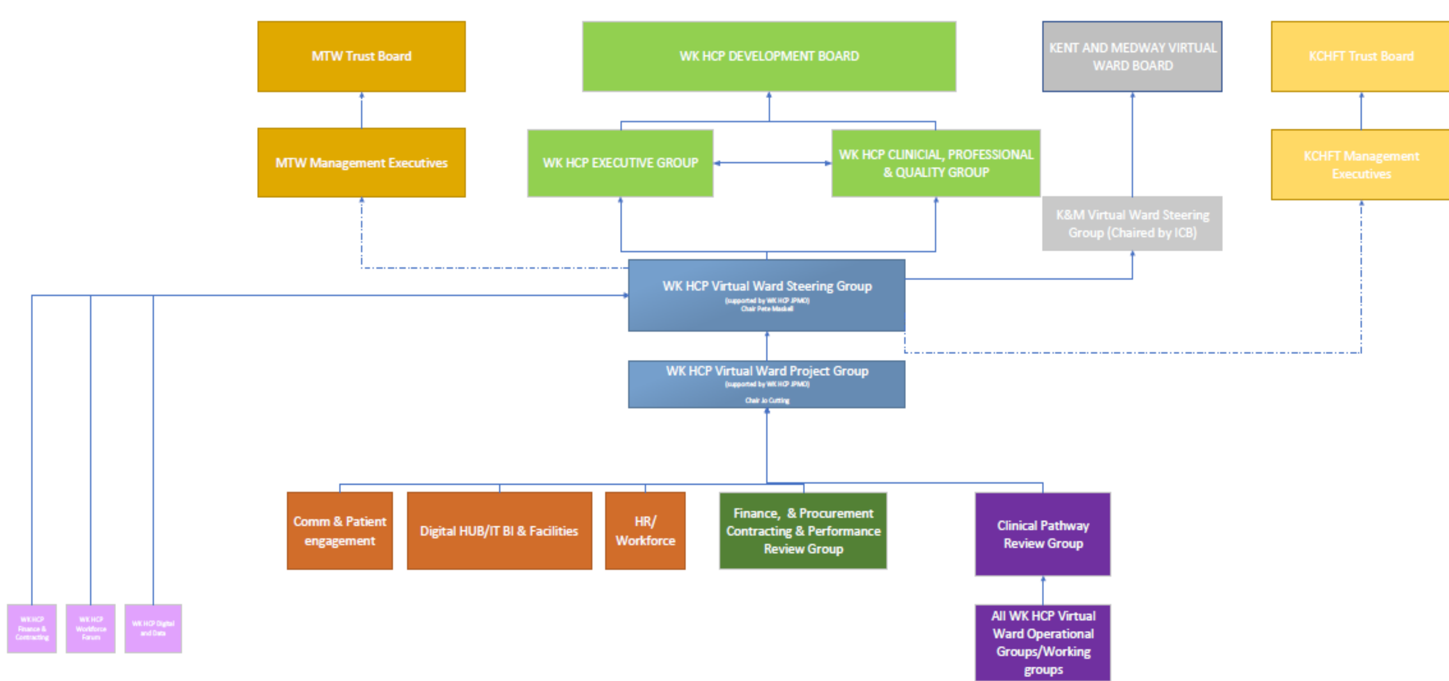


Table 12 Virtual Ward Implementation Governance Structure

All groups have agreed terms of reference and membership with notes and outputs of meetings recorded.

Delivering the key measurable benefits

Include key measurable benefits with quantification of change in value, measure, timing and responsibility. Summarise this on p2

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
Bed days saved	New Service	Circa 10,000 bed days for the 23/24 year at 75% occupancy.	Data to be confirmed on the BI dashboard	By 31st March 2024	Virtual Ward General Manager
Admissions avoided	New Service	Reduction in demand for inpatient hospital beds.	Data to be confirmed on the BI dashboard	By 31st March 2024	Virtual Ward General Manager
Patient feedback	New Service	Positive comments for to the Virtual Ward portion of the patient's treatment	FFT for patients on the Virtual Ward compared with feedback from traditional wards	By 31st March 2024	Virtual Ward General Manager
Hospital escalation capacity numbers	Currently utilising 1 ward per site (equivalent to 60 beds)	By Q4 23/24, reduce the demand on the escalation beds by providing capacity for 60 virtual ward beds at any one time.	Trust's Data	By 31st March 2024	Virtual Ward General Manager & Virtual Ward Lead Matron

Table 13 Key benefits

Timetable

Include, at a minimum, the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date. Summarise on p3

Milestone	Date
Staffed 8am – 8pm seven days a week with capacity of 30	December 2022
Staffed 24/7 with a capacity of 60	3rd April 2023. Develop treatment pathways, a monitoring/treatment model of care and confirm capacity
Specialities to provide further patient assessment in their SDEC's where required (eg X-ray's)	Q2 23/24
Introduce treatment pathway	Q2 23/24
Staffed 24/7 with a capacity of 60	July 2023. Introduce treatment and monitoring pathways. Increase specialty pathways

Table 14 Timetable

Managing any key risks associated with delivering the project

Below are the key risks for the project and the full risk register is located in appendix 8.

Risk	Baseline risk score (I x i)	Summary mitigation/ contingency	Mitigated risk score (L x i)	Lead
The lack of capacity in domiciliary care could impede the discharge of patients from virtual wards and hospital at home services in particular. Reduced patient flow, leading to inability to reduce acute in-patient beds	16	Agreement from KCC that patient who are already provide with a social care package and admitted to a virtual ward will not be affected, this package can remain in place and be added to. Close alignment with the local authority in order to understand capacity issues in the domiciliary care market Model the impact on community-based services during the first phase to reflect in future commissioning intentions. Robust discharge planning utilising SAFER bundle principles with complex discharges managed by the integrated discharge team. WK HCP Virtual Ward members to include Primary Care, KCC, patient reps, Secamb, voluntary sectors to ensure co-design and co-production of service. Select	6	Doug McLaren

