Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited to observe. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

12pm WEDNESDAY 20TH JULY 2016

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
7-1	To receive apologies for absence	Chairman	Verbal
7-2	To declare interests relevant to agenda items	Chairman	Verbal
7-3	Minutes of the Part 1 meeting of 29th June 2016	Chairman	1
7-4	To note progress with previous actions	Chairman	2
7-5	Safety moment	Chief Nurse	Verbal
7-6	Chairman's report	Chairman	Verbal
7-7	Chief Executive's report	Chief Executive	3
7-8	A patient's experiences of the Trust's services	Medical Director[1]	Verbal
7-9	Integrated Performance Report for June 2016 ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-led (workforce)	Chief Executive Chief Nurse Medical Director Dir. of Infect. Prevention and Control Director of Finance Chief Operating Officer Director of Workforce	4 (part to follow)
	Quality items		
7-10	Supplementary Quality and Patient Safety report	Chief Nurse	5
7-11	Planned & actual ward staffing for June 2016	Chief Nurse	6
7-12	Review of clinical outcomes	Medical Director	7
7-13	Safeguarding children update (ann. report to Board)	Chief Nurse	8
7-14	Trust Board Members' hospital visits	Trust Secretary	9
	Assurance and policy		
7-15	Review of medical rotas/contract update	Medical Director	Verbal
7-16	Estates and Facilities Annual Report 2015/16	Chief Operating Officer	10
	Reports from Board sub-committees (and the Trust Management Executive)		
7-17	Quality Committee, 06/07/16	Committee Chairman	11
7-18	Trust Management Executive, 13/07/16	Committee Chairman	12
7-19	Finance Committee, 18/07/16	Committee Chairman	13 (to follow)
7-20	**To consider any other business**		
7-21	**To receive any questions from members of the public**		
7-22	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meetings: ▪ 28th September 2016, 10.30am, Academic Centre, Maidstone Hospital ▪ 19th October 2016, 10.30am, Education Centre, Tunbridge Wells Hospital ▪ 30th November 2016, 10.30am, Academic Centre, Maidstone Hospital ▪ 21st December 2016, 10.30am, Education Centre, Tunbridge Wells Hospital		

Anthony Jones,
Chairman

[1] A patient's relatives will also be in attendance for this item

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 29TH JUNE 2016, 10.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jane Hurst	Improvement Director	(JH)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Tracey Karlsson	Head of Employee Services	(TK)
	Annemieke Koper	Staff Side representative	(AKo)
	Gianna Pollero-Payne	Communications Manager	(GPP)
	Camille Yvon	Foundation Year 2 Ophthalmology Trainee (from item 6-7)	(CY)
	David East	Member of the public	(DE)
	Conn Sugihara	Member of the public	(CS)

6-1 To receive apologies for absence

Apologies were received from Glenn Douglas (GD), Chief Executive; Alex King (AK), Non-Executive Director; and Jim Lusby (JL), Deputy Chief Executive.

AJ welcomed JH to her first Trust Board meeting since being appointed as Improvement Director.

6-2 To declare interests relevant to agenda items

JH declared that she had been appointed to the Trust on secondment from KPMG LLP.

6-3 Minutes of the Part 1 meeting of 25th May 2016

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

6-4 To note progress with previous actions

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

- **Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director")**. PS reported that there would be a ballot by Junior Doctors in July, and the intended review of Medical rotas would depend on the outcome. PS added that the Trust had had to issue contracts for the new Medical trainees that would start in August, and for this purpose, the previous Junior Doctors' contract had been used, to last for a 4-month period (until December 2016). RH confirmed the outcome of the aforementioned ballot would be known on 06/07/16.
- **Item 5-12i ("Circulate, to Trust Board Members, the totals for the data provided in the Appendices to the 'Nurse establishment review' report submitted to the Trust Board on 25/05/16")**. AJ noted that the requested details had been circulated by email on 27/06/16, and the action was therefore 'closed'.

- **Item 5-12ii ("Consider including details of income for 'ITU' within future 'planned and actual ward staffing' reports submitted to the Trust Board")**. SO reminded Trust Board Members that the suggestion was to use income as a proxy indicator for ITU, and reported that he was liaising with AB to consider whether this or an alternative indicator should be used. AB reported that the chosen indicator would be included in the 'planned and actual ward staffing' report to the July 2016 Trust Board.

6-5 Safety moment

AB stated that she wished to raise awareness of the work being done on patient falls, which was the number one patient safety priority for 2016/17. AB continued that a senior-level Task and Finish Group has been established, and invited Trust Board Members to ask clinical staff what action was being taken when they undertook their Ward visits. AB emphasised that it was not acceptable for a patient to fall, and therefore an intellectual inquiry needed to occur after each fall, to establish why it had occurred. AB pointed out that a target rate of 6.2 falls (per 1000 Occupied Bed Days) had been set for the year-end, and a further review by the Quality Committee had been scheduled for January 2017.

AJ invited comments. KT reiterated the suggestion he had made previously that an annual programme of themes could be applied to the 'Safety Moments' at all meetings. KT elaborated that a series of 12 themes could be agreed, so that that month's theme could be reinforced at all the Committee meetings held during that month. AB welcomed the suggestion.

6-6 Chairman's report

AJ highlighted that the Referendum on the UK's membership of the European Union (EU) had been held since the Trust Board last met. AJ reported that the Trust employed a large number of staff from EU nations, and would continue to employ such staff, and provide the necessary support. AJ noted that RH had issued a Trust-wide communication earlier that week to that effect. RH gave assurance that the Trust would continue to provide support to such staff as required.

6-7 Chief Executive's report

SO referred to the circulated report and highlighted the following points:

- The dedicated Children's A&E at Tunbridge Wells Hospital (TWH) had now been open for 1 month, and had been very successful thus far
- The findings of the recent national Inpatient survey were positive, despite the capacity pressures that the Trust had faced. This was noted to be on the agenda under item 6-12
- The Kent Oncology Centre was recently given a new bladder scanner by the Prostate Cancer Support Association Kent

AJ highlighted that the new Clinical Commissioning Group (CCG)-commissioned Patient Transport service would be transferred to G4S from the current provider, NSL, on 01/07/16. AG gave assurance that the Trust had made appropriate preparations for the transfer.

SD then congratulated Dr Jyothirmayi on the receipt of the 2016 Oncology Registrars' Forum Trainer Award (by the Royal College of Radiologists). AJ concurred with the commendation.

KT then noted the Trust had been chosen as a Maternity Choice and Personalisation Pioneer by NHS England, and asked how payments would be transferred between, for example, East Kent patient and the Trust. SO explained the processes available to enable cross-charging to occur, and noted that this was monitored, but added it would be interesting to see the impact of the initiative.

6-8 Integrated Performance Report for May 2016

AJ invited AG to commence the report of the latest monthly information.

Effectiveness / Responsiveness (incl. DTOCs)

AG referred to the circulated report and highlighted the following points:

- Performance against the A&E 4-hour waiting time and 18 week Referral to Treatment (RTT) targets had been good
- For Cancer, the Trust continued to perform well on the 31-day waiting time target, but performance against the 62-day wait for first definitive treatment had been poor for April (Cancer performance was reported one month in arrears). The bulk of the 62-day wait breaches were in Colorectal Cancer, although there had been some breaches in Breast Cancer. Work had been undertaken to manage the Colorectal Cancer pathway differently, and it was intended to initiate this in September or October 2016. A second Cancer Summit had been held in June, and assurance was provided in relation to the clinical leadership of Tumour sites. However, the volume of referrals in Colorectal Cancer continued to exceed supply, particularly in the Diagnostics phase

AJ remarked that the Trust's 62-day waiting time target performance was very disappointing, and noted that such performance was poor compared to the previous year. AG confirmed this was the case for April, but highlighted that performance had improved for May, which had not yet been reported. AG added that delays still occurred in relation to referrals from other Trusts, and work was continuing with such Trusts.

AJ asked AG whether she was confident that all of those involved in the Trust's Cancer arrangements were clear that the current performance was unacceptable. AG confirmed this was the case, and added that there had been very strong leadership by the Trust's Trust Lead Cancer Clinician. AG continued that the first Cancer Summit in January 2016 led to improvements in a number of Tumour sites, and she was therefore confident that further improvement would occur. AJ asked whether AG was confident in achieving the forecast contained within the circulated report. AG replied that the plan showed that the required 85% performance would be achieved by October 2016, and at present, she was confident this would be met.

SD for AG's prediction as to when the performance would stop getting worse, and highlighted that October 2016 was 4 months away, which was a long time for a Cancer patient. AG replied that October was considered a reasonable timescale to meet the 85% target, and pointed out that the target was already being met in some Tumour Groups. SD highlighted that both of the Tumour Groups involved in the recent poor performance (Colorectal and Breast) were linked to screening programmes, and suggested that demand could have therefore been foreseen. AG acknowledged the point. SD then asked for confirmation that AG was stating that the 62-day waiting time target of 85% would be achieved by October 2016. AG gave such confirmation, and added that the Trust's performance appeared to be returning to trajectory in May.

KT stated that even though the Trust was the fourth largest Oncology Centre in the UK, he was unable to judge how well it performed against other Oncology Centres. AG replied that benchmarking data was published quarterly, and the 62-day waiting time target was challenging nationally, with a number of organisations not achieving the target. KT stated it would be useful to circulate the comparative data, and, more importantly, the lessons learned. AG referred to the latter point, and stated that the 31-day waiting time target had been consistently met, but different rules applied to patients referred from screening services, in that the start-time of a patient's wait commenced from the date of their screening, not the date of their referral. AG added that the majority of 62-day waiting time breaches involved patients referred from screening services. KT queried whether more notice could be provided to the Trust in relation to national screening campaigns, to enable better preparation for the increased referrals. AG agreed to request that the Trust's Cancer Board consider whether more advanced notice of such campaigns was required.

Action: Request that the Trust's Cancer Board consider whether more advanced notice of national screening campaigns was required (to enable the Trust to better prepare for the increased referrals arising from such campaigns) (Chief Operating Officer, June 2016 onwards)

AG then continued, and highlighted that slow progress had been made in reducing Length of Stay (LOS), although this had reduced more at TWH than at Maidstone Hospital (MH). AG added that there was still more work to be done, but there were signs that the actions being taken were having the desired effect. AJ asked AG whether she wished the Trust Board to undertake any particular

action to assist in the efforts to reduce LOS. AG confirmed that no specific action was required at present, given the existing plans, and highlighted that the LOS Steering Group was focusing on internal actions i.e. those within the Trust's control. SDu stated she was surprised to hear that efforts were being primarily focused on the internal aspects of LOS, and proposed that the work be reviewed in further detail at the 'main' Quality Committee. AJ agreed this would be beneficial. SDu proposed this be considered at the Quality Committee in September 2016. This was agreed.

Action: Arrange for the work to reduce Length of Stay to be reported to the 'main' Quality Committee in September 2016 (Trust Secretary / Chief Operating Officer, June 2016 onwards)

AJ then asked for a comment on the status of Delayed Transfers of Care. AG acknowledged the current situation, but reiterated that efforts were focused on in-house improvements.

SDu then referred to the "NE LOS - Rolling Chart (Jun 13 to May 16)" chart on page 7 of 19, and noted that the "Mean" line was flat, and did not give an accurate reflection of the trend. PS pointed out that the "Mean" line would, by its nature, fall between the highest and lowest points. AJ asked for the issue raised by SDu to be considered outside of the meeting.

Action: Consider whether the "Mean" line within the "Integrated performance report analysis" charts submitted to the Trust Board was beneficial, in terms of demonstrating the trend in performance over time (Director of Finance, June 2016 onwards)

KT then asked for an update on the trial of the company who had been engaged to identify Care Home placements for the Trust's patients. AG confirmed that the arrangement was working well.

Safe (infection control)

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

- MRSA screening was performing well, and there had been no MRSA bacteraemia cases
- There had been 2 cases of Clostridium difficile per month, and although this was below the trajectory, continuing at 2 cases per month would lead to an increase in cases from that seen in 2015/16. The situation was however being closely monitored

AJ asked what needed to be done to address the Clostridium difficile cases seen thus far. SM replied that not all of the Root Cause Analysis (RCAs) on recent cases had been completed, but action had been taken to strengthen the "Period of Increased Incidence" process, and escalation now occurred earlier. SM added that the focus on the antibiotic-related CQUIN targets was also expected to have a positive impact.

AJ emphasised that the Trust Board supported whatever action was required regarding infection control, and requested SM to inform the Trust Board of any action she believed was required. SM acknowledged the offer and request.

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report and highlighted that

- The Summary Hospital-level Mortality Indicator (SHMI) was rated 'red', but SHMI was 6-months in arrears of the data for Hospital Standardised Mortality Ratio (HSMR), which had now recovered. The SHMI was expected to follow suit in due course, as no new concerns had been identified
- The focus on mortality continued, via the Mortality Steering Group

SDu asked whether the factors affecting the SHMI had changed. PS replied that although there had been some areas flagged as 'red', none of these gave him cause for concern. PS added that he had submitted a report to the 'main' Quality Committee on 06/07/16 which would enable the issue to be discussed further.

AJ queried whether the "Crude Mortality" figure on page 4 of 19 was low. PS replied that he did not pay particular attention to the crude mortality data. AJ queried why the indicator was therefore reported in the performance dashboard. PS clarified that he believed it was worthwhile for crude mortality to continue to be reported, as it gave an early indication of potential concerns.

Safe / Effectiveness / Caring

AB then referred to the circulated report and highlighted that the complaints response time had reduced to 58%, but this included a number of complex complaints. AJ asked whether AB was confident that the reported forecast of 75% would be achieved. AB confirmed her confidence.

Well-Led (finance)

SO then referred to the circulated report and highlighted the following points:

- The Trust had a deficit of £0.9m in month, and a £6.9m deficit for the year to date (which was adverse to plan by £1.1m)
- The drivers for this included the fact that the Trust did not have an agreed control total at present, and therefore it had been assumed that as the Trust was outside the Sustainability and Transformation Fund (STF) arrangements, it would be subject to contractual penalties for performance on the NHS Constitution-related access targets, which equated to £0.5m to £1.5m. The Trust was in discussion with CCGs regarding the application of contractual penalties if the Trust remained outside the STF framework
- The significant problem area in relation to elective activity was Trauma & Orthopaedics (T&O)
- Non-elective activity was above plan, and the Trust's income for such activity was adversely affected by the marginal rate of payment threshold
- The key milestones for June in relation to Agency expenditure had been achieved
- The Cost Improvement Plan (CIP) was expected to have a significant step-up in delivery in July, following the inclusion of schemes that had been unidentified at the start of the year

SDu referred to T&O elective activity, and asked for the reasons for the current underperformance. AG explained that 7 of the 15 trollies on the Day Care Unit at TWH remained in escalation, and this had an adverse effect on elective activity. AG added that there were some also some 'hearts and minds' issues within T&O, and work was required to instil the confidence that had been lost in the Directorate as a result of previous periods of escalation. SDu asked what other areas were in escalation. AG confirmed that the Day Care Unit was the only place escalated and work was being undertaken to try to resolve the situation. PS added that the issue was scheduled to be discussed at the next meeting of the Clinical Directors Committee.

KT asked for a further comment on the 'hearts and minds' issues to which AG referred. AG remarked that further support was required to fully utilise the 20 ring-fenced beds that would be available to T&O by w/c 04/07/16. AJ stated that significant improvement should be expected. AG pointed out that some improvement had already occurred, but T&O would be placed in a form of 'supportive turnaround' to attain further improvement.

Well-led (workforce)

RH then referred to the circulated report and highlighted the following points:

- The focus continued to be on reducing the number of vacancies, but good progress had been made on Medical recruitment, which was expected to reduce the usage of temporary staff
- Sickness absence had increased, but no specific area of concern had been identified. The Human Resources (HR) Department was working with Directorates regarding this
- The Trust was entering the final few days of the non-Medical appraisal cycle, so compliance rates would be able to be reported soon

KT remarked that the vacancy rate seemed to be too high. RH agreed the rate was high, but reflected the additional capacity that had been introduced, and therefore was unable to be accurately compared with the previous year. SO added that the Trust was in a downward trajectory regarding vacancies, but acknowledged that there was always more that could be done. KT stated that he did not recall that the current level of vacancies had been assumed within the Trust's plans/budget. SO confirmed that provision had been made within the budget, but acknowledged that there was an element of the vacancies that had not been incorporated. KT proposed that the issue be reviewed at the next meeting of the Workforce Committee. AJ agreed this should occur.

Action: Arrange for the next meeting of the Workforce Committee to review whether the current vacancy rate had been assumed in the Trust's plans for 2016/17 (Chairman of Workforce Committee / Director of Workforce, June 2016 onwards)

SDu referred to the large delta in terms of activity performance when compared to plan, and queried whether a review of the plan was warranted. SO replied that this had been discussed, to some extent, at the Finance Committee on 27/06/16, but acknowledged the value in reviewing this. KT clarified that the Finance Committee's focus was on re-forecasting. AJ agreed that plans should not be regarded as fixed when they were set.

6-9 The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow

AG referred to the circulated report and highlighted that:

- The "Trust Medical Outliers - Average per calender [sic] day - May-13 to May-16" graph on page 4 was incorrect, as this erroneously included a Ward that had not been used for escalation
- The new Ward had enabled an improvement in patient flow, which had allowed an increase in elective activity
- The Catheter Laboratory was now functioning again as intended
- Further work was required in relation to Ambulatory pathways, as the new Ward was not functioning exactly as intended. However AG was confident that the plans would lead to the required improvement

SO asked for an update on substantive recruitment for the Ward. AG replied that this was going well, and there were now only 1-2 vacancies and a small level of turnover.

SDu queried whether the report could be received again at a future meeting, as the Ward had been successful in providing beds, but had a longer LOS than had been planned, and was therefore not performing the task it had been established to perform, despite the high level of costs involved. AG acknowledged SDu's points, but pointed out that the new Ward had enabled progress in some areas, and had enabled patient flow to be maintained. AG gave assurance that the original aim had not been abandoned, and added that this was why the aforementioned Ambulatory pathway was being re-launched. It was agreed to submit a further report to the Trust Board in September 2016.

Action: Submit a further report to the Trust Board in September 2016 on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow (Chief Operating Officer, September 2016)

Quality Items

6-10 Planned & actual ward staffing for May 2016

AB referred to the circulated report and highlighted that

- The report included 'Care Hours Per Patient Day' (CHPPD) data for the first time, but the only comparative date available at present was from the Lord Carter efficiency report, which reported a range of CHPPD from 6.3 to 15.48, with a median of 9.13
- For MH, the overall CHPPD was 8.3, whilst for TWH it was 9.4, although there was a large variation between Wards
- The Delivery Suite's CHPPD was 30.5, which reflected the 1:1 care provided there, as well as the effect of Obstetric Theatres
- Other Trusts were expected to report their CHPPD data to their Boards from now onwards, which would enable comparison with their data, and enable conclusions to be drawn

AJ agreed it was too early to draw any conclusions from the CHPPD data.