		MTW pathways with low impact on other provider services.		
Medical Staffing support for the VW is not robust and is resulting in reticence of other medical colleagues to refer patients for care on the VW	20	Pilot commenced with 2PAs of consultant time in May 2023. Initial response is that the number increased on the VW rapidly	12	Peter Maskell
Uncertainty of substantive funding from 2024 and uncertainty of funding if virtual ward does not provide the number of acute beds as defined by NHSE/Impact on ability to recruit high quality staff committed to the VW model	16	Establishing a system wide position of virtual wards within overall strategy by Dec 23 to inform ICS strategy and future contract setting. Aligning effective use of virtual ward capacity to closure of escalation areas. HCP partners to revise service in line with the proposed assumed national funding and revise service capacity in line with clinically safe practice.	6	Sam Roberts
There is not enough genuine demand to utilise capacity effectively. A misunderstanding of virtual wards and pathways becoming resource intensive extensions of community services. Demand modelling needs to be undertaken to understand the actual opportunity for VW capacity within each specialty, ensuring this is clinically led. It is also imperative that we are clear on VW identifiable versus community services.	12	Completing clinically led audits of the 'opportunity' ahead of committing to capacity for each pathway to ensure that resource deployed is effective. Managing service expectations through robust process of identifying and implementing pathway. MTW comms advising trust staff of the virtual wards, what and why they are being implemented to create an understanding for all staff, clinical and operational. Operational groups to attend clinical governance to discuss virtual wards for peer to peer clinical engagement. Links with NHS Future Platforms to benchmark against trust throughout the country on the services being delivered within virtual wards. Agreed capacity and activity line with the HCP in the plan Development of pathways with assigned clinical leads for each service/directorate with clear and regular monitoring of demand against capacity. Revision of service to provide treatments at home; which will allow for a wider inclusion criteria. Expansion of the pathway to include a range of specialties (stroke, cardiology, haematology, orthopaedics, surgery, gynae, paediatrics) to extend the patient profile. Develop the service to include treatment with H@H input and	6	Sam Roberts / Fay Johnstone

		development of the Hub nursing workforce		
Cost of the service is too great to sustain the service; The reduction in the funding will limit the amount of activity that the Trust will be able to deliver and will have a consequence as numbers increase on non-pay and the potential requirement for increased staffing. This will be assessed against acute bed days savings.	20	Work with clinical team to develop and agree plans for growth of activity over the financial year and staff to achieve the activity. Plan to deliver a larger range of specialties using the service and expand to provide treatment.	16	Sam Roberts
Nursing / Care homes may not engage in the process completely, including not allowing people to return to the Nursing / Care home setting whilst on a Virtual Ward. This could be due to financial considerations, staffing levels within the Nursing / Care home, concerns surrounding the impact on the nursing registration or due to insurance implications.	9	Initial pathway development focusses on patient group not requiring social or nursing home care Communication and engagement with nursing/care homes within the co-design of the virtual wards. Review with Nursing/Care Homes Managers of the level of activity to monitor the outcome.	6	Fay Johnstone
Recruitment of staff groups required to keep patients at home, e.g. physio/OT etc may be difficult due to the limited number of qualified staff. Possible difficulty in recruiting to the establishment.	16	Steering group / operational group to review the requirements of staffing and impact on resource for each pathway and work with the relevant HR teams to promote vacancies. WK HCP Partners to use HCP work force forum for combined support and input. Prioritise recruitment of staffing and phase implementation to services. Skill mix review to look at alternative levels of recruitment and shared roles across the HCP, and within internal organisations.	6	Sam Roberts / Fay Johnstone

Table 15 Risks

Clinical Quality Impact Assessment (preferred option)

For guidance on QIA requirements contact the Project Management Office

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, identify lead	Yes
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	Yes
Are relevant Clinical Outcome Measures already being monitored?	Yes
Are there any risks to clinical effectiveness? If yes, list	No

Have the risks been mitigated?	Yes
Have the risks been added to the departmental risk register and a review date set?	
Are there any benefits to clinical effectiveness? If yes, list	Yes

- Providing early discharge.
- Reduced length of stay within the acute setting.
- Improving system wide patient flow.

Patient Safety. Has the impact of the change been considered in relation to: *(highlight as appropriate)*	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality Account priorities?	Y
CQUINS?	N/A
Are there any risks to patient safety? If yes, list	Y
Have the risks been mitigated?	Y
Have the risks been added to the departmental risk register and a review date set?	N
Are there any benefits to patient safety? If yes, list	Y

- The virtual ward will allow clinically appropriate patients to be discharged approximately 1-2 days earlier than their standard estimated discharge date
- The centralised hub team will be clinically led, with the nursing team comprising of qualified, trained nurses. Additionally, robust escalations plan for deteriorating patients will be implemented to ensure patient safety
- Patients are seen/followed up in the most appropriate setting.
- Improved flow of patients through the health care system.
- Positive impact on patient recovery.

Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed?	Y
Does the redesign lead to improvements in the care pathway? If yes, identify	Y
Are there any risks to the patient experience? If yes, list	Y
Have the risks been mitigated and / or added to the departmental risk register and a review date set?	Y
Are there any benefits to the patient experience? If yes, list	
Yes.	
Health inequalities	
What planned or potential positive or negative impacts will the development have on health inequalities? Consider who may have their service or access to service improved or compromised? Describe these impacts	

- Patients can be provided with an iPad and mobile data, so that patients who do not have access to a smart phone or tablet will not be disadvantaged for the service.

• LUSCII is able to provide patients with instructions and guide in alternative languages where English is not their 1st language. • Patients with mental health/learning disabilities will be assessed and monitored on regards their individual needs. • Patients have the right to choose regards deciding whether they consent to being referred to this service.

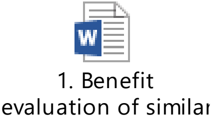
Service					
What is the overall impact on service quality? – please highlight one box					
Improves quality	☑	Maintains quality		Reduces quality	
Clinical lead comments					

For additional information: The approved QIA is located in appendix 9 and the approved EIA is located in appendix 10.

Appendices

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

Appendix 1 - Benefit evaluation of similar Virtual Ward models:



1. Benefit evaluation of similar

Appendix 2 – Option benefits scoring

Choose up to 5 key potential benefits. Use the same benefits for each option. Weight each benefit between 5 and 1 (5 = very important 1 = minimal importance) and score each option between 5 and 1 (5 = high score 1 = low score) on the same set of benefits. Add the weighted benefits together for each option. This allows you to show how each option compares against the others on the (non- financial) benefit associated with it.

Option benefits comparison table

Benefit description	**Benefit Weight (A)**	Option 1 – Do Nothing		Option 2 – Implement a Virtual Ward	
		Score (B)	A x B	Score (B)	A x B
1. Improving patient flow, enabling additional hospital ward capacity.	**5**	1	5	3	15
2. Provide additional patient choice for their care.	**4**	1	4	5	20
3. Support reduction in escalation beds and more dynamic management of the acute bed stock	**3**	1	3	4	12
4. Opportunity to identify wider Trust financial and non-financial efficiencies.	**1**	1	1	3	3
5. Ensure that national strategies are adhered too.	**4**	1	4	5	20
		Option 1 Total	18	Option 2 Total	70

Appendix 3 – Option risk scoring (example)

What are the pitfalls of taking each option? Identify up to three key risks. E.g. Risk of delay / Risk of missing a target/ Risk of reputational damage

Risk 1: Staffing – recruitment and retention

Risk 2: Clinical engagement

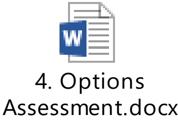
Risk 3: Not delivering the required activity to make affordable.

Compare the severity of risk for each option.
Using the table below, score each option against the same risks. Score the likelihood between 0 (no risk) and 5 (highly likely) and the impact between 0 (no impact) and 5 (catastrophic impact) of this risk for each option. Add the risk scores together and this will give you a risk score to use compare each option against the other options.

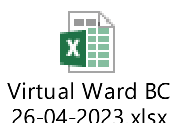
Option risks comparison table

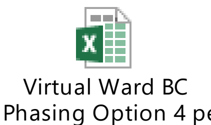
	Risk 1 – Staffing - recruitment and retention			Risk 2 – Clinical engagement			Risk 3 - Not delivering the required activity to impact on bed capacity			Sum of option risk scores
Option	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	
Option 1 – Do Nothing	1	1	**1**	2	5	**10**	5	5	**25**	**36**
Option 2	2	4	**8**	2	4	**8**	3	5	**15**	**31**

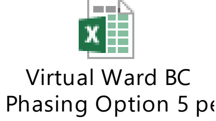
Appendix 4 – options Assessment


4. Options Assessment.docx

Appendix 5 - Finance







Appendix 6 – Governance Structure

Appendix 7 – Terms of Reference

WKHCP Respiratory Virtual Ward ToR DI

WKHCP Virtual Ward Clincial Pathw

WKHCP Virtual Ward Digital HUB, I

WKHCP Virtual Ward Enabler Group

WKHCP Virtual Ward Finance Contr

WKHCP Virtual Ward Steering Grou

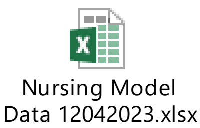
Appendix 8 - Risks

Appendix 9 - QIA

WKHCP Respiratory Virtual Ward QIA FIN

Appendix 10 – EIA

Appendix 11 – Nursing model audit



Appendix 12 – DPIA

Trust Board Meeting – 29th June 2023

Update from the SIRO (incl. approval of the Data Security and Protection Toolkit submission for 2022/23, and Trust Board annual refresher training on Information Governance)	**Director of Strategy, Planning and Partnerships**

The enclosed report provides an update and further detail in relation to the annual submission of the NHS England, Data Security and Protection Toolkit (DSPT) 2022 - 2023.

Which Committees have reviewed the information prior to Trust Management Executive submission?

- Information Governance Committee, 30/05/23

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

For approval and presentation to The Board.

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

1. Background and Scope

The purpose of this paper is to provide the Trust Management Executive with an update of the Data Security Protection Toolkit (DSPT) and the status at the point of submission to NHS England on the 30th June 2023.

2021 – 2022 submission was made as 'Standards Not Met' with a recategorization of 'Approaching Standards' in September 2022 on approval of an action plan by The Trust Board and NHS Digital (NHSD), now NHS England.

2. Current Status

The DSPT submission has been independently verified by TIAA in May 2023, accompanying report provided for information. There remain two assertions that are to be submitted as 'Standards not met'.
These are:

3.2.1 - At least 95% of all staff, have completed their annual Data Security Awareness Training in the last twelve months.

The current percentage of staff completed their annual IG Training is **88.75%.**

A significant push was made to improve this in readiness for the CQC inspection, however compliance remains low in clinical areas.

Month	No Staff	IG Training Compliance	IG Training Target
April	6501	90%	95%
May	6626	90.20%	95%
June	6650	90.32%	95%
July	6701	90.50%	95%
August	6743	90.10%	95%
September	6801	88.45%	95%
October	6698	88.00%	95%
November	6829	83.63%	95%
December	7018	88.89%	95%
January	7218	86.77%	95%
February	7238	88.75%	95%
March	7166	88.90%	95%
April	7211	88.60%	95%
May	7324	88.70%	95%

8.4.2 All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.

This assertion was not met in 2021/2022, and is expected remain the same in 2022/2023.

Several servers remain on infrastructure running unsupported software. An action plan has been in place since June 2022 to oversee the migration of these servers over a 24-month period. This has been approved by Trust Board and NHS England.

There has been significant progress, with only 30 servers requiring remediation. The table below provides an overview of the current systems that still require upgrade/migration:

System/Server	Comments	Expected Completion
Commvault	Initial data migration times were based on estimates with the best knowledge and information available at the time, migration has taken longer than expected. A third of data has now been migrated which has allowed calculations to be reviewed and more realistic timeframes set. Vendor support has been engaged to ensure the migration is as efficient as possible and does not impact overnight back up processes.	August 2023 Anticipated to be prior to this pending migration.
ONCDC01 - Domain controllers AND ONCDC02 - Domain controllers	An attempt to migrate and decommission this server was undertaken within the previous timeframe set, however this had to be rolled back due to unforeseen technical issues. These have now been overcome and a second attempt to migrate this server was scheduled for March 2023. This has been impacted by issues with the Storage Area Network [SAN]. Temporary solutions have been explored using server 2019. Testing remains ongoing. There remains 1x 2008 to decommission. Change request going through next week for TWH, MGH will follow once the above has completed.	September 2023
GRS (Global rostering System)	Requirement for historical data to be reviewed. Two servers remaining, one database and one web server. Exploring costs with GRS for migration works to be completed. Linked with Patchwork Pilot which is due to run for six months ETA November 2023.	October 2023
SQL Cluster	This work is being completed by a third party, Cloud 21. 13 databases are linked to this cluster that each require separate project and governance works.	October 2023

System/Server	Comments	Expected Completion
Oncology ZENworks Server	Devices team working with Oncology to remove digital dictation from a number of devices.	September 2023
TWHEUROKING01 2003 - E3	E3 physical server holding patient data that needs to be retained until 2036. Cannot decommission the server due to age of server and risk of data loss. Working with suppler to agree next steps.	October 2023
TWHEMETS01	EME Shires Server - RAMS 5000 went live in 2021, awaiting EME to confirm migration of data in order to decommission.	December 2023
MGHCURIIS01	Clinical Utilisation Review - Contract held with supplier, cloud-based solution purchased in 2021. Governance documentation in draft, further update from supplier when ready to be decommissioned.	September 2023
Aria (chemo)	Kent and Medway wide programme of work. Outline Business Case has been drafted and comments made. Engagement via Cancer delivery board to progress through Governance processes 2023/2024.	2023/2024
Supporting infrastructure	There are a small number of infrastructure items that cannot be decommissioned until all of the above work has been undertaken.	2023/2024

3. Mitigation & Assurance

Assertion 3.2.1 Training Compliance

An action plan to address training compliance has been drafted and presented to the Information Governance Committee alongside this document. This action plan addresses the training needs and focuses on the improvement of training compliance across the Trust.

This includes:

1. Enhanced Communications – Regular updates and training reminders via Pulse / News / Intranet
2. Dedicated training space for staff without dedicated workstations.
3. Additional reporting function for Managers via Learning and Development application.
4. Review of notifications from Learning and Development Team.
5. Enforcement of Multi Factor Authentication (MFA) across platforms key to the sharing of data.

Assertion 8.4.2 Unsupported Systems:

The following measures are currently used to provide mitigation where possible whilst the above work continues:

- **Patching**
  Where systems are unable to be patched due to vendor support no longer being available, the Trust strives to reduce the footprint of impacted systems and to isolate where possible while seeking a suitable, supported replacement.