6-11 Approval of Quality Accounts, 2015/16

AB referred to the circulated report and highlighted the following points:

- The Quality Accounts had been reviewed previously at the Quality Committee and Trust Management Executive (TME)

- The comments from Healthwatch Kent had been very positive
- The External Audit had resulted in an unqualified conclusion

Questions or comments were invited. None were received.

The Trust Board approved the Quality Accounts for 2015/16 as circulated.

Other Matters

6-12 Findings of the national inpatient survey 2015

AB referred to the circulated report and highlighted the following points:

- The Trust's response rate was 56.7%
- The Trust improved its performance in a number of areas, including those relating to the provision of care from Medical staff. The response to call bells had also improved, which was pleasing given the level of focus and monitoring undertaken at the Patient Experience Committee
- There were several clear issues of focus, which triangulated with data from the Trust's local surveys, as well as from the Friends and Family Test and complaints. The first area was discharge planning, communication and involvement, and the Integrated Discharge Team was expected to have a significant positive impact on this, but the Team had only been in place since October 2015
- The response to the findings regarding medication, and the provision of information regarding medication, needed further thought, and the Trust's new Chief Pharmacist was expected to contribute to this
- The information given to patients about how they were expected to feel after undergoing procedures also required further work
- However, despite these areas, the Trust's results were overall good, and some positive local media coverage had been received

AJ noted that the performance had improved, and was better than a number of other local Trusts, but was still, generally, average, and added that the performance should therefore be treated as work in progress. AB acknowledged the point.

KT referred to page 14 of 38 and stated it would be a good opportunity to have a programme to make wholescale improvements, to aim to shift the aspects currently rated as 'amber' towards a 'green' rating, and not just accept average performance. AJ agreed. AB acknowledged the validity of the point, but gave assurance that appropriate plans were in place.

Assurance and Policy

6-13 Update on the review of Medical rotas

AJ noted that this was covered under the item 6-4.

6-14 Responsible Officer's Annual Report 2015/16

PS referred to the circulated report and highlighted the following points:

- In addition to providing assurance to the Trust Board, the report was intended to provide assurance to Nigel Acheson, the higher-level Responsible Officer for the Trust
- There were no occurrences of relevant Doctors either not having an appraisal, or not having a rationale for not having an appraisal

The Trust Board approved the Statement of Compliance (Appendix F) as circulated.

Reports from Board sub-committees (and the Trust Management Executive)

6-15 Audit and Governance Committee, 25/05/16

The circulated report was noted. AJ asked how the External Audit fee compared to previous years. SO replied that the fee was a circa 20% reduction on the previous year's fee.

6-16 Charitable Funds Committee, 23/05/16

The circulated report was noted.

6-17 Quality Committee, 13/06/16

The circulated report was noted.

6-18 Trust Management Executive, 15/06/16

SO referred to the circulated report and invited questions or comments. KT referred to implementation of the Southern Acute Programme (SAcP) and stated that this emphasised the point he had raised at the Finance Committee on 26/06/16 that the updated 'road map' for the INSPIRE IT Strategy needed to contain reference to the Strategy's original milestones. The point was acknowledged.

6-19 Patient Experience Committee, 16/06/16

SD referred to the circulated report and highlighted that the Committee did not appreciate the strategic and financial significance of cancelled and missed appointments until the issue had been discussed in detail. SD added that the Committee had received a useful presentation from those working on the issue. SO reported that the team that had given that presentation had found the discussion helpful, and a number of ideas for improvement had emerged.

6-20 Finance Committee, 27/06/16

ST referred to the circulated report and highlighted that the Committee's Terms of Reference had been reviewed and some amendments agreed. The Trust Board's approval was requested.

Questions or comments were invited. None were received.

The Trust Board approved the Terms of Reference as circulated.

ST also noted that the Trust's creditor payment terms would be discussed at the 'Part 2' Trust Board meeting to be held later that day.

6-21 To consider any other business

KR reminded Trust Board Members that the 2016 Annual General Meeting would be held on 15/09/16, in the Academic Centre at Maidstone Hospital, and stated that any ideas for the main presentation/theme of the Meeting should be made known to AJ, GD or himself.

6-22 To receive any questions from members of the public

There were no questions.

6-23 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – July 2016

7-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	It was agreed at the Board on 25/05/16 that the Medical Director would provide an update to each Trust Board, from June 2016 onwards. A further verbal update (to cover contracts) has therefore been scheduled for the July 2016 Trust Board meeting
5-12ii (May 16)	Consider including details of income for 'ITU' within future 'planned and actual ward staffing' reports submitted to the Trust Board	Director of Finance / Chief Nurse	May 2016 onwards	The matter is still being considered
6-8ii (June 16)	Arrange for the work to reduce Length of Stay to be reported to the 'main' Quality Committee in September 2016	Trust Secretary / Chief Operating Officer	June 2016 onwards	The item has been scheduled for the September 2016 'main' Quality Committee
6-8iii (June 16)	Consider whether the "Mean" line within the "Integrated performance report analysis" charts submitted to the Trust Board was beneficial, in terms of demonstrating the trend in performance over time	Director of Finance	June 2016 onwards	An explanation of the Statistical Process Control (SPC) process has been included in the month 3 performance report, to make clear the purpose of the confidence limit and mean lines. In addition, consideration is being given as to whether it would be beneficial to include a) a trend line, or the planned position (for each chart)
6-8iv (June 16)	Arrange for the next meeting of the Workforce Committee to review whether the current vacancy rate had been assumed in the Trust's	Chairman of Workforce Committee / Director of Workforce	June 2016 onwards	The item has been scheduled for the September 2016 Workforce Committee

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

Ref.	Action	Person responsible	Original timescale	Progress [1]
	plans for 2016/17			
6-9 (June 16)	Submit a further report to the Trust Board in September 2016 on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer	September 2016	The item has been scheduled for the September 2016 Trust Board

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
6-8i (June 16)	Request that the Trust's Cancer Board consider whether more advanced notice of national screening campaigns was required (to enable the Trust to better prepare for the increased referrals arising from such campaigns)	Chief Operating Officer	July 2016	A request to consider the matter was made to the Cancer Board (but a response has not yet been received)

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-7	Chief Executive's update	Chief Executive

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

1. I have continued to work closely with colleagues to maintain safe, high standards of care for our patients. The high levels of demand we have seen for unplanned hospital care has continued, unabated, into the summer months, and we are working with our partners to ensure patients have timely access to all aspects of their hospital and community-based care.

   We are also starting to gear up for a potentially tough winter. With emergencies already running at 6% above last year, we are asking all areas of our Trust to begin planning for a possible 10% increase in A&E attendances this winter.

   Overall, our patients continue to receive care in a safe environment and this is testament to the ongoing efforts of our staff. We are alert to any individual issues, however, and I have reminded our staff about the importance of having a non-stop focus on pressure sores, infection control and falls. Other key learning points that I have shared with staff this month include:

   - The need to escalate to senior staff/specialists if recommended treatment is not proving to be effective
   - Checking tourniquets are removed as the final part of care and not left on patients
   - Being alert to known drug allergies/sensitivities when prescribing medications

2. We have agreed further investment in our staff and services this year to maintain high standards of patient care. In doing so, we continue to balance the need to move the Trust forward, and maintain a safe environment and modern services for our patients, with our steady, and carefully managed return, to long-term financial sustainability.

   Following a successful pilot scheme, we have put in place funding to provide a dichloride therapy service for men with prostate cancer. Radium-223 is the first alpha-particle emitting radioactive therapeutic agent recommended for use for the treatment of adult men with metastatic hormone relapsed prostate cancer within the NHS. Bone metastases are one of the main causes of mortality in these patients and the availability of radium-223 on the NHS will enable doctors and physicians to better manage the disease.

   We are installing automated ultraviolet environmental decontamination systems at Maidstone and Tunbridge Wells hospitals to enhance our ability to quickly, and effectively, deep clean and decontaminate our clinical areas. The new system uses UV radiation, instead of penetrative chemicals. A pilot exercise demonstrated significant improvement in environmental cleanliness and decontamination when compared with the Trust's existing methods.

   As a leading provider of ophthalmic services, we are investing in two state of the art ophthalmic surgical microscopes. These will provide our surgeons, who carry out over 3,000 highly delicate procedures a year, with highly advanced imagery and optimise outcomes for patients.

   We are undertaking multiple projects throughout the year to maintain our buildings and hospital environment. Although none of the schemes individually exceed £500,000, they collectively represent an investment of £2 million and improve standards for our patients and staff.

3. We have three new IBD nurses in post which is having a positive impact for patients with this debilitating long term condition, and continue to attract other high calibre staff to MTW.

4. We have seen a steady increase in the number of women choosing to give birth in the community, with 16% of all deliveries over the last six months occurring in women's homes, in the Maidstone Birth Centre, and more recently in the Crowborough Birth Centre. This is up from 12% for the first six months of last year. We are one of few NHS providers nationally to offer women the widest possible range of birth choices and this bodes well for the future.

5. The Trust has held its inaugural Quality Improvement Awards to showcase the excellent work taking place to improve care and outcomes for our patients. Winners included Dr Camille Yvon and Dr Meriam Islam who have improved on-the-day Oculoplastics theatre cancellations, Louise Morris and Daren Chambers, for their work on quality improvement in Acute Kidney Injury Care and Dr Natalie Ryan, Dr Heather Lee and Brendan O'Reilly who have worked on DVT doppler ultrasound service improvements.

6. Congratulations to our latest employee of the month winner Medical Secretary, Margarita Clarke. Margarita was nominated for her caring and hard-working approach and for always going the extra mile to help both patients and her colleagues.

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-9	**Integrated performance report for June 2016**	**Chief Executive**

The enclosed report includes:

- The 'story of the month' for June 2016
- A quality exception report
- A Workforce update
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section (this has been added in response to a query raised at the Trust Board in June 2016 regarding trend lines on the charts in the month 2 report)
- Integrated performance charts;
- Financial performance overview and Finance Pack (issued 19/07/16).

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 13/07/16 (performance dashboard)

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

Discussion and scrutiny

[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

‘Story of the month’ for June 2016

Responsiveness

At the end of month 3 the Trust is delivering within the agreed performance trajectories for the emergency 4 hour standard and 18 week referral to treatment. The cancer 62 day standard is also within the trajectory set for May, performance is at 77.1% against a trajectory of 75%.

1. Four-hour standard, non-elective activity and LOS

The Trust achieved 91% against our recovery trajectory plan of 89.8% for the 4 hour standard in June. A number of projects and improvement action plans remain in place to achieve a consistent and sustainable improvement across both sites and these are focused on reducing LOS and delivering the ambulatory model for acute medicine. The level of non-elective activity continues to be higher than plan and remains above last year’s level by 7% (800 more admissions YTD). The non-elective length is 7.7 days at the end of June against the internal phased target of 7.2. The LOS was affected by 3 patients discharged in the month, who all had a 100+ day in patient stay, with several others discharged after 50 days. There is a clear focus on LOS improvement as the key enabler to improve capacity and flow. Bed occupancy remains above 95% across the Trust and the DTOC level has increased in June to 6.2%, (1,332 bed days).

Count of Hospital ID																									
Row Labels	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**
A : Awaiting Assessment	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25
B : Awaiting Public Funding		2	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1			1	1	1	8
C : Awaiting Further Non-Acute NHS Care	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11
Di : Awaiting Residential Home		9	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37
Dii : Awaiting Nursing Home	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65
E : Awaiting Care Package	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39
F : Awaiting Community Adoptions	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	14	5	13	8	7	12
G : Patient of Family Choice	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19
H : Disputes				1							2	1			1	3	1	1		1				3	1
I : Housing	6	2				2		2		1	3	4	3	1		1	13	12	9	3	5	1			5
Grand Total	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**145**	**194**	**141**	**171**	**199**	**158**	**150**	**222**

Trust delayed transfers of care	3.4%	4.8%	4.1%	4.4%	4.8%	4.2%	3.6%	4.1%	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%

2. Cancer 2 week waits

The underperformance on cancer 2 week-wait standard is still largely due to patient choice and patient cancellation of appointments. There is a new guidance in the latest version of the national cancer access policy which will give more flexibility for allowing more choice to patients which does not affect the reported waiting time. The policy is currently out to consultation internally but has already been approved by the Intensive Support Team.

3. Cancer 62 day FDT

Performance is on trajectory for May although it remains volatile due to continuing pathway issues internally and late referrals from other Trusts. Clear actions have been agreed and are in place for each tumour group. A follow-up cancer summit was held in June to review actions and improvement plans that were agreed in January and much progress has been achieved, particularly in breast and lung cancer. The cancer delivery plan is monitored on a weekly basis with the relevant managers and clinical leads. An upgrade to the electronic patient tracking system has been purchased which will give real-time updates on progress for individual patients through their pathway – this is being implemented and tested and will be in use imminently.

62 Overall				% Target	85	Treated after day 104			
	Total treated	Accountable treated	Accountable Breaches	% meeting standard	National % Standard	MTW only	Other > MTW	MTW > Other	Acc
Apr 2016	133	113.5	40.5	64.3	82.7	**11**	**5**	**1**	**14.0**
May 2016	121	107.0	24.5	77.1	81.3	**6**	**4**	**1**	**8.5**

4. RTT and elective activity.

The Trust is on target to deliver the agreed RTT trajectory by the end of July and the improvement reflects the increase in the level of elective and day case activity undertaken year to date. The elective activity in June is above plan but under performing YTD due to the escalation issues and the doctor's strike in April. The overall waiting list has reduced x 400 patients since the 1st April.

Progress is maintained against the 18 week plan with all specialties with the bulk of the over 18 week backlog concentrated in 4 specialities, T&O, gynaecology, ENT and gastroenterology, all of which are being managed against recovery plans to achieve their targets. We are also continuing to outsource activity in T&O and neurology. The overall backlog is reducing as per the plan and is ahead of target by 73 at the end of June. The progress with 18 weeks and RTT is dependent on maintaining our elective and day case activity to the planned levels.

Quality Exception Report

There were 4 cases pf post -72 hour C difficile infection in June against a monthly limit of three cases. The Trust remains under trajectory year to date although cases must be reduced to achieve similar rates to those seen last year.

Friends and Family response rates remains an area of focus. Unfortunately Maternity response rate dropped from the significant progress that was made in previous 2 months as they had run out of the cards.

Workforce

The Trust now employs 5,100.1 whole time equivalent substantive staff representing a net increase of 11.6 WTE on last month. The Trust will continue to focus attention on recruitment, retention and establishment reviews in order to reduce the number of vacancies in the organisation further. Although the dependence upon temporary staff remains higher than planned, further work is ongoing to ensure we reduce our dependence upon

expensive agency and interim workers. The use of bank staff was 331.8WTE in June 2016 which was similar to the amount used in April and May but represented a significant improvement (+31.3 WTE) on the same period last year.

Sickness absence in the month was 3.8%, representing a 0.4% improvement on last month and a 0.1% improvement on the same period last year (3.9%). However sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance figure is 0.2% higher than the same period last year and despite the overall figure being rebased this year to include all subjects. Actions are in place to improve compliance further.

Results from the latest staff FFT quarterly response show an overall increase in the percentage of staff recommending the Trust as a place to work. 664 staff took part in the survey representing a significant improvement on the previous return and the largest response to date for the Staff FFT quarterly survey.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30 June 2016**

Governance (Quality of Service): **2.0** **Amber/Red** Based on TDA 2014/15 Methodology

Finance: **TDA** **Amber**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait monthly plan is Trust Recovery Trajectory

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	5.23	18.5	5.1	12.3	7.2	- 1.5	11.5	10.5	
'1-02	Number of cases C.Difficile (Hospital)	1	4	3	8	5	- 1	27 (18)	26	
'1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
'1-04	Elective MRSA Screening	100.0%	99.0%	100.0%	99.0%		1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%		4.0%	95.0%	99.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.4	2.5	2.1	2.5	0.4	- 0.5	*3.0*	2.6	3.0
'1-07	***Rate of Total Patient Falls	6.8	5.7	6.8	6.0	- 0.7	- 0.2	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	6.1	5.9	5.9	5.8	- 0.1			6.3	
'1-09	***Rate of Total Patient Falls TWells	7.6	5.6	7.4	6.2	- 1.2			6.9	
'1-10	Falls - SIs in month	1	2	7	3	- 4				
'1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
'1-12	Total No of SIs Open with MTW	24	28			4				
'1-13	Number of New SIs in month	6	11	19	27	8	- 3			
'1-14	**Serious Incidents rate	0.31	0.51	0.32	0.41	0.09	0.36	*0.0584 - 0.6978*	0.41	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.21	0.87	1.34	0.53	- 0.81	- 0.70	*0 - 1.23*	0.53	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.0%	95.0%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.2%	97.2%	96.9%	96.7%	-0.2%	1.7%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	2.33%	2.67%	2.31%	3.18%	0.87%	0.2%	*3.00%*	3.18%	
'1-20	C-Section Rate (non-elective)	13.5%	13.6%	13.5%	13.8%	0.29%	-1.2%	*15.0%*	13.8%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		-	105.0	105.0	5.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		108.0	104.0	- 4.0	4.0			100.0
2-03	Crude Mortality	1.0%	0.9%	1.2%	1.3%	0.1%				
2-04	****Readmissions <30 days: Emergency	11.2%	10.6%	11.5%	11.3%	-0.2%	-2.3%	*13.6%*	11.3%	14.1%
2-05	****Readmissions <30 days: All	10.4%	9.9%	10.6%	10.6%	0.0%	-4.1%	*14.7%*	10.6%	14.7%
2-06	Average LOS Elective	3.3	3.4	3.3	3.2	- 0.0	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.1	7.7	7.4	7.6	0.2	0.7	*6.8*	6.8	
2-08	******New:FU Ratio	1.26	1.34	1.29	1.27	- 0.02	- 0.24	*1.52*	1.27	
2-09	Day Case Rates	83.6%	83.6%	83.5%	84.4%	0.8%	4.4%	80.0%	84.4%	82.2%
2-10	Primary Referrals	9,512	9,266	26,888	28,117	4.6%	8.0%	104,825	104,825	
2-11	Cons to Cons Referrals	3,617	3,124	10,210	9,709	-4.9%	-8.3%	40,698	40,698	
2-12	First OP Activity	12,824	12,889	34,838	36,487	4.7%	3.2%	144,940	144,940	
2-13	Subsequent OP Activity	24,069	24,666	66,893	70,342	5.2%	1.5%	279,695	279,695	
2-14	Elective IP Activity	732	728	2,008	2,046	1.9%	-6.4%	8,755	8,755	
2-15	Elective DC Activity	3,552	3,495	9,707	10,169	4.8%	-6.3%	44,937	44,937	
2-16	Non-Elective Activity	3,709	3,926	11,425	12,227	7.0%	7.0%	45,985	45,985	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	13,044	13,628	38,831	40,355	3.9%	-0.7%	163,967	163,967	
2-18	Oncology Fractions	5,754	6,419	16,577	18,351	10.7%	5.6%	70,642	70,642	
2-19	No of Births (Mothers Delivered)	490	477	1,472	1,461	-0.7%	-0.7%	5,888	5,888	
2-20	% Mothers initiating breastfeeding	81.2%	85.5%	80.5%	85.7%	5.2%	7.7%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.8%	0.83%	0.40%	0.34%	*-0.1%*	*-0.1%*	*0.47%*	0.34%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	2.09	1.11	1.69	1.35	-0.3	0.03	*1.318-3.92*	1.42	
3-03	% complaints responded to within target	79.1%	73.7%	63.3%	67.8%	4.5%	-7.2%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	84.0%	87.2%	84.0%	87.2%	3.2%	8.2%	79.0%	87.2%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	98.3%	95.1%	96.6%	95.8%	-0.8%	0.8%	95.0%	95.8%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	91.3%	92.6%	89.2%	92.0%	2.8%	5.0%	87.0%	92.0%	84.9%
3-07	Maternity Combined FFT % Positive	94.1%	99.0%	94.5%	94.5%	0.0%	-0.5%	95.0%	95.0%	95.5%
3-08	OP Friends & Family (FFT) % Positive	77.9%	82.9%	77.6%	82.3%	4.6%			82.3%	

* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

***** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan

***** *IP Friends and Family includes Inpatients and Day Cases* ******SHMI is within confidence limit*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	93.9%	91.0%	92.3%	91.0%	-1.2%	4.4%	95.0%	95.0%	
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	RTT Incomplete Admitted Backlog	564	1528	564	1528	964	97	916	916	
4-06	RTT Incomplete Non-Admitted Backlog	85	541	85	541	456	- 177	459	459	
4-07	RTT Incomplete Pathway	96.9%	91.4%	96.9%	91.4%	-5.6%	0.3%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	3	0	- 3	0	*0*	0	
4-09	RTT Incomplete Total Backlog	649	2069	649	2069	1,420	- 80	1,375	1375	
4-10	% Diagnostics Tests WTimes <6wks	99.99%	99.8%	99.9%	99.8%	-0.1%	0.8%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	6	1	7	2	- 5	- 7	9	9	
4-12	*Cancer two week wait	91.4%	91.0%	93.0%	91.1%	-1.9%	-1.9%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	95.8%	86.4%	95.7%	85.0%	-10.7%	-8.0%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	98.8%	96.7%	98.8%	96.6%	-2.2%	0.6%	96.0%	96.6%	
4-15	*Cancer 62 day wait - First Definitive	78.7%	77.1%	81.9%	70.5%	-11.4%	-3.9%	85.2%	85.2%	
4-16	*Cancer 62 day wait - First Definitive - MTW	85.1%	81.7%	86.7%	74.9%	-11.8%		85.0%		
4-17	*Cancer 104 Day wait Accountable	4.0	8.5	4.0	22.5	18.5	22.5	*0*	22.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	New	101	New	101					
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	New	69	New	69					
4-20	Delayed Transfers of Care	6.8%	6.2%	5.7%	5.6%	-0.1%	2.1%	3.5%	3.5%	
4-21	% TIA with high risk treated <24hrs	62.5%	65.0%	72.4%	78.3%	6.0%	18.3%	60%	78.3%	
4-22	*******% spending 90% time on Stroke Ward	91.8%	82.0%	83.9%	84.3%	0.4%	4.3%	80%	84.3%	
4-23	*******Stroke:% to Stroke Unit <4hrs	59.2%	44.9%	59.2%	49.1%	-10.1%	-10.9%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	65.3%	57.1%	51.0%	56.1%	5.2%	8.1%	48.0%	56.1%	
4-25	*******Stroke:% assessed by Cons <24hrs	79.6%	67.1%	75.3%	67.8%	-7.5%	-12.2%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	0	1	0	4	4	4	*0*	4	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

*******Stroke Indicators run one month behind

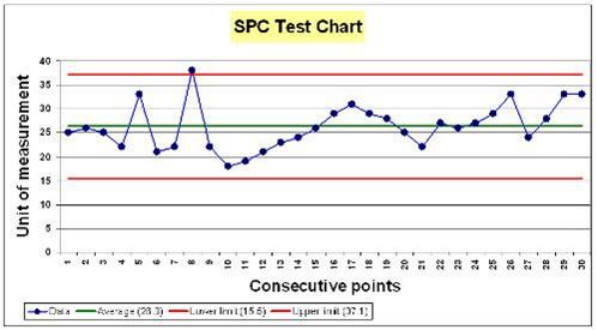
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

*** *Contracted not worked includes Maternity /Long Term Sick* **** *Staff FFT is Quarterly therefore data is latest Quarter*

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	34,118	34,812	97,103	102,121	5.2%	-1.6%	418,582	418,582	
5-02	EBITDA	1,599	(850)	2,232	(2,295)	-202.8%	392.2%	11,086	11,086	
5-03	Surplus (Deficit) against B/E Duty	1,296	(3,559)	6,353	(10,472)			(22,928)	(22,928)	
5-04	CIP Savings	1,661	1,614	4,717	4,334	-8.1%	0.6%	23,076	23,076	
5-05	Cash Balance	14,250	4,339	14,250	4,339	-69.6%	11%	1,000	1,000	
5-06	Capital Expenditure	445	201	1,324	383	-71.1%	-79.7%	*15,188*	15,189	
5-07	Establishment (Budget WTE)	5,487.5	5,851.3	5,487.5	5,851.3	6.6%	0.0%	5,837.3	5,837.3	
5-08	Contracted WTE	4,962.4	5,100.7	4,962.4	5,100.7	2.8%	-3.9%	5,427.1	5,427.1	
5-09	***Contracted not worked WTE	0.0	(88.1)	0.0	(88.1)			(100.0)	(100.0)	
5-11	Bank Staff (WTE)	300.5	331.8	300.5	331.8	10.4%		254.8	254.8	
5-12	Agency & Locum Staff (WTE)	241.1	244.5	260.6	244.5	-6.2%		155.3	155.3	
5-13	Overtime (WTE)	0.0	58.0	0.0	58.0			64.4	64.4	
5-14	Worked Staff WTE	5,512.6	5,646.9	5,512.6	5,646.9	2.4%	-3.5%	5,801.7	5,801.7	
5-15	Vacancies WTE	525.1	612.7	525.1	612.7	16.7%		408.6	408.6	
5-16	Vacancy %	9.6%	10.5%	9.6%	10.5%	0.9%		8.5%	8.5%	
5-17	Nurse Agency Spend	(874)	(867)	(2,488)	(2,520)	1.3%				
5-18	Medical Locum & Agency Spend	(1,051)	(1,410)	(2,977)	(4,081)	37.1%				
5-19	Temp costs & overtime as % of total pay bill		17.0%		17.0%					
5-20	Staff Turnover Rate	9.8%	10.6%		10.1%	0.8%	0.1%	*10.5%*	10.1%	8.4%
5-21	Sickness Absence	3.9%	3.8%		4.1%			*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	88.9%	89.1%		89.1%	0.2%	4.1%	85.0%	89.1%	
5-23	Appraisal Completeness	Not reported for Quarter 1								
5-24	Overall Safe staffing fill rate	101.3%	99.6%	102.7%	101.5%	-1.8%		93.5%	101.5%	
5-25	****Staff FFT % recommended work	58.8%	64.2%	58.8%	64.2%	5.4%	2.2%	62.0%	64.2%	62.9%
5-26	***Staff Friends & Family -Number Responses	393	664	393	664	271				
5-27	*****IP Resp Rate Recmd to Friends & Family	30.1%	25.9%	28.3%	22.4%	-5.9%	-2.6%	25.0%	25.0%	24.9%
5-28	A&E Resp Rate Recmd to Friends & Family	7.9%	21.0%	8.0%	12.2%	4.2%	-2.8%	15.0%	15.0%	13.3%
5-29	Mat Resp Rate Recmd to Friends & Family	15.5%	7.6%	15.3%	20.8%	5.5%	-4.2%	25.0%	25.0%	24.6%

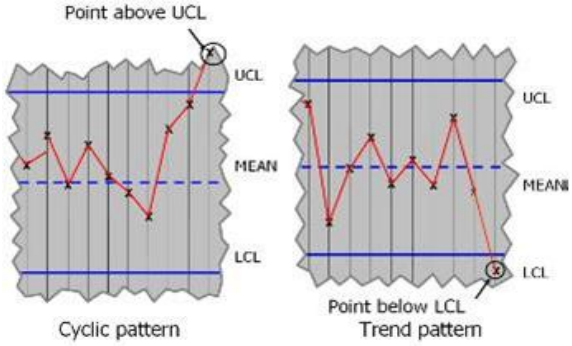
Explanation of Statistical Process Control (SPC) Charts

In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. *A*n SPC chart looks like this:

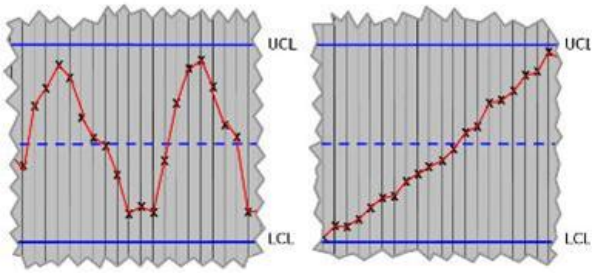


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only 'common cause ' variation is present.

Rule 1: Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change to a service such as Tunbridge Wells Hospital opening, then we will recalculate the centre and control lines. This is called a step change.

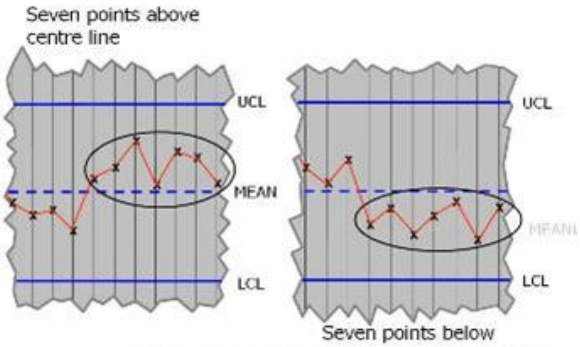


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.

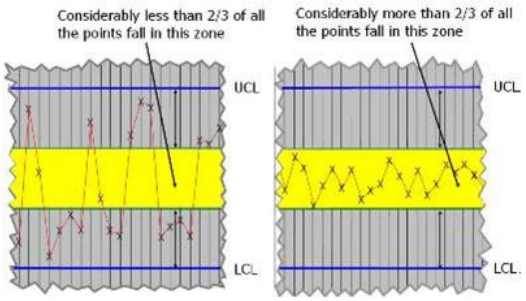


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

Rule 3: A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.

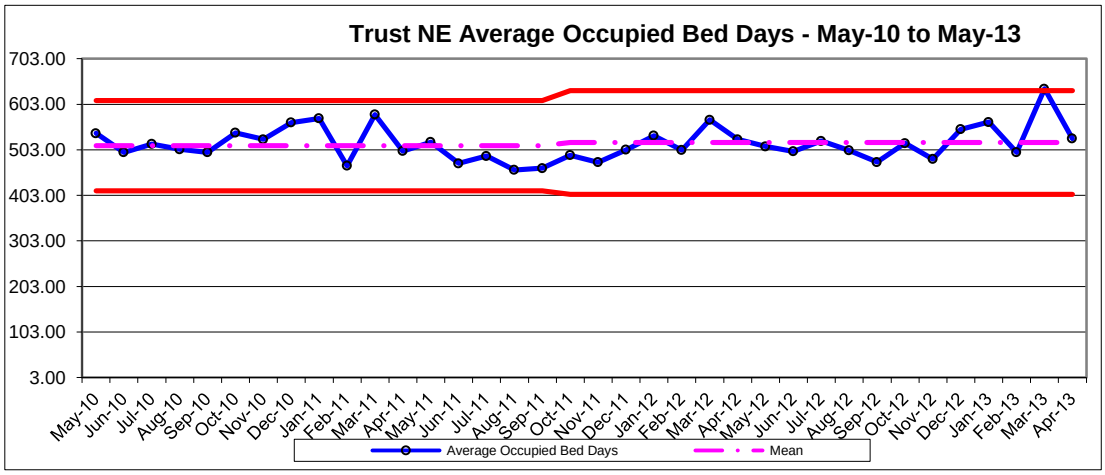


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

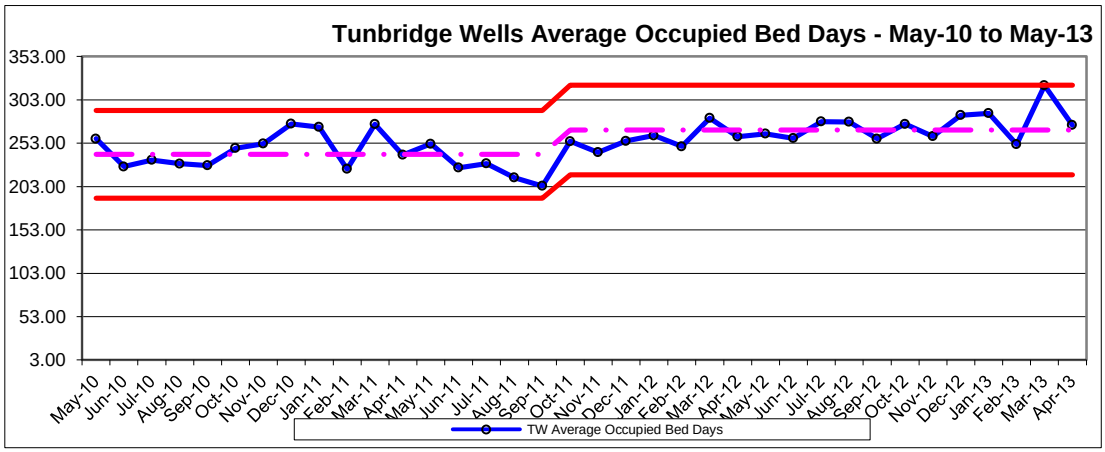


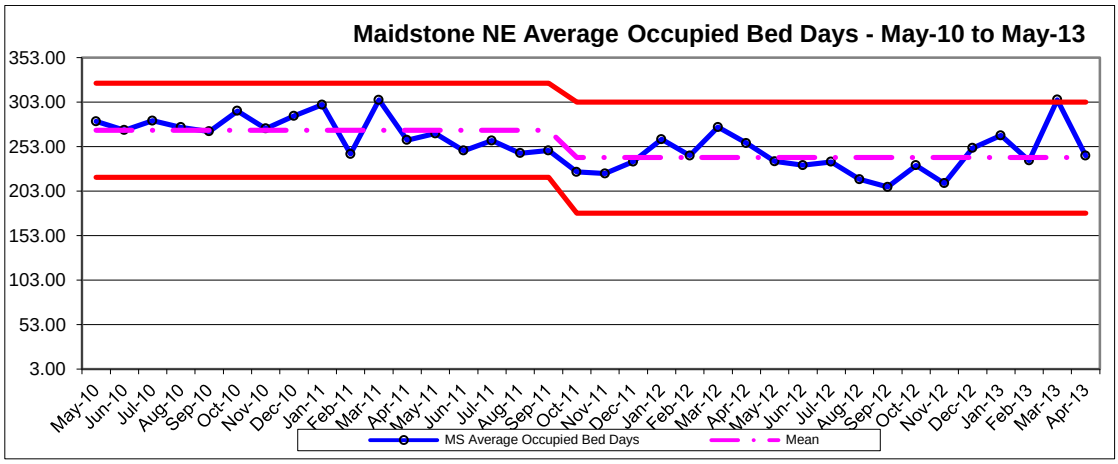
Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:

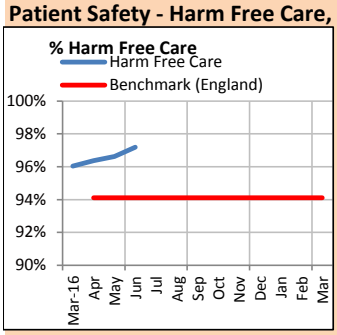


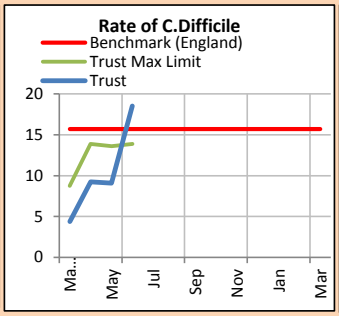


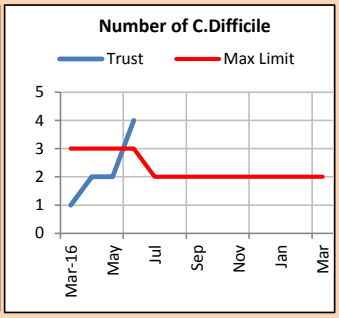
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information team based on a real life changes in process or service.