- **Access Control**
  The Trust uses multi factor authentication where possible including Wifi and VPN remote access. Privileged accounts are kept to an absolute minimum and where used, they are for specific tasks only and not for day to day work.

- **Monitoring**
  The Trust is registered with the early warning service. High risk and critical alerts are actioned immediately. Internet facing infrastructure is patched as required.

- **Backups**
  Our data is backed up daily, weekly and monthly with files restored from back up daily.
  As part of the IVE Programme, data has been migrated from old to new infrastructure with backups being taken as part of this process.

- **Microsoft Defender**
  The Trust is enrolled in Microsoft Defender and shares its data with the NHS Cyber Security Team.

- **Antivirus**
  The Trust uses Sophos Antivirus.

- **Attack Surface**
  External PEN testing is undertaken yearly.

- **Secure Boundary**
  The Trust uses Palo Alto Firewalls to secure its internet boundaries.

4. Conclusion

The Trust's Data Security and Protection Toolkit 2022 / 2023 will remain as 'Standards not met' for the two noted assertions, with suitable action plans and mitigations of risks in order to achieve recategorization to 'Approaching Standards' by NHS England after submission.

The Regional Cyber Security Principal Consultant (South-East) has been kept appraised of progress of the submission and is met with monthly to ensure continued oversight of progress

The Kent & Medway ICB have been in discussion with the IG Team with regards to the DSPT status and upcoming submission.

5. Recommendation

The Trust Executive Management are asked to prepare for a non-compliant DSPT, for presentation and approval at the meeting on the 20th June 2023. Following approval of this paper, further presentation will be made to Trust Board in order for final submission to be made on 29th June 2023.

Internal Audit

FINAL

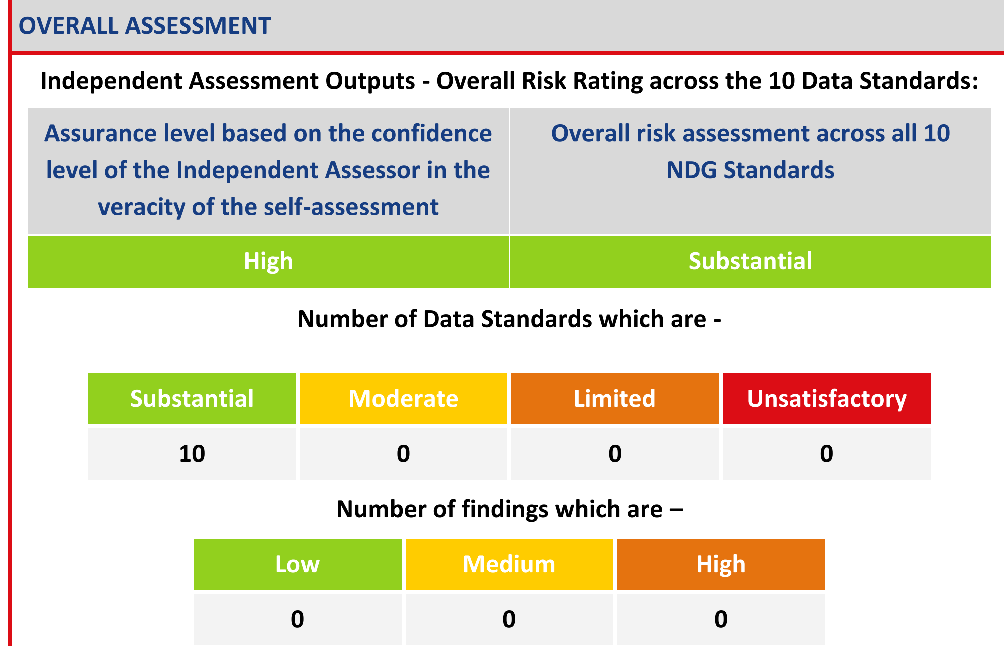
Maidstone and Tunbridge Wells NHS Trust

Data Security and Protection Toolkit (DSPT) v5

2022/23

June 2023

Executive Summary



OVERALL ASSESSMENT

Independent Assessment Outputs - Overall Risk Rating across the 10 Data Standards:

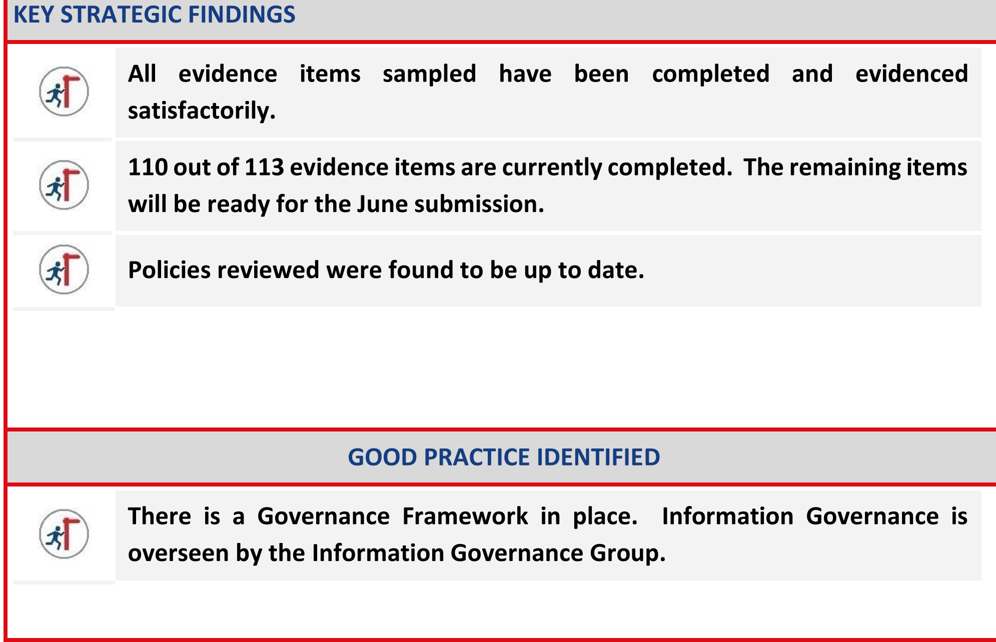
Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment	Overall risk assessment across all 10 NDG Standards
High	Substantial

Number of Data Standards which are -

Substantial	Moderate	Limited	Unsatisfactory
10	0	0	0

Number of findings which are –

Low	Medium	High
0	0	0



KEY STRATEGIC FINDINGS

- **All evidence items sampled have been completed and evidenced satisfactorily.**
- **110 out of 113 evidence items are currently completed. The remaining items will be ready for the June submission.**
- **Policies reviewed were found to be up to date.**

GOOD PRACTICE IDENTIFIED

- **There is a Governance Framework in place. Information Governance is overseen by the Information Governance Group.**

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

NHS Digital have published their "Strengthening Assurance Audit Framework" for independent assessments of Data Security and Protection Toolkits.

SCOPE

The objective of this independent assessment from the organisation's perspective is to understand and help address data security and data protection risk and identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission

TIAA undertook an independent audit of the 10 Data Security Standards. The audit coverage aligned to the mandated areas in the Toolkit as selected by NHS Digital for 2022-2023. There are 13 mandatory assertions – 1.3, 2.1, 3.4, 4.1, 4.2, 4.5, 5.1, 6.3, 7.2, 7.3, 8.3, 9.3 and 10.1. The review is a single review in advance of the final submission in June 2023, resulting in a full report showing DSS risk scores and the audit opinion.

The DSP Toolkit submissions are also included as part of the CQC's Well-Led inspections.

Introduction

Why data security and data protection issues require attention from Independent Assessors

Data and information is a critical business asset that is fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their data assets. Any personal data collected, stored and processed by public bodies are also subject to specific legal and regulatory requirements. Data security and data protection related incidents are increasing in frequency and severity; with hacking, ransomware, cyber-fraud and accidental data losses all having been observed across the Health and Social Care sector. For example, we need look no further than the WannaCry ransomware attack in May 2017 that impacted NHS bodies and many local authorities' IT services. Although Microsoft released patches to address the vulnerability, many organisations including several across the public sector didn't apply the patches, highlighting an inadequate ability to adapt to new and emerging threats.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks has been amplified by the introduction of the EU Directive on security of Network and Information Systems (NIS Directive) and the EU General Data Protection Regulation (GDPR). The NIS Directive focuses on Critical National Infrastructure and 'Operators of Essential Services'. The GDPR focuses on the processing of EU residents' personal data. As such, it is essential that Health and Social Care sector organisations take proactive measures to defend themselves from cyber-attacks and evidence their ability to do so in line with regulatory and legal requirements.

An additional complexity arises when a Health and Social Care organisation needs to share data. Organisations need to have mutual trust in each other's ability to keep data secure and also have a requirement to take assurance from each other's risk management and information assurance arrangements for this to happen successfully. Not getting this right means that either organisations fail to deliver the benefits of joining up services or put information at increased risk by sharing it insecurely across a wider network.

Achieving a realistic understanding of data security and data protection issues is therefore essential to protecting Health and Social Care organisations, personnel, patients and other stakeholders; particularly as the drive to making Health and Social Care services more 'digital' continues.

The DSP Toolkit is one of several mechanisms in place to support Health and Social Care organisations in their ongoing journey to manage data security and data protection risk. The DSP Toolkit allows organisations which access NHS patient data and systems to measure their performance against the National Data Guardian's ten data security standards, as well as supporting compliance with legal and regulatory requirements (e.g. the GDPR and NIS Directive) and Department of Health and Social Care policy through completion of an annual DSP Toolkit online self-assessment.

Completion of the DSP Toolkit therefore provides Health and Social Care organisations with valuable insight into the technical and operational data security and data protection control environment and relative strengths and weaknesses of those controls. However, the completion of the DSP Toolkit itself by the organisation is not the only mechanism in place to provide the level of comfort Health and Social Care organisation Boards need to achieve a reliable understanding of data security and data protection risk. Another mechanism is to independently assess/audit the data security and protection control environments of health and social care organisations.

Objectives

The independent assessment aimed to produce the following outputs:

- An assessment of the overall risk associated with the organisation's data security and data protection control environment. i.e. the level of risk associated with weak or failing controls and data security and protection objectives not being achieved;
- An assessment as to the veracity of the organisation's self-assessment / DSP Toolkit submission and the Independent Assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

The objective of this independent assessment from the organisation's perspective is to understand and help address data security and data protection risk and identify opportunities for improvement; whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission.

Limitations of Scope

The scope of this review will be limited to the 13 assertions defined during the scoping exercise. The assessment will consider the organisation meets the requirement of each evidence text, and also considers the broader maturity of the organisation's data security and protection control environment. Results will be based on interviews with key stakeholders as well as a review of key documents where necessary to attest controls/processes. As we are assessing the operational effectiveness of a sub-set of assertions, our assessment should not be expected to include all possible internal control weaknesses that an end-to-end comprehensive compliance assessment might identify. We are reliant on the accuracy of what we are told in interviews and what we review in documents. Efforts will be made to validate accuracy only on a subset of evidence texts and therefore there is a dependency on the organisation to provide accurate information. Furthermore, onsite verbal recommendations by the Independent Assessor staff do not constitute formal professional advice and should be considered in line with broader observations. Our report will contain recommendations for management consideration to address the weaknesses found.

Key Findings and Management Action Plan (MAP)

There are no Findings to report.

Overall risk rating and confidence level

The assurance is based on the confidence level of the Independent Assessor in the veracity of the self-assessment is ‘Substantial’. This means that the organisation’s self-assessment against the Toolkit agrees with what has been observed in the Independent Assessment.

Independent Assessment Outputs - Overall Risk Rating across the 10 Data Standards:

Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment*	Overall risk assessment across all 10 NDG Standards**
High	Substantial

***Confidence Level**

Once the Independent Assessment Provider has completed the fieldwork and calculated the ratings for assertions, for each of the 10 NDG standards and the overall risk, the confidence-level in the veracity of the organisation’s DSP Toolkit self-assessment submission should be determined by comparing the independent assessment findings against the latest DSP Toolkit submission. The following definitions should be used for aiding the decision of applying a confidence-level. It is noted that the evidence available to the Independent Assessor at the time of the assessment may differ or may have changed from the evidence in place at the time of the self-assessment. Furthermore, the self-assessment may not have much in the way of evidence. As such the Independent Assessor will need to take that into consideration when determining the confidence level and when writing the report and putting it into context. i.e. a like for like comparison may not be possible so the self-assessment and independent assessment may differ but not necessarily due to a lack of veracity or honesty in the self-assessment.

Key (as per NHSD Strengthening Assurance guidance):

Level of deviation from the DSP Toolkit submission and assessment findings	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" or "Standards Exceeded" but the independent assessment has found individual NDG standards as 'Unsatisfactory' and the overall rating is 'Unsatisfactory'.	Low
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a nontrivial deviation or discord between the two.	Medium
Low level of deviation- the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	High

** Overall risk assessment across all 10 NDG Standards

See Standard Level table below.