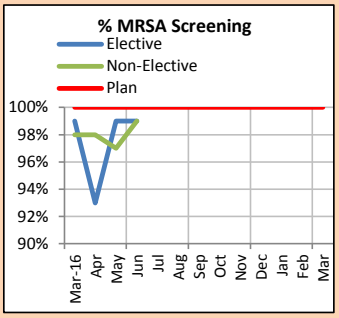
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

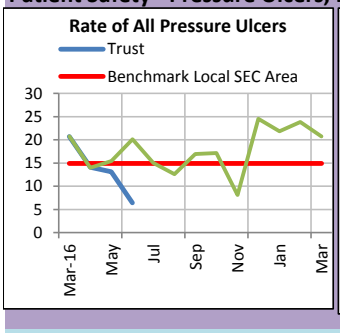


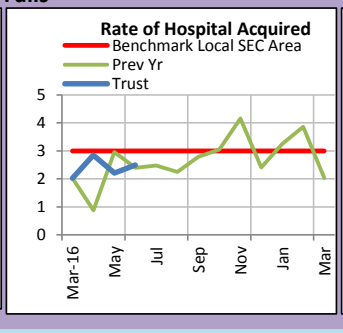


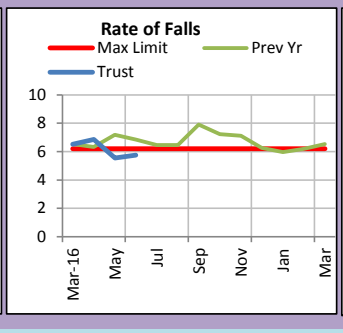


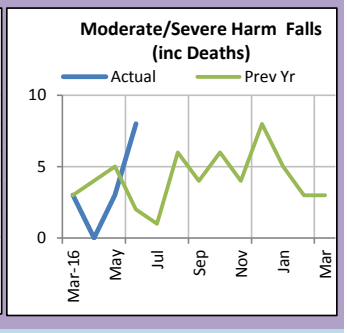


Patient Safety - Pressure Ulcers, Falls

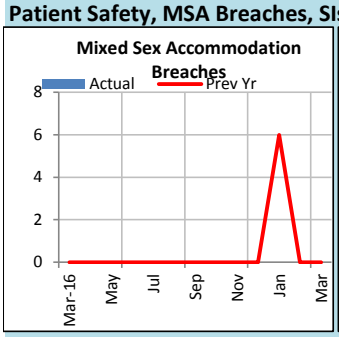


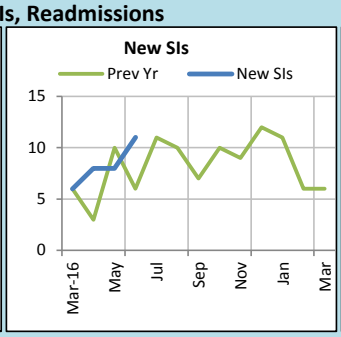


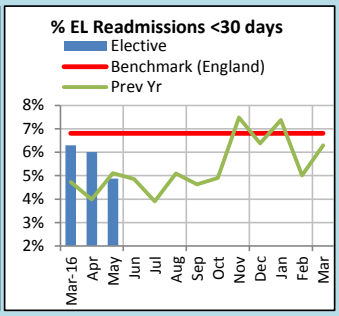


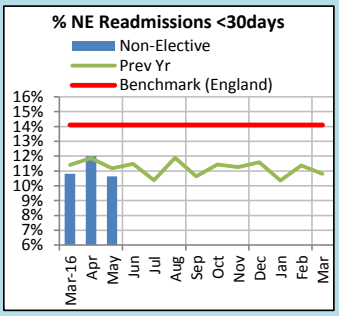


Patient Safety, MSA Breaches, SIs, Readmissions

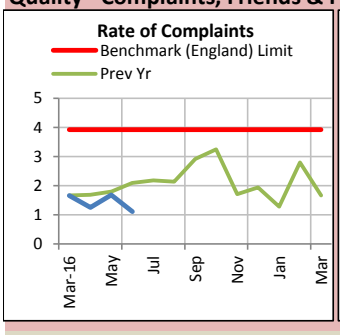


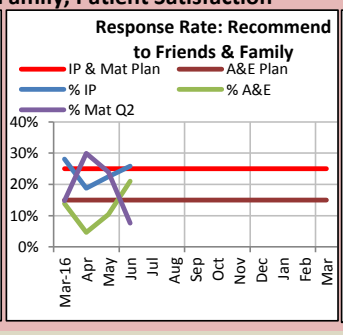


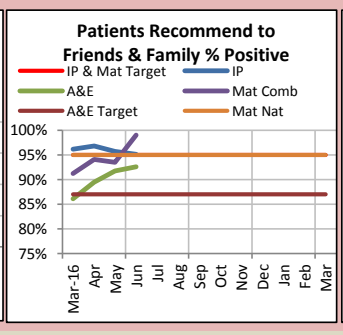


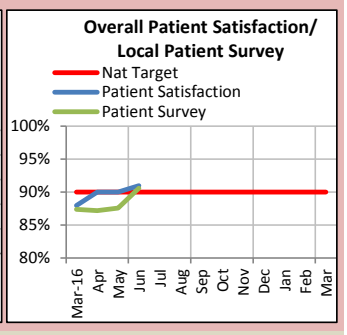


Quality - Complaints, Friends & Family, Patient Satisfaction

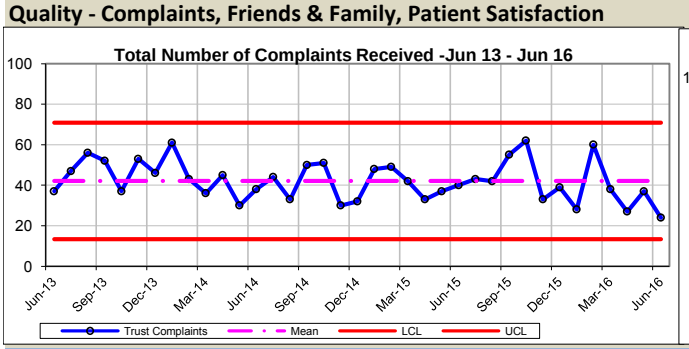


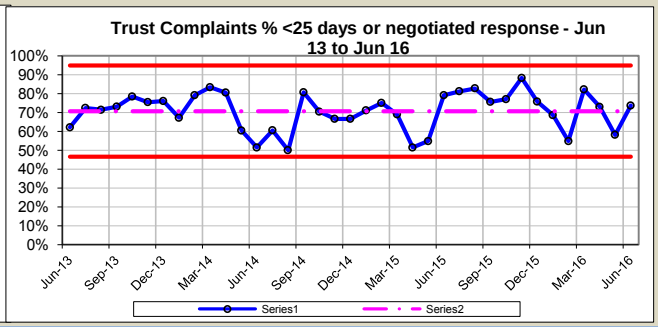




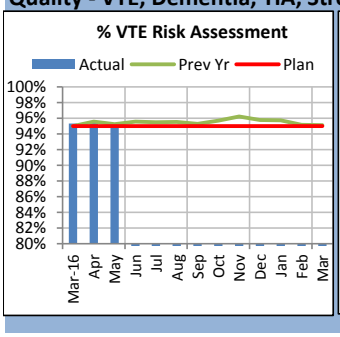


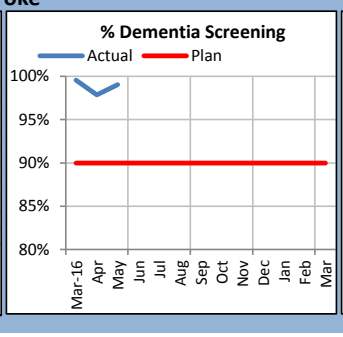
Quality - Complaints, Friends & Family, Patient Satisfaction

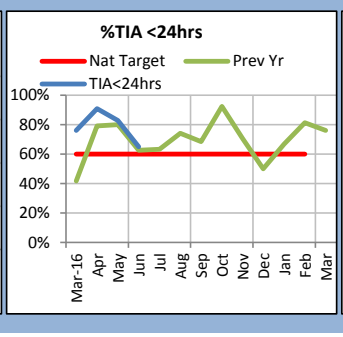


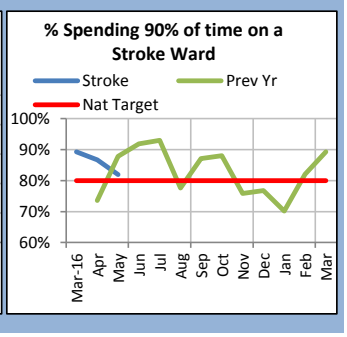


Quality - VTE, Dementia, TIA, Stroke



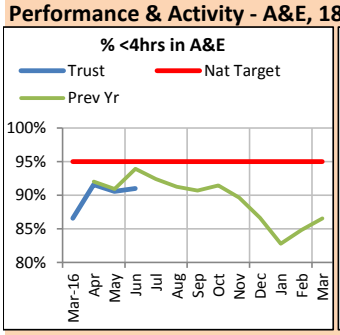


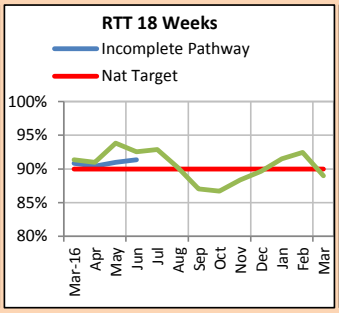


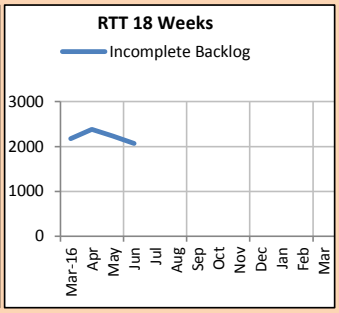


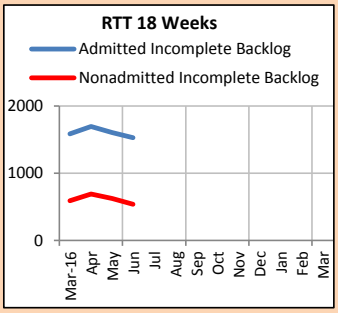
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

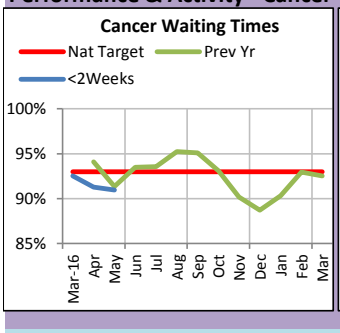


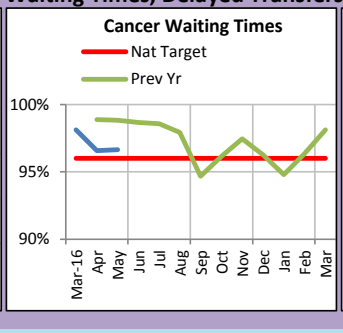


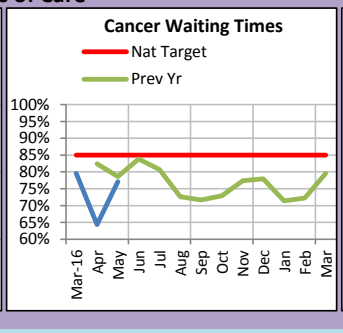


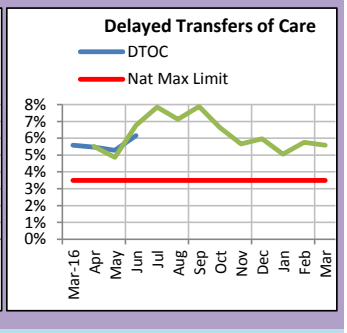


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

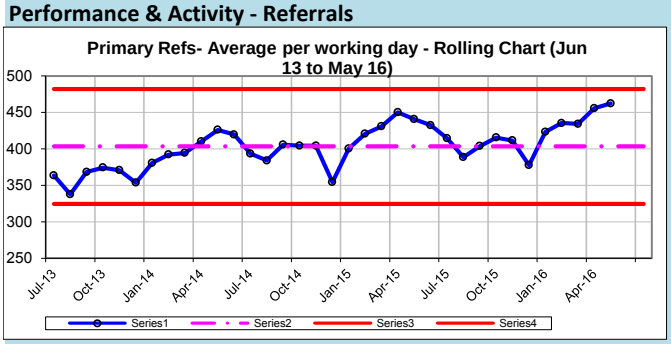


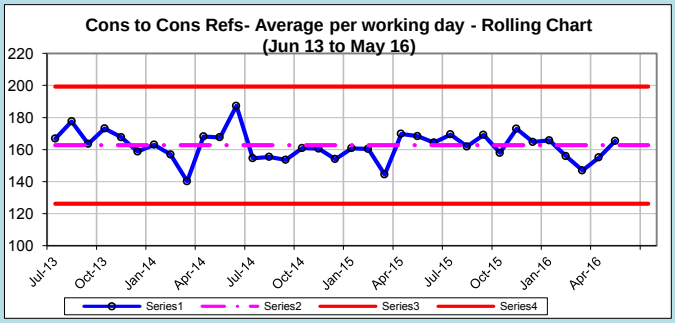




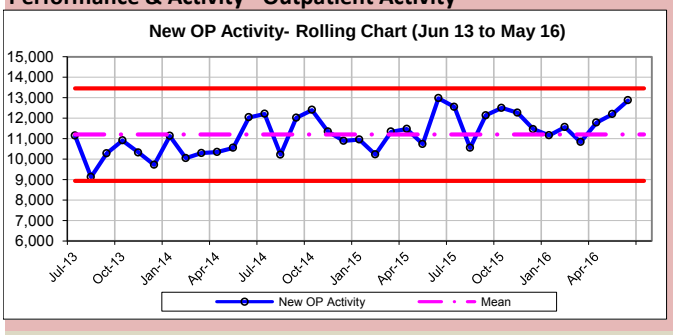


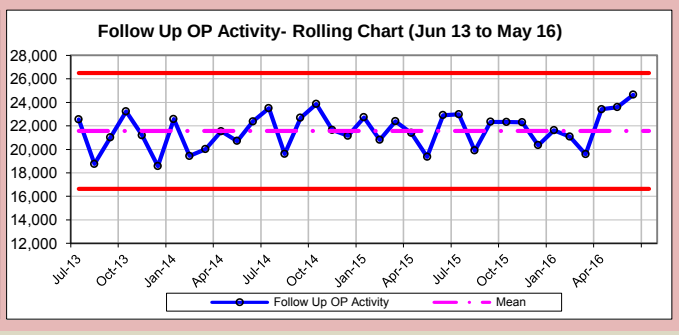
Performance & Activity - Referrals



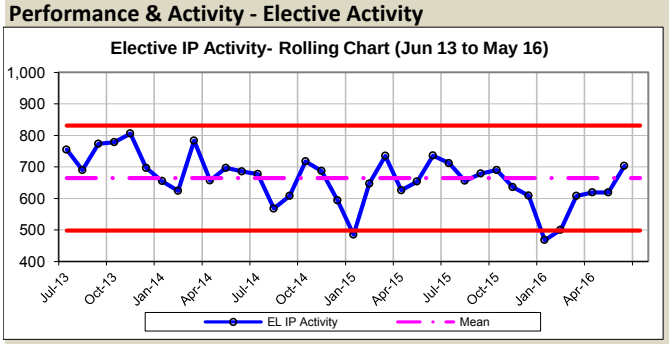


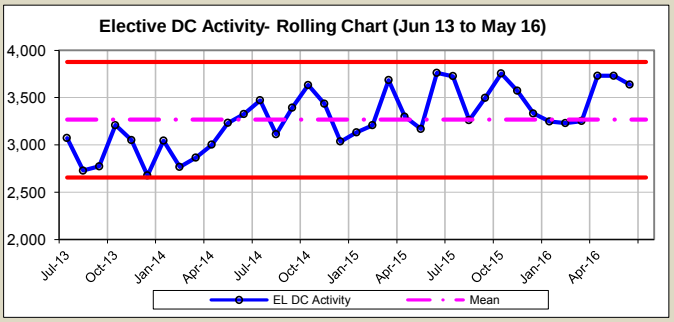
Performance & Activity - Outpatient Activity



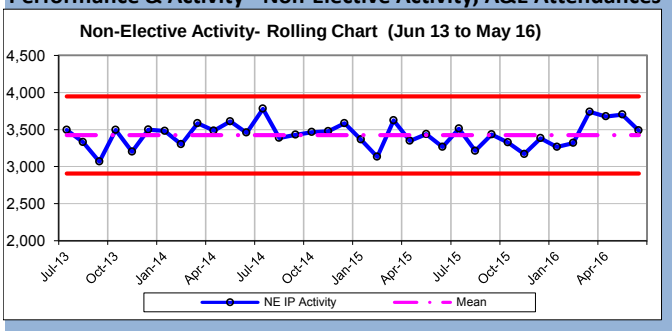


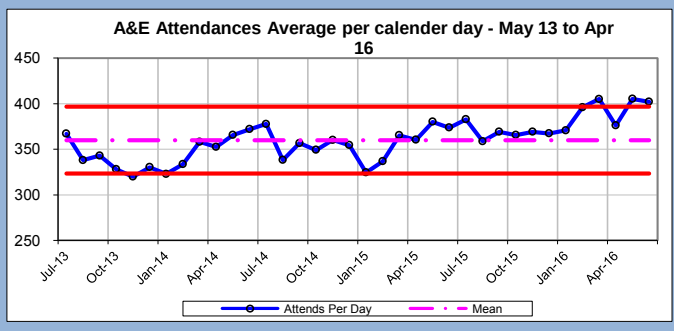
Performance & Activity - Elective Activity





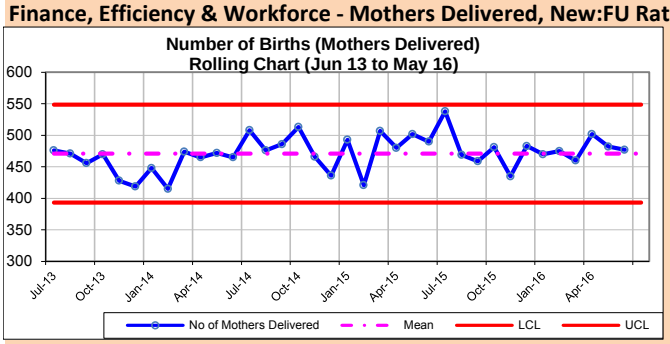
Performance & Activity - Non-Elective Activity, A&E Attendances

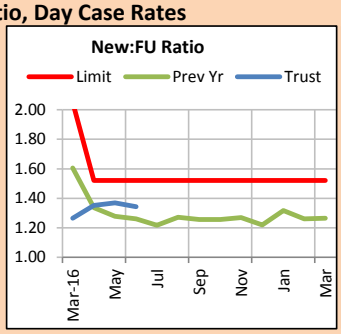


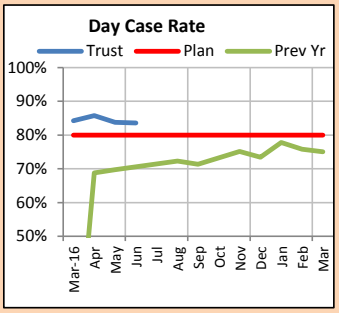


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

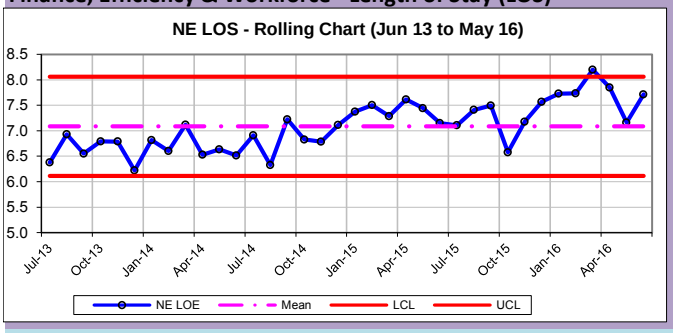
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