Standard Level

National Data Guardian (NDG) Standard	Number of DSP Toolkit Assertions Assessed by Independent Assessor	Assertion Level Risk Assessments				NDG Standard Level Risk Ratings		Overall DSP Toolkit level Ratings***
		Number of Assertions rated Critical (Weighted Risk Score)	Number of Assertions rated High (Weighted Risk Score)	Number of Assertions rated Medium (Weighted Risk Score)	Number of Assertions rated Low (Weighted Risk Score)	Risk Rating Scores (total points/ no. assertions assessed)*	Overall Risk Rating at the National Data Guardian Standard level**	Overall risk assessment across all 10 NDG Standards
1. Personal Confidential Data	1 assertion assessed in this standard				1	1	Substantial	Substantial
2. Staff Responsibilities	1 assertion assessed in this standard				1	1	Substantial	
3. Training	1 assertion assessed in this standard				1	1	Substantial	
4. Managing Data Access	3 assertions assessed in this standard				3	3/3 = 1	Substantial	
5. Process Reviews	1 assertion assessed in this standard				1	1	Substantial	
6. Responding to Incidents	1 assertion assessed in this standard				1	1	Substantial	
7. Continuity Planning	2 assertions assessed in this standard				2	2/2 = 1	Substantial	
8. Unsupported Systems	1 assertion assessed in this standard				1	1	Substantial	
9. IT Protection	1 assertion assessed in this standard				1	1	Substantial	
10. Accountable Suppliers	1 assertion assessed in this standard				1	1	Substantial	

Assertion Level Risk Assessments

***Points corresponding to Assertion Risk Ratings**

Key (as per NHSD Strengthening Assurance guidance):

Rating	Points for each Assertion
Critical	40
High	10
Medium	3
Low	1

****Calculation and assignment of the NDG Standard risk ratings**

Key (as per NHSD Strengthening Assurance guidance):

Rating	Rating Thresholds when only 1 assertion per NDG Standard is in scope	Rating Thresholds when 2 or more assertions are in scope for each NDG Standard. Mean score (Total points divided by the number of in-scope assertions)
Substantial	1 or less	1 or less
Moderate	Greater than 1, less than 10	Greater than 1, less than 4
Limited	Greater than/equal to 10, less than 40	Greater than/equal to 4, less than 5.9
Unsatisfactory	40 and above	5.9 and above

***** Overall risk assessment across all 10 NDG Standards**

Key (as per NHSD Strengthening Assurance guidance):

Overall risk rating across all in-scope standards	
Unsatisfactory	1 or more Standards is rated as ‘Unsatisfactory’
Limited	No standards are rated as ‘Unsatisfactory’, but 2 or more are rated as ‘Limited’
Moderate	There are no standards rated as ‘Unsatisfactory’, and 1 or none rated as ‘Limited’. However, not all standards are rated as ‘Substantial’.
Substantial	All of the standards are rated as ‘Substantial’

Evidence Item - Independent assessment results and ratings

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
1.3.1	There are board-approved data security and protection policies in place that follow relevant guidance.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.3	SIRO responsibility for data security has been assigned.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.4	There are clear documented lines of responsibility and accountability to named individuals for data security and data protection.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.5	Your organisation operates and maintains a data security and protection risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.6	List your organisation's top three data security and protection risks.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
1.3.9	Data security and protection direction is set at board level and translated into effective organisational practices.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
2.1.1	There is a data protection and security induction in place for all new entrants to the organisation.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
3.4.1	Have your SIRO and Caldicott Guardian received appropriate data security and protection training?	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
3.4.2	All board members have completed appropriate data security and protection training.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.1.1	Your organisation understands who has access to personal and confidential data through your systems, including any systems which do not support individual logins.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
4.1.2	Not Mandatory for 2022/23						
4.2.1	When was the last audit of user accounts with access to the organisation's systems held?	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
4.2.2	Not Mandatory for 2022/23						
4.2.3	Logs are retained for a sufficient period, managed securely, reviewed regularly and can be searched to identify malicious activity.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.2.4	Unnecessary user accounts are removed or disabled.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.5.1	Your organisation has a password policy giving staff advice on managing their passwords.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
4.5.2	Technical controls enforce password policy and mitigate against password-guessing attacks.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.5.3	Multifactor authentication is used wherever technically feasible.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.5.4	Passwords for highly privileged system accounts, social media accounts and infrastructure components shall be changed from default values and should have high strength.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
4.5.5	Not Mandatory for 2022/23						
5.1.1	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security or protection incident, with findings acted upon.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
6.3.1	If you have had a data security incident, was it caused by a known vulnerability?	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
6.3.2	The organisation acknowledges all 'high severity' cyber alerts within 48 hours using the respond to an NHS cyber alert service.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
6.3.3	The organisation has a proportionate monitoring solution to detect cyber events on systems and services.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
6.3.4	All new digital services that are attractive to cyber criminals (such as for fraud) are implementing transactional monitoring techniques from the outset.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
6.3.5	Not Mandatory for 2022/23						
7.2.1	Explain how your data security incident response and management plan has been tested to ensure all parties understand their roles and responsibilities as part of the plan.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
7.2.2	From the business continuity exercise, explain what issues and actions were documented, with names of actionees listed against each item.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
7.3.1	On discovery of an incident, mitigating measures shall be assessed and applied at the earliest opportunity, drawing on expert advice where necessary.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
7.3.2	All emergency contacts are kept securely, in hardcopy and are up-to-date.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
7.3.3	Not Mandatory for 2022/23						
7.3.4	Suitable backups of all important data and information needed to recover the essential service are made, tested, documented and routinely reviewed.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
7.3.5	Your organisation tests its backups regularly to ensure it can restore from a backup.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
7.3.6	Your organisation's backups are kept securely and separate from your network ('offline'), or in a cloud service designed for this purpose.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.1	How do your systems receive updates and how often?	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
8.3.2	How often, in days, is automatic patching typically being pushed out to remote endpoints?	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.3	There is a documented approach to applying security updates (patches) agreed by the SIRO.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
8.3.4	Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted, reviewed regularly and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.5	Where a security patch has been classed as critical or high-risk vulnerability has not been applied, explain the technical remediation and risk management that has been undertaken.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.6	Your organisation is actively using and managing Advanced Threat Protection (ATP) and regularly reviewing alerts from Microsoft defender for endpoint.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.7	95% of your organisation's server estate and 98% of your desktop estate are on supported versions of operating systems.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
8.3.8	Your organisation is registered for and actively using the NCSC early warning service.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.1	All web applications are protected and not susceptible to common security vulnerabilities, such as described in the top ten Open Web Application Security Project (OWASP) vulnerabilities.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
9.3.3	The organisation has a technology solution or service that prevents users from accessing potentially malicious websites, reducing the risk of the organisation's infrastructure being infected with malware.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.4	The organisation ensures that changes to its authoritative DNS entries can only be made by strongly authenticated and authorised administrators.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	

Evidence Item Ref	Evidence Item Text	Organisations position on Toolkit	Independent Assessor Opinion	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
9.3.5	The organisation understands and records all IP ranges in use across the organisation.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.6	The organisation protects its data in transit (including email) using appropriate technical controls, such as encryption.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.7	The organisation has registered and uses the National Cyber Security Centre (NCSC) Web Check service, or equivalent web check service, for its publicly-visible applications.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.8	The organisation maintains a register of medical devices connected to its network.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
9.3.9	What is the organisation's data security assurance process for medical devices connected to the network.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	
10.1.1	The organisation has an up to date list of its suppliers, which enables it to identify suppliers that could potentially pose a data security or data protection risk to the organisation. The list includes which suppliers process personal data or provide IT services on which critical services rely, details on the product and services they deliver, contact details and contract duration.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Insignificant	Very low/insignificant	Low
10.1.2	Not Mandatory for 2022/23						