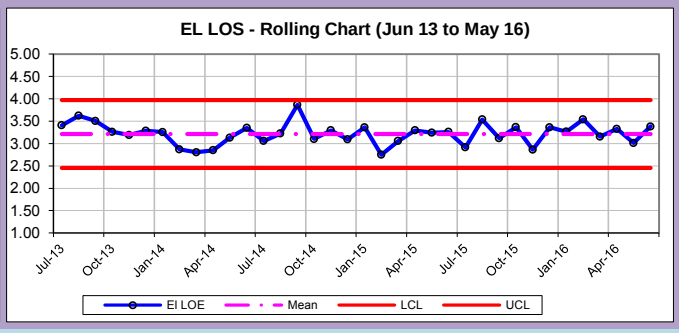




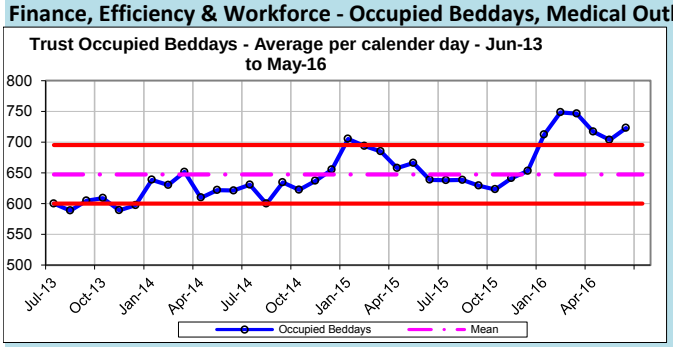


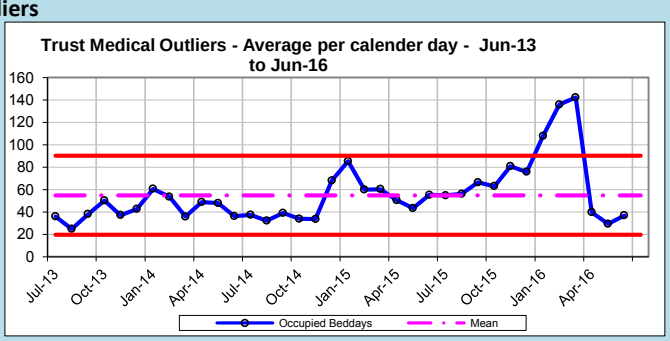
Finance, Efficiency & Workforce - Length of Stay (LOS)



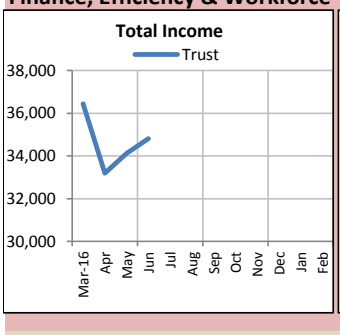


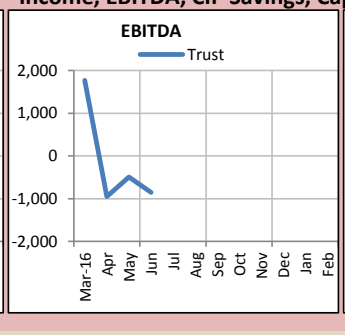
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

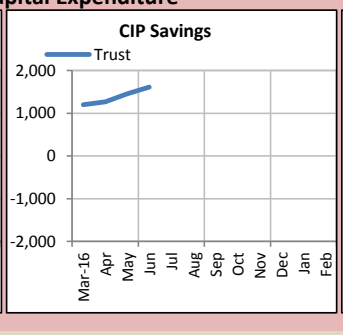


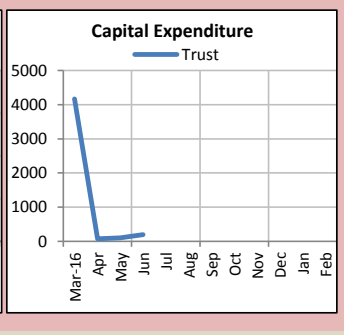


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

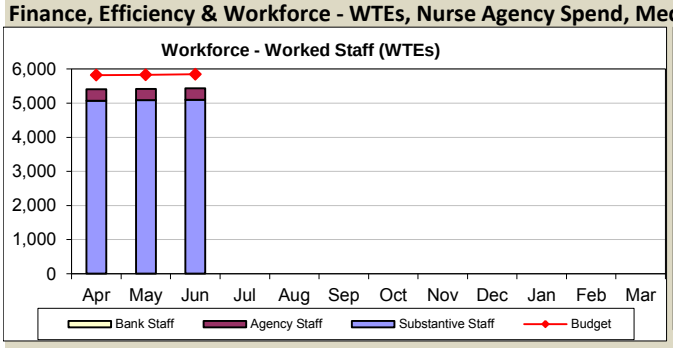


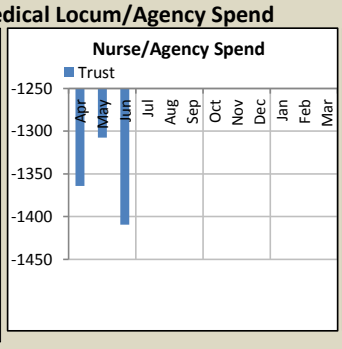


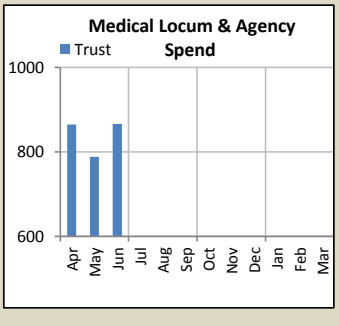




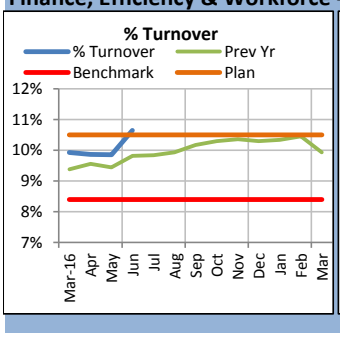
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

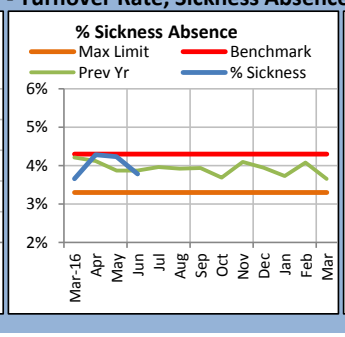


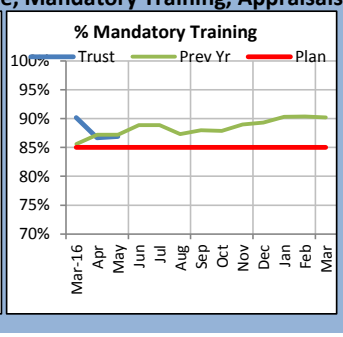




Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals







Appraisal Data not reported for Quarter 1

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-9	Review of Latest Financial Performance	Director of Finance

Summary / Key points

- The Trust had an adverse variance against plan in of June 2016 of £0.5m
- The Trust's net deficit to date (including technical adjustments) is £10.5m against a planned deficit of £8.9m, therefore £1.6m adverse to plan.
- The key drivers of the variance in the month are as follows:
    - Total income is adverse to plan by £0.5m, Clinical income over performed in the month by £0.3m, Daycase income is £0.2m adverse, which is offset by a net £0.3m favourable variance in Non Elective activity (net of Non Elective Threshold). Fines and contract penalties are £0.5m in month with RTT (£0.2m) and A&E fines (£0.1m). HCD income was £0.9m adverse in the month which is a result of the YTD plan being adjusted so the YTD plan matches the HCD costs incurred.
    - Pay underspent by £0.1m, spend increased across all staff groups but mainly within Medical (£0.2m). May included a one-off benefit of £0.1m. Admin and Clerical costs increased by £0.1m between months.
    - Non Pay is overspent by £0.3m which relates to consultancy spend.
- The CIP performance in June delivered efficiencies of £1.6m which was £0.2m favourable to plan.
- In June the Trust operated with an EBITDA deficit of £0.8m which was £0.7m adverse to plan.
- T&O is adverse to plan by £1.8m YTD, £1.5m under performance on income and £0.2m overspend on pay.
- The Trust held £4.3m of cash at the end of June which is £0.4 higher than plan. The Trust is currently forecasting to draw down of £2m in July, £2m in August at 3.5% interest and a further £8m in September.

Which Committees have reviewed the information prior to Board submission?
- Finance Committee (18/07/16)

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To note the June's financial position and actions needed to deliver the £22.9m annual plan

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

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 3
2016/17

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance for June 2016

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

1a. Executive Summary June 2016

Key Variances £m

	June	YTD		Headlines
Total Deficit	**(0.5)**	**(1.6)**	Adverse	The reported Trust position for June is a deficit of £3.6m which is £0.5m adverse to plan The main drivers were: Clinical Income, £1.5m adverse to plan, £0.7m relating to fines, £0.1m net non elective favourable and Elective £0.7m adverse. Other non pay costs were adverse by £0.3m relating to consultancy spend.
Pay	0.1	0.9	Favourable	Pay was £0.1m underspent in the month with costs increasing by £0.4m between months the main increases were within Medical (£0.2m) and A&C (£0.1m). YTD overspends on Medical (£0.6m) and Scientific and technical staffing (£0.2m) are offset by underspends on Nursing (£0.9m) and Admin and Clerical (Corporate) (£0.5m)
Non Elective threshold	(0.2)	(1.0)	Adverse	Non Elective activity is £0.5m over plan in June (£2m YTD) however part of this income has been lost due to the non elective threshold
Contract Penalties & Challenges	(0.5)	(1.6)	Adverse	18 week RTT is the main driver of the penalties (£0.2m in month, £0.9m YTD). A&E % 4 hours Arrival to Exit incurred £0.1m penalty in the month (YTD £0.2m)
KPMG	(0.3)	(0.6)	Adverse	Costs have been capped at procurement contract cap (£0.5m) and includes £0.1m relating to Improvement Director
Daycase Activity	(0.2)	(0.8)	Adverse	Main driver is T&O which internal activity is 130 cases less than the same period last year
CIP	0.2	0.0	Favourable	CIP plan for June was £1.39m with a delivery of £1.61m, £0.2m favourable to plan due to a YTD non recurrent benefit (corporate pay)

Financial Forecast

Risks:
Unidentified CIPS (£3.4m) phased from 1st July 16 equating to a reduction in budget of £0.4m per month.

Ability to deliver elective activity (backlog) within financial envelope (tariff)

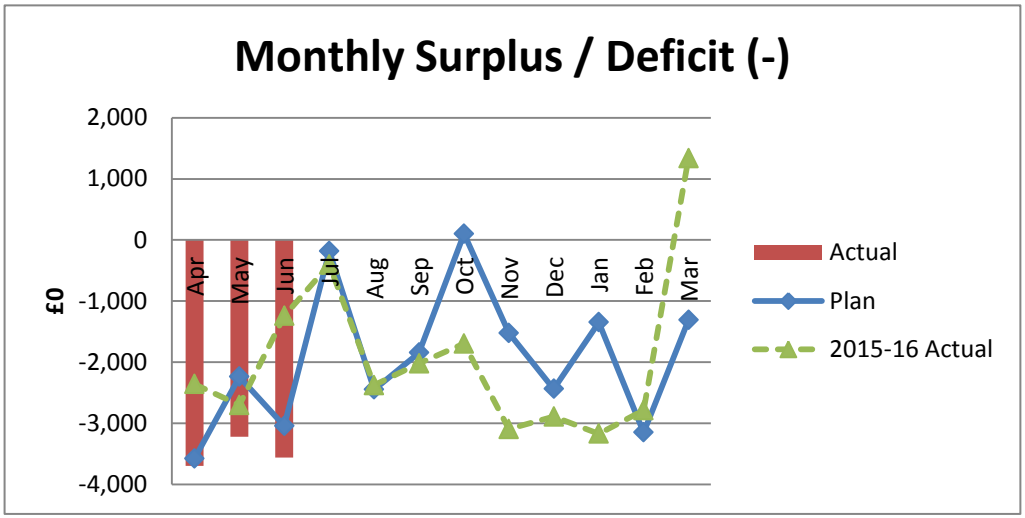
CQUINs are still being negotiated with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing

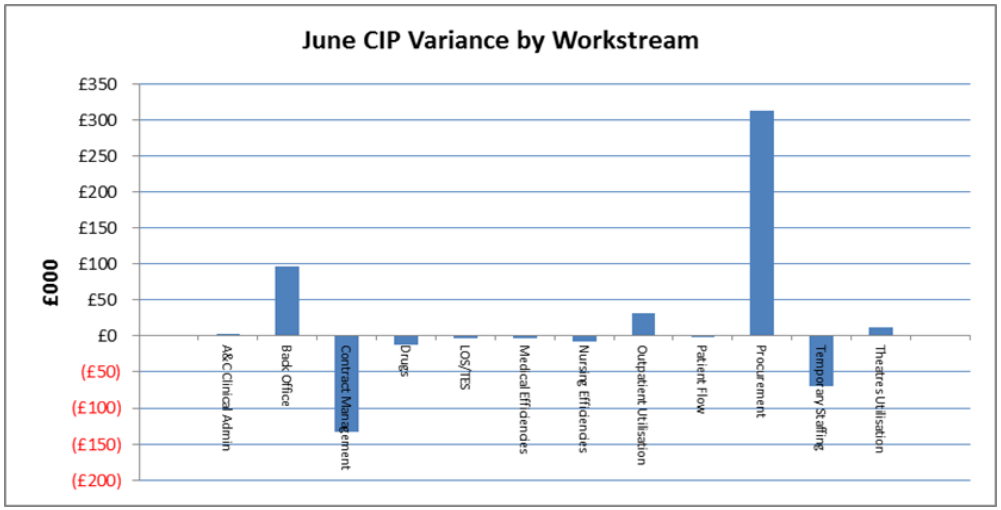
Opportunities:
Lord Carter efficiencies programme being led by the PMO team with clinicians and operational teams

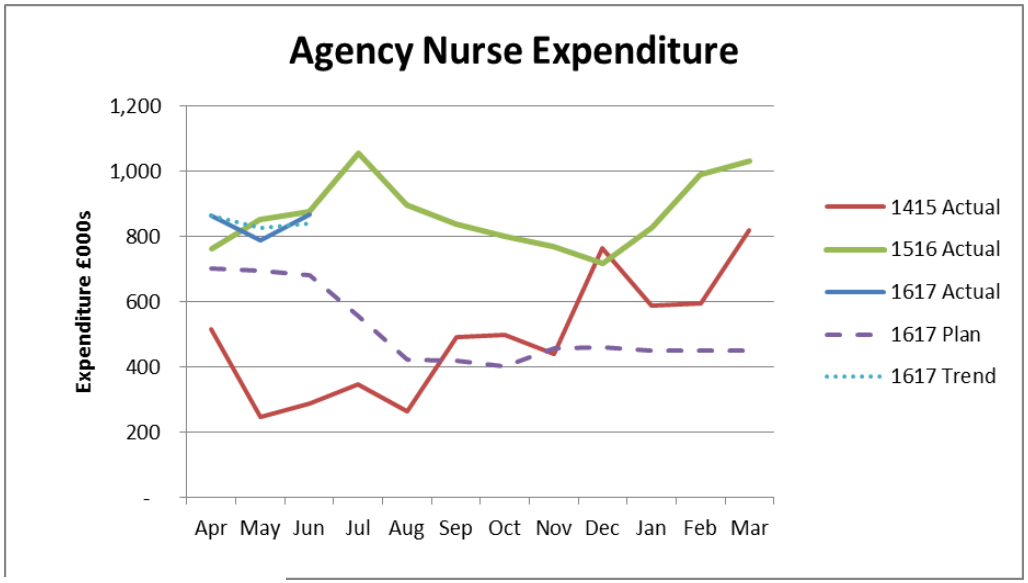
Unidentified savings workshops are taking place over the next month

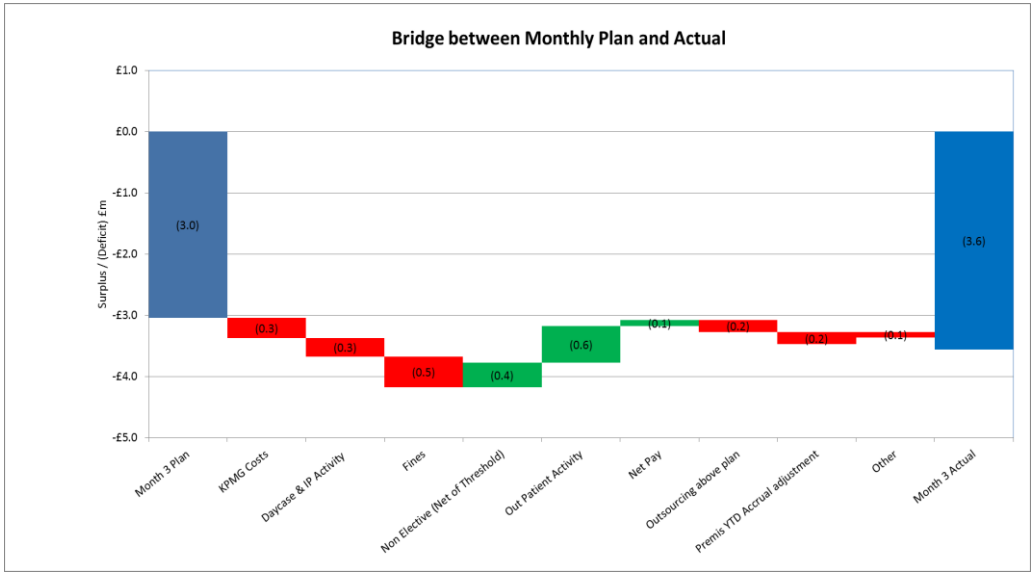
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's June 2016









Financial Performance

Maidstone and Tunbridge Wells NHS Trust

2a. Consolidated Income & Expenditure

Income & Expenditure June 2016/17

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	28.4	28.1	0.3	82.7	85.1	(2.4)	344.2	344.2	0
	High Cost Drugs	2.8	3.7	(0.9)	8.2	7.5	0.7	29.6	29.6	0
	Other Operating Income	3.6	3.5	0.1	11.2	11.1	0.1	44.8	44.8	0
	Total Revenue	34.8	35.3	(0.5)	102.1	103.7	(1.6)	418.6	418.6	0
Expenditure										
	Substantive	(18.1)	(18.8)	0.7	(53.8)	(55.9)	2.1	(223.0)	(223.0)	0
	Bank	(0.8)	(0.9)	0.1	(2.4)	(2.7)	0.4	(11.9)	(11.9)	0
	Locum	(1.0)	(0.5)	(0.5)	(3.1)	(1.6)	(1.5)	(6.6)	(6.6)	0
	Agency	(1.7)	(1.4)	(0.3)	(4.6)	(4.2)	(0.5)	(13.5)	(13.5)	0
	Pay Reserves	0.0	(0.1)	0.1	0	(0.4)	0.4	2.1	2.1	0
	Total Pay	(21.6)	(21.6)	0.1	(64.0)	(64.8)	0.9	(253.0)	(253.0)	0
	Drugs & Medical Gases	(4.4)	(4.7)	0.3	(12.7)	(12.0)	(0.7)	(47.5)	(47.5)	0
	Blood	(0.2)	(0.2)	(0.0)	(0.6)	(0.5)	(0.0)	(2.2)	(2.2)	0
	Supplies & Services - Clinical	(2.7)	(2.6)	(0.0)	(7.6)	(7.9)	0.4	(31.6)	(31.6)	0
	Supplies & Services - General	(0.5)	(0.5)	0.0	(1.3)	(1.4)	0.0	(5.5)	(5.5)	0
	Services from Other NHS Bodies	(0.8)	(0.7)	(0.1)	(2.2)	(2.1)	(0.1)	(8.1)	(8.1)	0
	Purchase of Healthcare from Non-NHS	(0.8)	(0.6)	(0.2)	(2.3)	(1.9)	(0.4)	(7.7)	(7.7)	0
	Clinical Negligence	(1.5)	(1.5)	(0.0)	(4.6)	(4.6)	(0.0)	(18.2)	(18.2)	0
	Establishment	(0.3)	(0.3)	(0.0)	(0.9)	(0.8)	(0.0)	(3.4)	(3.4)	0
	Premises	(1.9)	(1.3)	(0.6)	(5.6)	(5.0)	(0.6)	(20.0)	(20.0)	0
	Transport	(0.2)	(0.1)	(0.0)	(0.5)	(0.4)	(0.1)	(1.6)	(1.6)	0
	Other Non-Pay Costs	(0.6)	(0.4)	(0.2)	(1.4)	(1.1)	(0.3)	(4.3)	(4.3)	0
	Non-Pay Reserves	(0.4)	(0.8)	0.4	(0.9)	(1.7)	0.8	(4.3)	(4.3)	0
	Total Non Pay	(14.1)	(13.8)	(0.3)	(40.4)	(39.4)	(1.1)	(154.5)	(154.5)	0
	Total Expenditure	(35.7)	(35.4)	(0.2)	(104.4)	(104.2)	(0.2)	(407.5)	(407.5)	0
EBITDA	**EBITDA**	(0.8)	(0.1)	(0.7)	(2.3)	(0.5)	(1.8)	11.1	11.1	0
		(0.0)	*(0.0)*	*0.0*	*-2.2%*	*-0.4%*	*113.7%*	*2.6%*	*2.6%*	
Other Finance Costs										
	Depreciation	(1.4)	(1.4)	(0.0)	(4.1)	(4.1)	0.0	(16.5)	(16.5)	0
	Interest	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	0.0	(1.3)	(1.3)	0
	Dividend	(0.3)	(0.3)	0.0	(0.9)	(0.9)	0.0	(3.4)	(3.4)	0
	PFI and Impairments	(1.1)	(1.1)	0.0	(3.4)	(3.4)	(0.0)	(27.0)	(27.0)	0
	Total Finance Costs	(2.8)	(2.8)	0.0	(8.5)	(8.5)	0.0	(48.2)	(48.2)	0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(3.7)	(3.0)	(0.7)	(10.8)	(9.0)	(1.8)	(37.1)	(37.1)	0
Technical Adjustments	**Technical Adjustments**	0.1	(0.1)	0.2	0.4	0.2	0.2	14.2	14.2	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty**	(3.6)	(3.0)	(0.5)	(10.5)	(8.9)	(1.6)	(22.9)	(22.9)	0.0

Commentary:

The Trust had a higher deficit in month than May (£0.5m) with the YTD deficit £1.6m adverse to plan . The Trusts deficit for Q1 is a deficit of £10.5m this financial year, this time last year was £6.3m deficit.

The key drivers of the deficit are clinical income (£0.3m favourable in month, but £2.4m adverse YTD) due to the Trust continuing to manage non elective demand which is having a detrimental effect on elective activity, which is £1.3m adverse to date. There has been an continued improvement in elective activity in month 3 (see page 25) with overall elective activity levels increasing by 226 cases between months , however elective income has remained constant therefore the average income per case has reduced.

In theory this Elective income is recoverable in line with the operational trajectory. This is therefore considered a timing variance at this stage.

The Trust has managed the adverse YTD income variance with an underspend on pay (£0.9m) and non-pay underspent (£0.4m after excluding pass through drugs cost).

The YTD plan relating to HCDs has been adjusted so the income plan matches the HCDs spend being incurred.

Pay is underspent YTD by £0.9m, overspends on Medical (£0.6m) and Scientific and Technical Staffing (£0.2m) offset by underspends on Nursing (£0.9m) and Admin and Clerical (£0.5m). Pay spend increased in June within all staffing groups (mainly Medical £0.2m (£0.1m relating to one off benefit in May) and A&C (£0.1m))

Other non pay costs is adverse by £0.2m in month due to consultancy spend (KPMG = £0.3m).

Maidstone and Tunbridge Wells NHS Trust

2b. Year to Date Variance by Directorate

Income & Expenditure June 2016/17

		Year to Date Variance by Directorate													
		Urgent Care	Diagnostics & Pharmacy	Surgery	Head and Neck	Critical Care	Trauma & Orthopaedics	Private Patient Unit	Cancer	Patient Admin	Paediatrics	Womens & Sexual Health	Estates & Facilities	Corporate	TOTAL
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue															
	Clinical Income	804	39	134	16	139	(1,524)	(125)	79		108	(464)		(1,772)	(2,566)
	High Cost Drugs	(6)	(14)	(0)	(0)		(0)		(0)		(0)			737	716
	Other Operating Income	(63)	78	(4)	3	(10)	(17)	119	(12)	2	1	(5)	(89)	95	99
	Total Revenue	**736**	**104**	**129**	**20**	**129**	**(1,542)**	**(6)**	**66**	**2**	**108**	**(469)**	**(89)**	**(940)**	**(1,751)**
Expenditure															
	Substantive	285	107	63	58	207	(51)	36	(25)	12	86	115	25	1,174	2,092
	Bank	153	58	(45)	15	167	(17)	(28)	5	17	34	77	16	(101)	352
	Locum	(973)	(72)	(135)	(126)	(49)	(41)	6	(20)		12	(98)		(5)	(1,503)
	Agency	(150)	(43)	(34)	125	(90)	(46)	(0)	(33)	6	3	20	(20)	(204)	(467)
	Pay Reserves	161									(21)	61		193	395
	Total Pay	**(523)**	**50**	**(152)**	**73**	**235**	**(155)**	**13**	**(73)**	**35**	**113**	**176**	**21**	**1,056**	**869**
	Drugs & Medical Gases	(88)	(75)	(0)	(55)	15	4	(21)	(222)	(4)	13	(13)	0	(268)	(715)
	Blood	0	(39)								0			(8)	(48)
	Supplies & Services - Clinical	183	(168)	2	79	(199)	201	119	(16)	12	(9)	70	5	77	357
	Supplies & Services - General	25	(0)	4	2	32	2	(1)	(1)	0	2	10	(49)	15	42
	Services from Other NHS Bodies	46	5	(61)	(10)	0	4		(10)		5	(31)	2	(48)	(98)
	Purchase of Healthcare from Non-NHS	(23)	(151)	(10)	21	(9)	(351)	1	(3)		(6)	17	(19)	173	(359)
	Clinical Negligence													(1)	(1)
	Establishment	20	18	6	4	1	3	3	2	0	7	1	(36)	(38)	(9)
	Premises	(3)	1	11	3	30	2	5	(3)	(31)	(3)	(10)	(254)	(386)	(637)
	Transport	4	(5)	(0)	1	0	(0)		(1)	0	0	10	(89)	5	(76)
	Other Non-Pay Costs	229	219	(46)	16	(52)	51	(61)	(142)	1	(8)	(37)	(3)	(507)	(339)
	Non-Pay Reserves	(1)	(34)						17			7		804	793
	Total Non Pay	**392**	**(231)**	**(95)**	**62**	**(181)**	**(83)**	**45**	**(377)**	**(22)**	**1**	**24**	**(443)**	**(181)**	**(1,089)**
	Total Expenditure	**(131)**	**(180)**	**(247)**	**134**	**54**	**(238)**	**58**	**(450)**	**14**	**114**	**200**	**(422)**	**874**	**(220)**
EBITDA	**EBITDA**	**604**	**(77)**	**(118)**	**154**	**183**	**(1,780)**	**52**	**(384)**	**16**	**222**	**(268)**	**(510)**	**(66)**	**(1,972)**
Other Finance Costs															
	Depreciation													1	1
	Interest													0	0
	Dividend													8	8
	PFI and Impairments													(6)	(6)
	Total Finance Costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**3**
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	**604**	**(77)**	**(118)**	**154**	**183**	**(1,780)**	**52**	**(384)**	**16**	**222**	**(268)**	**(510)**	**(62)**	**(1,968)**
Technical Adjustments	**Technical Adjustments**													364	**364**
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty**	**604**	**(77)**	**(118)**	**154**	**183**	**(1,780)**	**52**	**(384)**	**16**	**222**	**(268)**	**(510)**	**301**	**(1,605)**

Commentary:

T&O: Underperformance in clinical activity (£1.5m) despite overspending on outsourcing (£0.35m), Medical banding arrears due to diary card failure (£0.1m)

Womens and Sexual Health: YTD adverse variance of £268k which is due to Maternity pathway (Including Crowborough) underachieved by £400k

Estates and Facilities: Private Ambulances (£130k YTD) due to NSL not fully meeting contract, new contracted started July which should lead to a reduction in spend, CIP slippage (£185k) however alternate schemes have been identified commencing from August 16, Rental for overseas Nurses (£70k) and postage costs overspent by £50k.

Cancer: Increase in bad debt relating to Private Patients (£0.1m) and drug cost increase of £0.2m relating to activity increase of 7%

Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Revenue	Clinical Income	28.1	29.0	26.3	27.3	27.3	26.3	26.4	25.5	25.7	26.9	26.6	27.7	28.4
	High Cost Drugs	2.2	1.9	1.8	2.8	2.5	2.8	2.8	2.7	2.6	3.1	2.8	2.6	2.8
	Other Operating Income	3.9	4.3	4.1	4.3	4.3	4.1	4.0	4.0	4.6	6.5	3.8	3.8	3.6
	Total Revenue	**34.1**	**35.2**	**32.2**	**34.4**	**34.0**	**33.2**	**33.2**	**32.2**	**33.0**	**36.4**	**33.2**	**34.1**	**34.8**
Expenditure	Substantive	(17.1)	(16.8)	(17.0)	(17.1)	(17.0)	(17.5)	(17.4)	(17.3)	(17.7)	(18.1)	(17.8)	(17.9)	(18.1)
	Bank	(0.8)	(0.8)	(0.9)	(0.8)	(0.8)	(0.8)	(0.8)	(0.9)	(0.9)	(1.1)	(0.9)	(0.8)	(0.8)
	Locum	(0.6)	(0.7)	(0.8)	(0.8)	(0.8)	(0.6)	(0.9)	(1.0)	(0.7)	(0.6)	(1.2)	(0.9)	(1.0)
	Agency	(1.7)	(2.0)	(1.9)	(1.9)	(1.7)	(1.6)	(1.6)	(1.4)	(1.7)	(1.9)	(1.3)	(1.6)	(1.7)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(20.3)	(20.3)	(20.5)	(20.6)	(20.2)	(20.4)	(20.6)	(20.6)	(21.0)	(21.8)	(21.2)	(21.2)	(21.6)
Non-Pay	Drugs & Medical Gases	(3.4)	(3.2)	(3.1)	(4.2)	(3.7)	(4.0)	(4.1)	(4.1)	(3.9)	(4.0)	(4.3)	(4.1)	(4.4)
	Blood	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
	Supplies & Services - Clinical	(2.6)	(2.9)	(2.6)	(2.8)	(2.8)	(3.0)	(2.8)	(2.5)	(2.3)	(2.3)	(2.2)	(2.7)	(2.7)
	Supplies & Services - General	(0.4)	(0.5)	(0.5)	(0.4)	(0.4)	(0.5)	(0.4)	(0.6)	(0.4)	(0.7)	(0.4)	(0.5)	(0.5)
	Services from Other NHS Bodies	(0.2)	(1.0)	(0.6)	(0.8)	(0.4)	(0.5)	(0.6)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.8)
	Purchase of Healthcare from Non-NHS	(1.2)	(0.5)	(0.6)	(0.6)	(0.8)	(0.6)	(0.7)	(0.3)	(0.7)	(1.1)	(0.8)	(0.7)	(0.8)
	Clinical Negligence	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.5)	(1.5)	(1.5)
	Establishment	(0.4)	(0.3)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)
	Premises	(1.8)	(1.6)	(1.6)	(1.7)	(2.0)	(1.9)	(1.8)	(1.4)	(1.0)	(1.1)	(2.1)	(1.7)	(1.9)
	Transport	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)
	Other Non-Pay Costs	(0.5)	(0.6)	(0.3)	(0.6)	(0.4)	(0.3)	(0.4)	(0.5)	(0.8)	(0.8)	(0.2)	(0.7)	(0.6)
	Non-Pay Reserves	0	0	0	0	0	0	0	0	0	0	(0.2)	(0.2)	(0.4)
	Total Non Pay	(12.2)	(12.4)	(11.2)	(13.1)	(12.7)	(13.0)	(12.8)	(12.0)	(11.8)	(12.9)	(12.9)	(13.4)	(14.1)
	Total Expenditure	(32.5)	(32.7)	(31.7)	(33.7)	(32.9)	(33.5)	(33.4)	(32.6)	(32.8)	(34.7)	(34.1)	(34.6)	(35.7)
EBITDA	EBITDA	1.6	2.4	0.5	0.7	1.1	(0.3)	(0.2)	(0.4)	0.2	1.8	(1.0)	(0.5)	(0.8)
		5%	*7%*	*2%*	*2%*	*3%*	*-1%*	*-1%*	*-1%*	*1%*	*5%*	*-3%*	*-1%*	*-2%*
Other Finance Costs	Depreciation	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.4)	0.9	(1.4)	(1.4)	(1.4)
	Interest	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
	Dividend	(0.4)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.2)	(0.4)	(0.4)	0.1	(0.3)	(0.3)	(0.3)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(1.4)	(14.2)	(1.1)	(1.1)	(1.1)
		(2.9)	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.8)**	**(2.9)**	**(3.2)**	**(13.2)**	**(2.9)**	**(2.8)**	**(2.8)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(1.3)	(0.5)	(2.3)	(2.1)	(1.8)	(3.2)	(3.1)	(3.3)	(3.0)	(11.5)	(3.8)	(3.3)	(3.7)
Technical Adjustments	Technical Adjustments	(0.1)	(0.1)	0.0	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(12.8)	(0.1)	(0.1)	(0.1)
Surplus/ Deficit (-) to B/E Duty	Surplus/ Deficit (-) to B/E Duty	(1.2)	(0.4)	(2.4)	(2.0)	(1.7)	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.7)	(3.2)	(3.6)

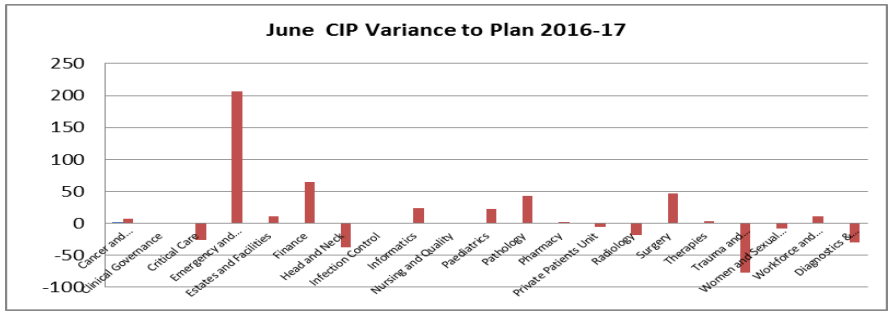
Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a. Cost Improvement Programme

Directorate Performance

	Current Month			Year to Date			Plan				
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Fully developed*	*Plans in progress*	*Opportunity*	*Unidentified*	*Grand Total*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	0.25	0.24	0.01	0.78	0.84	(0.05)	2.32	0.17	0.03	0.00	2.52
Clinical Governance	0.00	0.00	(0.00)	0.02	0.01	0.01	0.04	0.00	0.00	0.00	0.04
Critical Care	0.11	0.13	(0.03)	0.29	0.40	(0.11)	1.33	0.01	0.00	0.00	1.34
Emergency and Medical Services	0.42	0.21	0.21	1.11	0.64	0.47	2.01	0.96	1.04	1.74	5.75
Estates and Facilities	0.09	0.08	0.01	0.24	0.23	0.01	1.41	0.79	0.00	0.00	2.20
Finance	0.10	0.03	0.06	0.12	0.10	0.02	0.42	0.00	0.00	0.00	0.42
Head and Neck	0.05	0.09	(0.04)	0.18	0.26	(0.09)	0.91	0.11	0.01	0.00	1.03
Infection Control	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Informatics	0.05	0.03	0.02	0.10	0.09	0.01	0.35	0.00	0.00	0.00	0.35
Nursing and Quality	0.00	0.00	(0.00)	0.00	0.00	(0.00)	0.00	0.00	0.00	0.01	0.01
Paediatrics	0.06	0.03	0.02	0.14	0.10	0.04	0.78	0.04	0.05	0.00	0.87
Pathology	0.08	0.04	0.04	0.19	0.12	0.07	0.48	0.00	0.01	0.00	0.48
Pharmacy	0.01	0.01	0.00	0.01	0.01	(0.00)	0.00	0.03	0.00	0.00	0.03
Private Patients Unit	0.01	0.01	(0.01)	0.04	0.04	(0.00)	0.16	0.00	0.00	0.13	0.28
Radiology	0.03	0.05	(0.02)	0.09	0.12	(0.02)	0.45	0.08	0.00	0.00	0.53
Surgery	0.17	0.12	0.05	0.39	0.36	0.03	1.09	0.20	0.04	0.00	1.33
Therapies	0.01	0.01	0.00	0.04	0.01	0.03	0.09	0.00	0.00	0.00	0.09
Trauma and Orthopaedics	0.10	0.18	(0.08)	0.35	0.61	(0.26)	2.01	0.80	0.03	0.00	2.85
Women and Sexual Health	0.05	0.06	(0.01)	0.16	0.19	(0.03)	0.38	0.37	0.03	0.73	1.51
Workforce and Communications	0.02	0.01	0.01	0.03	0.03	(0.00)	0.07	0.11	0.00	0.00	0.18
Diagnostics & Pharmacy	0.02	0.05	(0.03)	0.05	0.14	(0.10)	0.56	0.00	0.01	0.62	1.18
Total	**1.61**	**1.39**	**0.23**	**4.33**	**4.31**	**0.03**	**14.84**	**3.67**	**1.25**	**3.32**	**23.08**



Critical Care: Procurement schemes identified are currently undelivering. Procurement team are working closely with this directorate to recover the shortfall.