* Likelihood Rating Table

Evidence texts are risk assessed on their likelihood and impact based on the assessment rationale in the tables below:

Likelihood rating	Assessment rationale
Almost Certain	Almost certain to happen in the next 12 months (80% or more)
Likely	Likely to happen in the next 12 months (60-80%)

Moderate	Moderately likely to happen in the next 12 months (40-60%)
Unlikely	Unlikely to happen in the next 12 months (20-40%)
Rare	Very low likelihood to happen in the next 12 months (less than 20%)

****Impact Rating Table**

Key (as per NHSD Strengthening Assurance guidance:

Impact rating	Assessment rationale
Catastrophic	• A Catastrophic Impact Finding could apply to Health and Social Care organisations that use extremely complex technologies to deliver multiple services or process large volumes of patient data, including processing for other organisations. Many of the services are at the highest level of risk, including those offered to other organisations. New and emerging technologies are utilised across multiple delivery channels. The organisation is responsible for/ maintains nearly all connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties. A catastrophic finding that could have a: • Catastrophic impact on operational performance or the ability to deliver services / care; or • Catastrophic monetary or financial statement impact; or • Catastrophic breach in laws and regulations that could result in material fines or consequences; or • Catastrophic impact on the reputation or brand of the organisation which could threaten its future viability.
Significant	• A Major Impact Finding could apply to a Health and Social Care organisation that uses complex technology in terms of scope and sophistication. The organisation may offer high-risk products and services that may include emerging technologies. The organisation is responsible for/ maintains the largest proportion of connection types to transfer/store/process personal, patient identifiable or business-critical data with customers and third parties; other organisations and/or third-parties are responsible for/maintain a low proportion of connection types. A Significant finding that could have a: • Major impact on operational performance; or • Major monetary or financial statement impact; or • Major breach in laws and regulations resulting in large fines and consequences; or • Major impact on the reputation or brand of the organisation.
Moderate	• A Moderate Impact Finding could apply to a Health and Social Care organisation that uses technology which may be somewhat complex in terms of volume and sophistication. The organisation is responsible for/maintains some connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties; other organisations and/or third-parties are responsible f or/maintain a most of the organisation's connection types. A Moderate finding that could have a: • Moderate impact on the organisation's operational performance; or • Moderate monetary or financial statement impact; or • Moderate breach in laws and regulations with moderate consequences; or • Moderate impact on the reputation of the organisation.

Impact rating	Assessment rationale
Minor	A Minor Impact Finding could apply to a Health and Social Care organisation with limited complexity in terms of the technology it uses. It offers a limited variety of less risky products and services. The institution primarily uses established technologies. It is responsible for/maintains minimal numbers of connection types to transfer/store/process personal, patient identifiable or business-critical data to customers and third parties; other organisations and/or third-parties are largely responsible for/maintain connection types. A Minor finding that could have a: • Minor impact on the organisation's operational performance; or • Minor monetary or financial statement impact; or • Minor breach in laws and regulations with limited consequences; or • Minor impact on the reputation of the organisation
Very Low Insignificant	• A Low/Insignificant Impact Finding could apply to a Health and Social Care organisation that has very limited use of technology. The variety of products and services are limited and the organisation has a small geographic footprint with few employees. It is responsible for/maintains no connection types to transfer/store/process personal, patient identifiable or business-critical data too customers and third parties. A Low finding that could have a: • Very low/ insignificant impact on the organisation's operational performance; or • Very low/ insignificant monetary or financial statement impact; or • Very low/ insignificant breach in laws and regulations with little consequence; or • Very low/ insignificant impact on the reputation of the organisation.

*** Evidence Items Risk Ratings

Key (as per NHSD Strengthening Assurance guidance):

	Impact Rating				
Likelihood Rating	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost Certain	Low	Low	Medium	High	Extreme
Likely	Low	Low	Medium	Medium	High
Moderate	Low	Low	Low	Medium	Medium
Unlikely	Very Low/ Insignificant	Low	Low	Low	Low
Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low	Low	Low

****Assertion Risk Rating

The DSP Toolkit Independent Assessment Provider must then exercise professional judgement to assign a risk rating at the assertion level. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to assign each assertion a risk rating of 'Critical', 'High', 'Medium' or 'Low' based on the evidence text ratings and the Independent Assessor's knowledge of the relative importance of the controls in question and the mitigating or compensating controls in place.

Explanatory Information

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Acknowledgement

3. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

4. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	23 February 2023	18th May 2023
Draft Report:	8th June 2023	13th June 2023
Final Report:	19th June 2023	

Audit Planning Memorandum

Client:	Maidstone and Tunbridge Wells NHS Trust		
Review:	Data Security and Protection Toolkit v5		
Type of Review:	ICT Audit	Audit Lead:	Angela Antunovich – Senior Audit Manager – ICT Audit and IG Assurance

Outline scope (per Annual Plan):	NHS Digital have published their "Strengthening Assurance Audit Framework" for independent assessments of Data Security and Protection Toolkits.
Detailed scope will consider:	The objective of this independent assessment from the organisation's perspective is to understand and help address data security and data protection risk and identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission TIAA will undertake an independent audit of the 10 Data Security Standards. The audit coverage will be aligned to the mandated areas in the Toolkit as selected by NHS Digital for 2022-2023. Our review is a single review in advance of the final submission in June 2023, resulting in a full report showing DSS risk scores and the audit opinion.
Requested additions to scope:	(if required then please provide brief detail)
Exclusions from scope:	

Planned Start Date:	A single review in Q1 (April - June 2023)	Exit Meeting Date:	June 2023	Exit Meeting to be held with:	Gemma Stephenson - Head of Information Governance and ICT Risk Management Michael Valentine - Cyber Security Architect

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	
Have there been any significant changes to the process?	
Are there any particular matters/periods of time you would like the review to consider?	

Training Needs Analysis - Information Governance and Data Security Training:

Reason for submission:
To seek SIRO approval of the noted recommendations for Information Governance and Data Security Training.

Background:
The Trust is required to maintain a 95% Mandatory training compliance for all staff having completed their annual Data Security Awareness [Information Governance] Training in the previous 12-month period. NHS England requires confirmation to be submitted as part of the Trust annual return of the Data Security and Protection Toolkit.

The Trust aims to ensure that all staff who interact directly with or come into contact with Personal Identifiable Data and / or Special Category Data as defined in the Data Protection Act 2018 (DPA 2018) will be appropriately trained in the following areas:

- Data Protection
- Confidentiality
- Data Security
- Caldicott Principles
- Information Governance

This will ensure practices of each and every member of staff, volunteer, bank and agency staff is consistent and appropriate to for the work carried out in the organization. It also allows both the organization and the individual to demonstrate fitness for role in the event of an audit or investigation, and follows best practice.