Radiology: Hybrid and Overseas Visitors schemes slippage WIP with IT technical teams to resolve the technical interface issue with GE for Hybrid

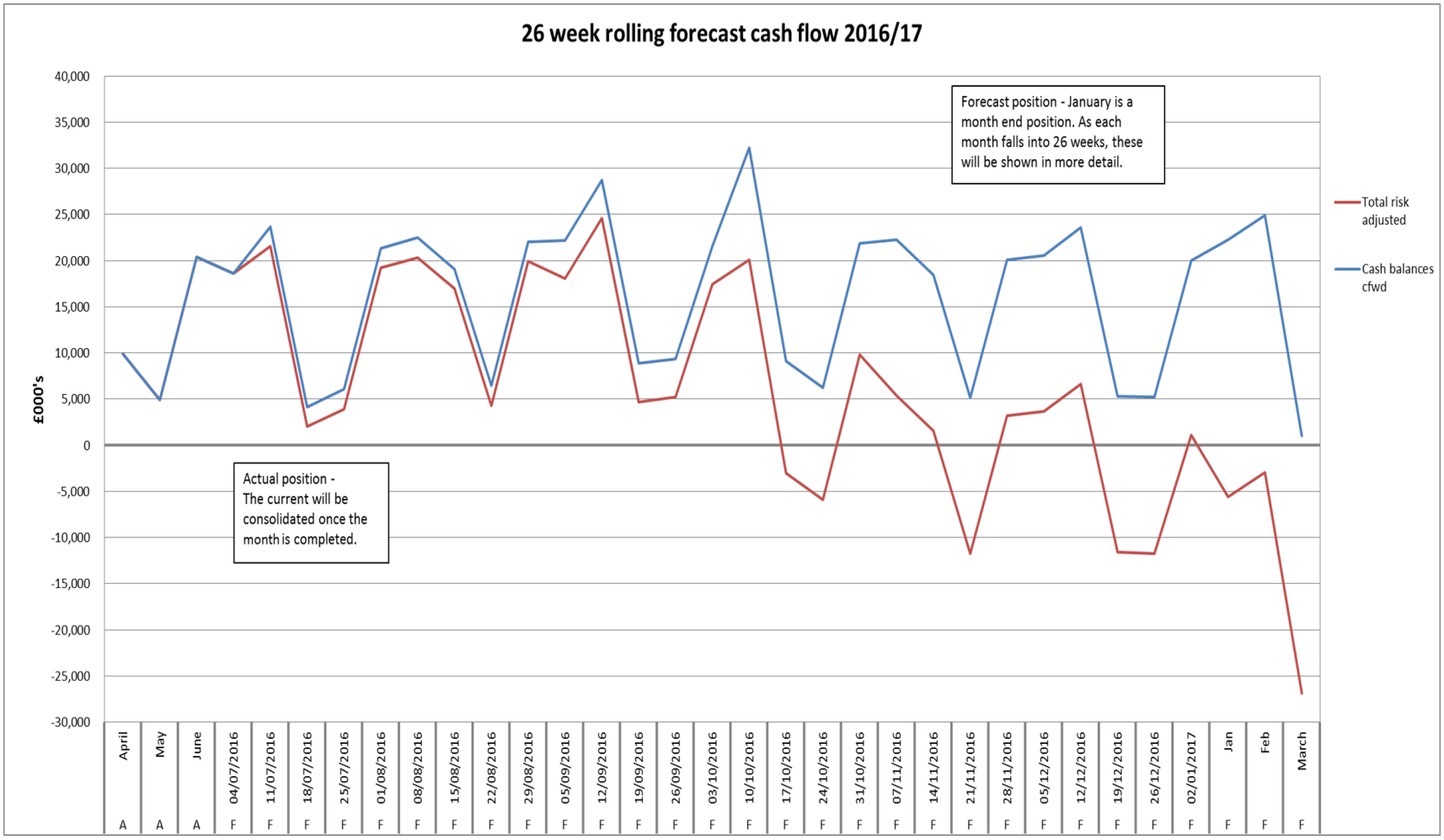
T&O: Additional activity not achieved as planned, a T&O Transformation group has been formed to focus on the recovery plan.

Diagnostics and Pharmacy: Procurement schemes identified for D&P are currently undelivering. Procurement team are working closely with this directorate to recover the shortfall.

Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

5a. Liquidity
Cash Flow



Commentary:

The blue line shows the Trust's cash position from the start of April, after receiving a double block from WKCCG in April. The forecast shows £2m draw down expected in July (at 3.5% interest) and a further £8m required in September, the remaining balance (£12.9m) is forecast to be received in the second half of the year.

The red line demonstrates if external funding is unavailable and the impact on the Trust cash position.

The 15/16 cash draw down converted to a loan in the final quarter of last financial year. This is repaid on an interest only basis and full repayment will be made in February 2019.

This cash forecast is driven by the I&E position with adjustments for working capital movements therefore if elective activity does not improve cash support may be required sooner.

The Trust is undertaking a programme to reduce the requirement on funding lower interest payments.

Maidstone and Tunbridge Wells NHS Trust

5b. Balance Sheet

June 2016

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

	June			May	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	346.9	347.6	(0.7)	348.0	335.5	335.5
Intangibles	3.0	1.7	1.3	3.1	1.5	1.5
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.1	1.2	(0.1)	1.1	1.2	1.2
Total Non-Current Assets	**351.0**	**350.5**	**0.5**	**352.2**	**338.2**	**338.2**
Current Assets						
Inventory (Stock)	8.7	8.3	0.4	8.7	8.3	8.3
Receivables (Debtors) - NHS	32.4	6.2	26.2	27.2	21.1	21.1
Receivables (Debtors) - Non-NHS	12.8	9.9	2.9	13.5	10.0	10.0
Cash	4.3	8.4	(4.1)	5.9	1.0	1.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**58.2**	**32.8**	**25.4**	**55.3**	**40.4**	**40.4**
Current Liabilities						
Payables (Creditors) - NHS	(5.1)	(5.0)	(0.1)	(5.2)	(5.0)	(5.0)
Payables (Creditors) - Non-NHS	(63.5)	(31.1)	(32.4)	(57.5)	(33.0)	(33.0)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.0)	(5.0)
Provisions for Liabilities and Charges	(1.9)	(2.3)	0.4	(1.9)	(1.0)	(1.0)
Total Current Liabilities	**(77.5)**	**(45.4)**	**(32.1)**	**(71.6)**	**(46.2)**	**(46.2)**
Net Current Assets	(19.3)	(12.6)	(6.7)	(16.3)	(5.8)	(5.8)
Finance Lease - Non- Current	(201.9)	(202.5)	0.6	(202.3)	(198.2)	(198.2)
Capital Loan - (interest Bearing Borrowings)	(14.5)	(14.5)	0.0	(14.5)	(44.6)	(44.6)
Interim Revolving Working Capital Facility	(16.9)	(16.9)	0.0	(16.9)	(16.4)	(16.4)
Provisions for Liabilities and Charges	(1.3)	(1.4)	0.1	(1.4)	(0.7)	(0.7)
Total Assets Employed	**97.1**	**102.6**	**(5.5)**	**100.8**	**72.5**	**72.5**
Financed By						
Capital & Reserves						
Public dividend capital	(203.3)	(203.3)	0.0	(203.3)	(203.3)	(203.3)
Revaluation reserve	(53.8)	(53.8)	0.0	(53.8)	(53.8)	(53.8)
Retained Earnings Reserve	160.0	154.5	5.5	156.3	184.6	184.6
Total Capital & Reserves	**(97.1)**	**(102.6)**	**5.5**	**(100.8)**	**(72.5)**	**(72.5)**

Commentary:

The balance sheet remains relatively constant since April. Key movements from April to June are in working capital where the cash balance has reduced as debtors have increased and creditors have also increased. As mentioned on the cashflow slide the Trust is putting a focus on increasing cash and will be looking at these working capital metrics.

Non-Current Assets PPE - The value of PPE continues to fall as depreciation is greater than the current capital spend, this is due to capital projects being prioritised. This is in line with plan and is not creating an unsustainable backlog of maintenance or required replacements.

Current Assets Inventory has remained at the same level as the reported May position, with pharmacy stock at £4.1m, cardiology stocks £1.2m, materials management £1m and all other stock including theatres of £2.4. Inventory reduction is a cash management and potential CIP being discussed. NHS Receivables have increased since May and are still significantly above plan. Work is ongoing to collect debtors but with the financial situation of many neighbouring NHS organisations this will be difficult. Of this £32.4m debt, £11.2m is over 90 days. Agreement has been reached with High Wealds on 15/16 SLA position and they have paid £1m in July. The Trust is also working closely with EK hospitals and is focusing on reducing the over 90 day debtor and creditor balances Trade receivables is also above plan (by £2.9m), included within this balance is trade invoiced debt of £2.1m and private patient invoiced debt of £1.5m.

Current Liabilities Trade payables has increased since May and remains significantly above plan. At present the Trust has a policy to pay approved invoices within 30 days but there are £7.7m of unapproved invoices, and £3.3m approved invoices at month end. £30.1m of accruals, including TAX, NI, Superannuation and PDC. Also included with trade payables is £27.5m of deferred income primarily relating to the advance received from WK and Medway CCG's in April of c£18 million.

Capital Programme

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Current Month			Year to Date			Annual Forecast	Committed
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Plan*	
	£000	£000	£000	£000	£000	£000	£000	£000
Estates	-1	250	-251	-1	250	-251	9,384	1
ICT	363	977	-614	363	977	-614	2,671	1,046
Equipment	21	460	-439	21	460	-439	2,581	213
PFI Lifecycle (IFRIC 12)	0	0	0	0	0	0	552	552
Donated Assets	18	200	-182	18	200	-182	800	126
Total	**401**	**1,887**	**-1,486**	**401**	**1,887**	**-1,486**	**15,988**	**1,938**
Less donated assets	-18	-200	182	-18	-200	182	-800	-126
Contingency Against Non-Disposal	0	0	0	0	0	0	0	0
Adjusted Total	**383**	**1,687**	**-1,304**	**383**	**1,687**	**-1,304**	**15,188**	**1,812**

Commentary:

The total resource for the 2016/17 capital programme is £15.9m, including PFI lifecycle and donated assets, which has been approved by the Trust Board and prioritised by the relevant lead Directors.

The Estates projects include significant investment for Backlog Maintenance of £2m, the majority of which relates to deferred 2015/16 schemes, and a new electrical substation at Maidstone Hospital at a cost of c£2.6m. The OBC for the TWH Linac Bunkers has been approved by the Trust Board and has a capital value of c£7.3m phased over 2 years (£4m in 16/17), the case is due for submission to the NHSI once specialist commissioner support is obtained.

The list of equipment schemes currently exceed the funding available, a prioritisation process is in progress and expected to be finalised by beginning of July. This takes consideration of schemes that were deferred from 15/16. The Procurement Inventory project is underway and being implemented in early 2016/17.

There is a contingency allocation of £200k within the equipment schemes to allow for any emergency purchases within the year e.g. x-ray tube replacement.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-10	Clinical Quality and Patient Safety Report	Chief Nurse

Summary / Key points

This report provides information on actions being taken to improve the Trust's position in regard to falls prevention, Friends & Family response rates, Care Assurance Audits and Protected Meal-times.

Attached to this report is also the Internal Assurance CQC report for Critical Care which took place in April 2016 .

Which Committees have reviewed the information prior to Board submission?

- n/a

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

Information, assurance, discussion and recommendations.

[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

Quality Report – July 2016

The purpose of this report is to bring to the attention of the board any specific quality or patient safety issues that are either not covered within the integrated monthly performance report but require board oversight or are covered but require greater detail.

This report is intentionally brief, highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. The Board is asked to note the content of this report and make any recommendations as necessary.

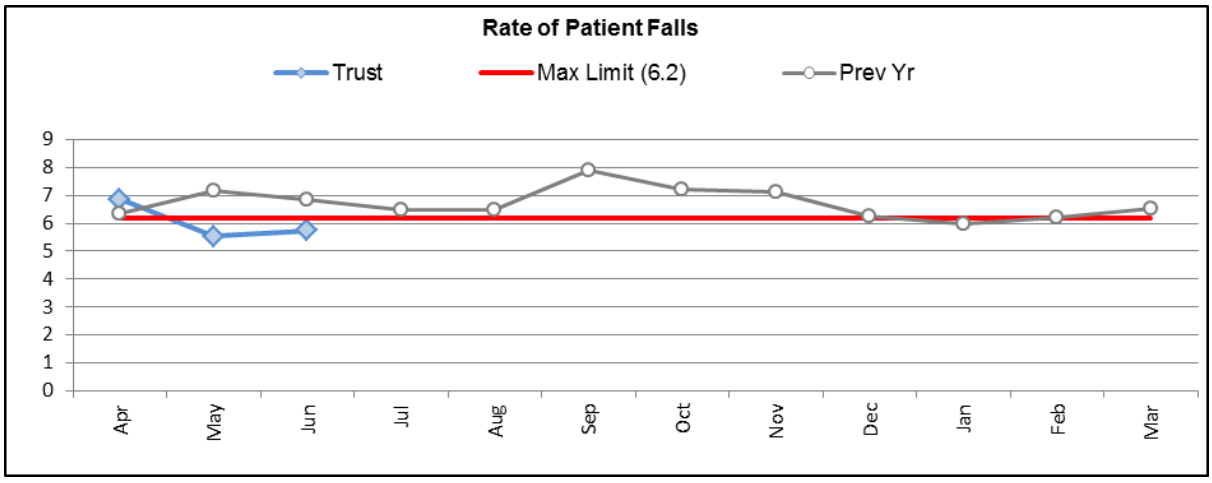
Falls prevention:

Reducing the number of patient falls has been identified as a patient safety priority this year. The focus is on ensuring falls prevention is part of all our business and to engage all staff groups in falls prevention at MTW. Our plan is to reduce the rate of falls in the year to 6.2 (per 1,000 occupied bed days) which we have achieved for the first quarter (6.0). A number of additional strategies have been employed over the last three months to help us achieve this:-

Actions for 2016/17

- Set up Task and Finnish group for reducing falls chaired by the chief nurse and supported by Director of Infection Prevention and Control and Deputy CEO.
- Review terms of reference for Slips, Trips and Falls group to engage and representation from all staff groups
- Revise the Period of increase Incidence (PII) monitoring framework for falls has been reviewed and reintroduced
- Reviewed threshold for falls number on each ward/unit and Ward Manager for any Ward exceeding threshold is supporting to bring the position back under the threshold
- Reviewing nursing assessment documents for falls prevention
- Develop dashboard to enable falls data to be collated and viewed in one place with support from PMO to undertake data analysis
- National Falls Audit – Comprehensive action plan to address areas requiring improvement

Comparison of Patient Falls 2014/2015 to 2015/2016



Friends and Family (FFT)

Following an external tender process supported by procurement the Trust has just secured a renewed contract with an external company; I want Great Care (IWGC) who will continue to support the Trust with the collection and reporting of our FFT data. To date the Trust has had a basic level of service from the company.

Now that we have secured a contract with them they are able to offer the Trust a more comprehensive contract, which will mean an increased range of reporting options, and increased opportunities to invite patients to comment on up to 5 key questions of our choice on the FFT cards. We will be introducing new FFT cards which mean we will be able to introduce more user friendly cards for some key areas including children's services and for patients with a learning difficulty.

As part of the new contract we will be re launching the service within the Trust and will use this as an opportunity to raise awareness among staff of the importance of obtaining the FFT feedback from patients. With the addition of key questions on the FFT cards it is anticipated that our volunteers may wish to support patients with completion of these cards, which would be helpful.

In anticipation of the new contract and with an increased focus over the last two months around the need for improved response rates from a number of areas, the response rates for A&E have demonstrated significant improvement for June with a move from 10.4 % in May to 21% in June. This was as a result of increased leadership of this agenda and the efforts of all staff in both departments who positively engaged with this.

The maternity response rate for June is 7.6% with the response rate dropping from 24% in May which was disappointing. To counterbalance the poor response rates, the positive responses have gone up to 99% in June from 93.5% in May which is excellent. Unfortunately in June the directorate ran out of FFT cards.

Overall the Inpatient response rate has shown a small increase with consistent positive responses noted.

Care Assurance Audits.

The Trust has benefited from the support of Trust wide volunteers and volunteers from Healthwatch with a range of patient experience audits including Care Assurance audits and the PLACE audits. These audits have provided opportunities for patient representatives to talk with patients about different aspects of their experience as a patient in our care. Some of the areas reviewed include the welcome that patients receive from staff, and whether patients described feeling involved in decisions about their care. The patient representatives also use these opportunities to observe a number of issues for example; feedback on their views as to whether the ward feels calm and organised, and whether they observe that patients are being given an explanation about their medication.

We have taken the opportunity to invite our patient representatives to meet with the Deputy Chief Nurse and colleagues from estates in late July to review the range of patient experience audits that are completed and importantly to obtain their views and suggestions around any potential changes to the range of audits that are carried out. It is anticipated that we will review all current audits and the results from both locally run surveys and the recently published National inpatient survey to ensure that any changes that are considered reflect the key priorities for the Trust. We are keen to ensure that we continue to engage our patient representatives with patient experience audits as they provide valuable and objective feedback to the Trust, which can help us to focus on and identify areas for improvement.

This review of audits coincides with the new contract that the Trust has recently secured with the company IWGC who will continue to support the Trust in the collection of the Friends and Family

data, (FFT) as previously referred to in this paper. The new contract will provide us with greater opportunities to add in some key questions to the FFT post cards that are completed by patients on discharge from hospital. The views of our patient representatives and third sector organisation representatives in agreeing these questions will be helpful and appreciated.