Analysis of the training needs at the Trust have been completed and the findings outlined in this report.

Findings:
The Trust training compliance is reported monthly to the Information Governance Committee. The Trust has not achieved 95% since July 2021.

Month	Number of Staff	Training Compliance
July 2021	6437	95.8%
August 2021	6444	92.7%
September 2021	6497	90.40%
October 2021	6461	90.80%
November 2021	6418	91.53%
December 2021	6685	91.95%
January 2022	6607	91.63%
February 2022	6541	91.70%
March 2022	6538	89.85%
April 2022	6501	90%
May 2022	6626	90.20%
June 2022	6650	90.32%
July 2022	6701	90.50%
August 2022	6743	90.10%
September 2022	6801	88.45%
October 2022	6698	88.00%
November 2022	6829	83.63%
December 2022	7018	88.89%
January 2023	7218	86.77%
February 2023	7238	88.75%
March 2023	7166	88.90%

The number of staff employed by the Trust has steadily risen over the period, however compliance rates continue to reduce.

A number of contributory factors have been identified, these include:

- Covid 19 Recovery
- Winter Pressures / Flu Season
- Staff Sickness / Absence
- Lack of access to Computers / Mobile Devices
- Nursing Strikes
- Junior Doctor Strikes

It is noted that new joiners to the Trust are required to complete mandatory training prior to commencement in their role.

Divisional training reports are provided via MTW learning to Directors and Service Leads, as well as dedicated email reminders to staff at 90 days, 60 days and 30 days ahead of training falling overdue.

The below schedule outlines available training at Maidstone and Tunbridge Wells NHS Trust.

TRAINING	TYPE	FREQUENCY	DURATION	NOTES
Data Security Awareness Training [eLearning for health]	Mandatory	Annually	90 Minutes	Delivered via MTW Learning, reminders and notifications are delivered via NHSmail.
Information Governance Face to Face Training [Delivered by the Head of Information Governance]	Mandatory	Annually	60 Minutes	Run at various intervals through the year, to assist and maintain staff / department contact and build relations with staff.
Information Asset Owner	Mandatory	Annually	60 Minutes	Delivered via MTW Learning, reminders and notifications are delivered via NHSmail.
Read and acknowledge changes to Trust policies, procedures and all ad-hoc emergency and resilience arrangements	Mandatory	Continuously	Various	Policies available via Trust Intranet [Q-Pulse]
Caldicott Guardian Training [Role Specific]	Mandatory	Annually	Up to 1 Day	On completion, annual update can be attendance to conference or such event.

Caldicott National Conference [Role Specific]	Mandatory	Annually	Up to 1 Day	Hosted by National Caldicott Guardian Council.
Information Sharing – Advanced information governance for Frontline Staff	Optional	Bi-Annually	60 Minutes	Provided by eLearning for Health, registration required. Free of charge for NHS Mail users.
NCSC Certified Board Training	Role Specific	Annually	Up to 3 Hours	Provided by National Cyber Security Centre [NCSC]
Business Continuity - Attend an exercise designed to 'test' Business Continuity Plans	Optional	Bi-Annually	Various	Not required if attended a true incident and debrief session completed.

Available resources:
MTW Learning https://mtwlearning.org/login/index.php
E Learning for Health - e-Learning for Healthcare Authentication (learninghub.nhs.uk)

Recommendations:

- It is recommended that staff complete as a minimum the Data Security Awareness Training via MTW Learning, with additional modules to be completed applicable to their role if required.
- Further role-based learning both face to face and via eLearning platforms are available for more specialised roles such as Caldicott Guardian and Information Asset Owner.
- Whilst training for staff is awareness focused, consideration needs to be made for those staff that fail to comply.
- Implementation of Multi-Factor Authentication (MFA) - The Cyber Security Team are working with NHSE to implement MFA across NHSmail with all new users being mandatory from 1st July 2023. MFA will provide an additional layer of security across one of the main information sharing platforms in use at the Trust, as well as provide assurance that additional controls are in place regarding access to data.
- Consider removal of access to systems for continued non-compliance with training with appropriate management and SIRO oversight.
- Learning and Development to create automated divisional and department compliance reports that can be accessible to leads in order to monitor compliance within their teams. (NB Currently only Directors receive this information and it is not in a format that can be easily manipulated/circulated).

- Compliance with MTW Appraisal Programme – Completion of mandatory training modules is a requirement for the annual appraisal. HR and Appraisers to ensure robust processes are adopted to check that training compliance has been met prior to Appraisal being approved/signed off.
- Communication – A variety of communications to be released across the available networks in the Trust such as: MTW News, Pulse, MTW Facebook Group and Screen Savers.
- A variety of face to face training sessions hosted by the Information Governance Team across all sites to ensure all staff have the opportunity to attend dedicated training sessions, this includes staff working anti-social hours and across a number of locations.
- Tailored training sessions to be facilitated for high risk areas such as Health Records, Patient Safety, CAU's to be made available to ensure staff have role-based training relating to their specific areas of responsibility
- Monthly reporting to be reviewed by the Head of Information Governance, and reported to the Information Governance Committee and Senior Information Risk Officer (SIRO) for oversight and assurance.

The SIRO is asked to support this training needs analysis and recommendations be approved for action.

Appendix 1 Document: Information Governance - Role Based Training Requirement

Information Governance Training Needs Analysis

Reviewed March 2021

– Mandated Training shown in Red

Admin/Clerical - Access to Personal Information ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Admin/Clerical - Other ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Caldicott Guardian ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training

Clinical - Allied Health Professional ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Allied Health Professional Student ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Doctor ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Medical Student ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Midwife ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Nurse ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - Nursing / Midwifery Student ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical - other ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Clinical – Specialist Nurse ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Data Protection & Confidentiality Responsibilities ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training

Director - Senior Manager - Other ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training

Director - Senior Manager -Access to Personal Info ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training

Estates/Maintenance-eg:Porters,Domestics,Laundry ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Freedom of Information Lead or support staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Health Care Assistant/Auxiliary Nurse ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Health Records Manager and support staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

IAA - Information Asset Administrator ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

IAO - Information Asset Owner ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Information Governance Manager or support ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training
- Immersive Labs online cyber security e-learning

Information Risk Manager ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Information Security Officer/Lead or support ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- Immersive Labs online cyber security e-learning

Information Technology Management ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- Immersive Labs online cyber security e-learning

Information Technology Support Staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Non clinical staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Non Executive Director ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training

Operational Manager & Support Staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Operational Mngr/Support -Access to Personal Info ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Records Manager and support staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

SIRO - Senior Information Risk Owner ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness
- GCHQ-certified board training
- Specialist training for SIROs

Social care staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness

Voluntary Staff ⊟

Modules assigned to this job role:

- Information Governance including Data Security Awareness