Protected Meal Times:

The Meal Time Standard Policy has been subject to trust wide scrutiny, supported and led by the Clinical Manager for Nutrition and Dietetics. The Policy is currently being disseminated to all staff groups including nursing, midwifery, therapy, radiology and facilities staff. The Meal Time Standard sets out the principles of a protected meal time, allowing patients to be free of unnecessary interruption during these essential times of the day.

The standard recognises the value that immediate family and friends can have, in terms of support and encouragement for people with reduced appetite; therefore visiting during mealtime is discouraged unless the visit assists with food intake (either by encouragement or assistance with eating).

The policy presentation to various staff groups includes a plan for a more formal launch, which would incorporate the use of banners, patient and visitor information sheets and ward level signs. It is anticipated that full launch of the policy will commence in August.

Internal Assurance Care Quality Commission (CQC) Audits:

This process has been introduced to gain assurance that our quality standards comply with CQC regulations. An audit programme has been developed to ensure that a Directorate is inspected every month. These monthly reviews will be used to triangulate information that is gained from local feedback and concerns; local and national audits; internal audits and observations and previous CQC reports and Quality Improvement plans.

It is acknowledged that this CQC style inspection is not as comprehensive as those undertaken by the CQC but it does provide a snapshot in time of the area inspected within that directorate. The inspection team is made up of both clinical and non-clinical staff and invites are extended to members of Healthwatch and the Clinical Commissioning Group. Reports are then compiled and actions identified with the management teams of those Directorates inspected, a summary of which is presented to the Clinical Governance Committee and the Trust Management Executive.

The first Directorate to be inspected was Critical Care and this report can be found in Appendix 1 for information.

Appendix 1

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Governance Team

Internal CQC Inspection Report for Critical Care 19th April 2015.

Summary

The Trust is undertaking a series of monthly internal reviews of different areas within the Trust. The reviews are mini versions of the CQC inspections, looking at the five elements of Safe, Effective, Responsive, Caring and Well-led.

These reviews will help us identify good practice, areas of improvement and where we could look to do better. The CQC can undertake unannounced inspections at any time so this is a really good way of making sure we know how we are getting on. It is acknowledged that these mini-reviews are in no way as comprehensive as the CQC inspections, but provide an opportunity for reflection, peer review and re-focus. For this reason an overall conclusion regarding the service has not been provided.

Methodology

Data was gathered from numerous sources prior to the on-site review. This included local feedback and concerns (complaints, PALS, anonymous reports), local and national data (patient safety incidents, SI's, surveys, mortality data, performance, audits, rota's and staffing data), previous CQC reports and QIP's. This data was reviewed and Key Lines of Enquiry (KLOE) agreed that provided a focus for the on-site review.

The following documents were used for structured approach to the on-site review; CQC KLOE core services, Care Assurance Audit, Aide Memoire (Observational / 12 steps model). The on-site review team consisted of volunteers, both clinical and non-clinical, from across the trust recruited via advertising and word of mouth. For further information see the following document: *CQC; meeting regulations and continual assurance Process and procedure.*

The leads for the area were informed of the peer review 2 weeks in advance but staff were not made aware to ensure business as usual was observed. All staff who were involved or communicated with during the review were fully engaged. Patients and relatives of patients were willing to share their thoughts and answer some questions by the peer review team.

This was the first review undertaken in the trust so was limited to trust only team of reviewers and only covered a small physical area (only ITU on both sites were reviewed). The learning from the methodology will inform future internal reviews and it is intended to invite stakeholders and commissioners to be part of the peer review team in the future.

Findings

Below is a brief summary by each of the 5 domains of the findings from both ITU of the pilot inspection of Critical Care.

1. Safe

On both ITU's nursing staffing were at expected levels on the day of inspection. Both areas had vacancies but were interviewing for staff on that day and had received authority to over establishment as winter contingencies for Tunbridge Wells. At TWH the current consultant rota was

reviewed and showed compliance. Consultants were rostered to cover weekend on each site. Consultants are present at weekends and notes were reviewed that evidenced consultant weekend ward rounds morning and evening. The consultant interviewed confirmed that consultant locum/agency is not used, however, he described that if locum/agency doctors are required the clinical director would check the CV and references and the locum doctor will meet the consultant for a verbal handover. It was discussed that a pack similar to nursing agency staff could be developed for locum doctors as it includes competency checking.

Bare below elbow and no lanyard policy were fully observed at all times as was hand gel before and after touching patients by nursing staff, no doctors were observed during this inspection with regard to hand hygiene.

Drug cupboards were tested and all found to be locked when not in use. There were some large pallets containing unsecured IVI fluids in a non-public accessible area (staff access corridor) on the TWH site but overall both units were clean and tidy. At TWH there were some tables and chairs observed in walkway that could be perceived as some clutter. Dirty and clean linen were found to be kept separate at all times. All risk assessments were up to date with accompanying signature lists, and firefighting equipment was all within inspection dates.

Two sets of bed curtains were found to be out of date on the MGH site, these were reported to domestic services on the day. Nurses are not expected to know the policy on curtain change timescales, however, the current failsafe policy would not appear to be effective.

Staff interviewed were able to describe the 2 recent Never Events and incidents that had occurred within the department and how they had learnt from them (TWH). Two serious incident investigations were reviewed showing compliance with the SI framework and with Duty of Candour (MH). Documentary evidence was shared about how learning is disseminated to staff via monthly e-mail (TWH). A senior Nurse (TWH) described how learning from a complaint led to the development of a follow up clinic for patients who had been in ITU. Staff could articulate how to report incidents using DATIX.

Nursing staff articulated how they would escalate any safeguarding concerns if they occurred. Documentation was provided to demonstrate compliance with Deprivation of Liberty Safeguards (MH).

The unit infection rates for Ventilator Assisted Complications including VAP were discussed as no specific data collected. The matron felt this was difficult to define and a suggestion was made that ITU / IC team developed own definitions and collected data (TWH). TWH was under a Period of Increased Incident (PII) due to a CDiff incident that was under investigation.

2. Effective

Staff on both sites demonstrated when questioned an awareness of good practice and NICE guidelines. Both sites have a dedicated Nurse Educator who explained the excellent support staff get in both practise development and welfare. Nursing staff interviewed were aware of patient flow and current bed state.

All mandatory training was up to date on both sites to an acceptable level. Only conflict resolution was lower than 90% this was due to the recent departure of the manager responsible for organising this training.

Posters for telephone numbers for security and psychiatric services were evident on both sites.

All outcome data is collected and sent to the national database (ICNARC) which is reported quarterly. The data is reviewed and any flagged areas reviewed in detail by the CD. This is triangulated with current action plans (document provided). Unplanned readmission rate within 48hrs to ICU is reported on the SECCCN quality reports and as part of data submitted to ICNARC. An audit calendar was not available at the time of site review, but both network and local audit information is collected.

A comprehensive programme for new nursing staff was shared. This was further supported by a competency programme and progression onto an ITU formal course. The matron described how she reviewed the nursing skill mix every shift to ensure the right levels of competency were achieved. Nursing staff interviewed had completed all elements of this development process (TWH). A clinical pharmacist was not available to talk with.

The physiotherapist was present on the ward and notes reviewed showed regular physiotherapy and dietetic involvement with patients. Notes were reviewed that included a patient moved from a ward to ITU. There was evidence of multidisciplinary involvement CC outreach involvement and consultant decisions making in the transfer to ITU.

A SOP for admissions and discharges and escalation was in place and was described by the matron.

3. Caring

Staff were observed talking with patients and relatives with kindness and respect. Staff were seen offering emotional and physical comfort (hugs) to patients and relatives. Notes are locked away at all times. Notes review showed involvement of families / relatives in care and in decisions. At TWH the single room environment means privacy is good, although this leads to other challenges such as being able to observe patients and to work together safely (bringing staff together to turn patients for example).

On both units and after discharge patient diaries were encouraged for relatives (and staff) to complete to explain to patient the journey they have been on whilst in ICU. Patients are invited to attend a follow up appointment 3-months after discharge from Critical Care with a Senior Nurse to answer any queries.

Patients have full and preferred names on the bay boards at MGH, however, only full names appeared to be used on the TWH site where it was observed that there was no named nurse and inconsistency in the named doctor.

All bed areas were free from unnecessary clutter, fresh water where applicable was available at all times. Call buzzers were within patient reach and a suitable volume to ensure privacy and dignity was maintained at all times. Beverages regularly offered to both patients and relatives.

Although no patients were able to be interviewed on the MGH site, relatives when questioned were very happy with the care their relatives were receiving and the level of information given to them by the staff. This was the same on the TWH site and echoed by the patients.

The consultant described how consultants lead discussions with relatives about organ donation, but will often include junior staff for their learning and development (TWH).

Toilet and wash facilities for patients were seen to be compliant with dignity and privacy requirements (TWH).

4. Responsive

Family & Friends results were displayed in staff room at TWH but were not displayed on MGH site, on questioning the Matron demonstrated that they did not have access to the relevant folder to be able to print them off.

'Knowing How We Are Doing' boards were displayed and current, as were staffing level boards. Both patient leaflet rack were prominently placed and fully stocked with core leaflets.

A nurse described the current translation system as being difficult due to the booking process. Another nurse described using a staff member to translate for a patient (TWH). There was no specific arrangements described for patients with learning disabilities but nursing staff described carer involvement, using the 'this is me' book, using IMCA and multidisciplinary discussions (TWH)

Staff described the current challenges with capacity and dependency. There have been periods over winter where recovery areas at TWH have been escalated to ITU care with appropriate staff in attendance. Delayed discharge information was displayed in the ward area.

5. Well Led

Staff were aware of Trust visions and values, as well as management structures and lines of communication. Staff were aware of speaking out safely and all those interviewed felt supported in both practise and welfare. A consultant was aware of the clinical strategy that was under development.

Staff demonstrated and described a high level of team work and ethic.

There are monthly Clinical Governance meetings, well attended and multidisciplinary Minutes reviewed). There are a few standing agenda items (SI's and M&M) but not all CG subjects are covered and the Trust template for CG meetings is not followed. However staff described that attendance was much improved and the meetings were more productive.

Staff knew that there was an IV lead for the trust

Senior staff described that 'Guidelines for Provision of Intensive Care Services' (2015) are under review and being mapped out against current service provision

National Safety Standards for Invasive Procedures (NaSSIPs) 2015 was described as also under review but it was felt this is a trust wide development and would need central oversight / management.

Central assurance is via the quarterly ICNARC data which was displayed in the ward area

Actions/Recommendations

Generally

- Audit plan should be available and progress monitored by the department (supported by the clinical audit team)
- The unit infection for Ventilator Assisted Complications including VAP should be defined and data collected.
- Resurrect newsletter (shows sharing across both ITU and can be sent out to medical/surgical ward)
- Development of a locum / agency induction and competency pack for locum / agency doctors
- All staff need to be made aware of how to access translation service at any time
- All staff need to be clear about appropriate support for patients with learning difficulties
- Clinical Governance meetings need to ensure the core areas of quality and governance are included
- NaSSIPs and 'Guidelines for Provision of Intensive Care Services' review and actions need to be progressed

TWH

- Boxes on floor in clinical room and equipment room should be removed
- Larger equipment (drip stands) should have clean labels similar to smaller equipment
- Consider moving or securing 3 large pallets of fluids stored in corridor (risk of tampering)
- Review how to store liquid drugs in the clinical room (to remove them from the side)
- Some loose sheets were seen in medical notes; consider how to ensure additional sheets are secured before use.
- Not all MCA/NOK/DNACPR information was completed in the records reviewed; consider documentation training and spot checks.

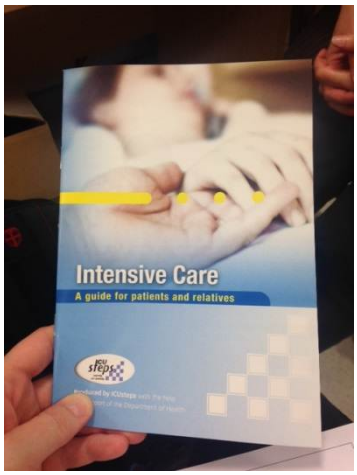
MGH

- Review of bed curtain changing operations to review robustness of current method of working
- Post Family & Friend scores in notice board
- How will the service evidence 'Consultant sees patient in person within 12 hours of admission'? Check whether could be retrospective audit undertaken by F1

Additional areas of Good Practice

There were numerous examples of good practice observed and experienced by the reviewers. Staff were welcoming, professional and engaging. Below are some additional areas of good practice not currently covered in the report.

- Clean tape on grab boxes - TWH
- Clear labelling (colour coded) in clinical room – TWH
- Excellent ITU leaflets in use for relatives



- Photographs of all staff prominently displayed included all staff, Consultants, Nurses, Ward Clerk, Domestics etc. - MGH
- Overnight relatives room. – MGH

Below is the summary from the checklist completed during site reviews. This can be used as a quick check of progress and improvements.

CQC Inspection Toolkit Site Comparison				
	Ward: ICU			
		Domain	TWH	MGH
Q1	Are all the staff welcoming?	*Caring*	Outstanding	Outstanding
Q2	Does the ward feel calm, organised and well managed?	*Well-led*	Outstanding	Good
Q3	Is information about the ward's quality of care displayed?	*Effective*	Good	Good
Q4	Is information available, clear and visible to patients, family and friends?	*Effective*	Good	Good
Q5	Is the patient's named nurse displayed on the patient information board (above the bedhead or on the door)?	*Effective*	Good	Outstanding
Q6	Is the name of the patients consultant displayed on the patient information board (above the bedhead or on the door)?	*Effective*	Requires Improvement	Outstanding
Q7	Do patients have their privacy respected during all procedures or when receiving personal care or sensitive information?	*Caring*	Outstanding	Outstanding
Q8	Do all staff behave in a way that is respectful of patients' dignity?	*Caring*	Outstanding	Outstanding
Q9	Where appropriate, are patients' call bells, drinks, side tables, glasses, walking aids etc. within easy/safe reach?	*Caring*	Outstanding	Outstanding
Q10	Where/when patients have called or expressed a need, is it responded to in a timely manner?	*Responsive*	Outstanding	N/A
Q11	Are patients prepared and offered the chance to clean their hands before eating?	*Caring*	Good	Good
Q12	Are all patients who have been identified as requiring assistance, or at risk of poor nutrition or dehydration, receiving appropriate support/help?	*Caring*	Outstanding	Outstanding
Q13	Are patients able to eat their meal without interruption?	*Responsive*	Outstanding	Outstanding
Q14	Is there a member of staff dedicated to overseeing the mealtime?	*Responsive*	N/A	N/A
Q15	Are patients aware of who their named nurse is?	*Caring*	Good	Outstanding
Q16	Do patients know the name of their consultant or doctor caring for them?	*Caring*	Good	Outstanding
Q17	Have patients received information about their condition or treament?	*Effective*	Outstanding	Outstanding
Q18	Have patients had an opportunity to be involved in decisions regarding their care and treatment?	*Caring*	Outstanding	Outstanding
Q19	Where appropriate, are next of kin/carers/visitors involved in decision making and support?	*Caring*	Outstanding	Outstanding
Q20	Is there evidence of patients being asked their views or preferences?	*Caring*	Outstanding	Outstanding
Q21	Is there evidence of patients being given an explanation about their medication?	*Safe*	Good	Good

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-11 Safe Staffing: Planned v Actual – June 2016 Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of June 2016. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day

CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

Timescales for national publication have not yet been announced, as NHS England is currently reviewing a number of options.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for Maidstone Hospital for June was 8.0, and for Tunbridge Wells Hospital it was 8.5, compared to 8.3 and 9.4 for May.

A review of data currently available in Trust's published board reports would suggest many organisations are still debating this internally. None of our neighbouring trusts have, to date, published their care hours per patient day alongside their staffing fill rates. A wider review of trusts in the south (16 trust board papers reviewed) did not provide data on care hours. Many trusts are reporting 3 months behind.

A number of trusts to the north have published their care hours, and have wide variation at ward level, similar to Maidstone & Tunbridge Wells. These Trusts had a range between:

Medical Ward (Respiratory or General Medical) 5.2 – 7.4
Critical Care – 21.3 – 33
Maternity – 8.5 – 35
Inpatient range generally – 2.0 – 33.1

Maternity variation may be explained by the current recommended approach of using the number of occupied beds at 23.59. Whilst this approach broadly works for general inpatient wards, for areas such as delivery suites and birth centres, this does not reflect the activity over the full 24hour period. Data over a longer period of time would be required to establish a normal safe range.

Planned vs. Actual

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues. Notable in this respect are Ward 10, Ward 11 and Foster Clark.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Stroke – Maidstone and CCU at Tunbridge Wells have a higher fill rate in their CSW cohorts, due to a number of EU nurses awaiting PIN but who are actively contributing to patient care. They have been reflected in the CSW numbers as they cannot legally function fully as a Register Nurse.

Escalation areas account for the remainder of the over-fill. These areas remain the same; namely AMU (UMAU) Maidstone, and MAU Tunbridge Wells.

A number of areas had a reduced fill rate, most notably CCU at Maidstone. This unit is co-located with Culpepper Ward, and as such staff move between the two areas as required.
Maternity is now adopting a similar approach with support staff. Ante-natal, delivery suite, post-natal, maternity triage and the maternity day unit operate as a 'floor' and support staff between the areas as required.

Neonatal Unit support workers show a significant under-fill. The numbers of support works on any given shift are small. There was some unscheduled absence which was not backfilled, as the skill mix was adequate to ensure both babies and parents were provided with the support needed. The Paediatric directorate were aware and staff were available elsewhere in the directorate if required.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels. Maidstone A&E had a reduced fill rate for support workers overnight however this was acceptable given the acuity of presenting patients. TWH A&E had additional RNs during the day to cover the escalation of bays J-M.

When the fill rate is only marginally over 100% by +/- 5% this is normally related to working patterns which required staff to work an additional shift periodically as long shifts result in a staff member either working over or under their contracted hours in any given month.

The RAG rating for the fill rate is rated as:
Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff and as a consequence may have a detrimental impact on the quality of patient care.

The exception reporting rationale is RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set out below:
The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

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

Assurance

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

June'16		Day		Night			Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	84.0%	148.3%	99.2%	133.3%	8.1	15.2%	100.0%	9	1		CSW fill rate is artificially inflated as the ward is supporting 4 RN awaiting NMC PIN (3 EU, 1 UK) and 2 RNs requiring additional support. These have been included in the CSW numbers as they require direct supervision.	128,739	128,498	241
MAIDSTONE	Foster Clark	102.1%	105.8%	97.8%	146.7%	6.5	0.0%	0.0%	3	0		11 nights of enhanced care requirements for a named patient.	101,090	126,490	-25,400
MAIDSTONE	Cornwallis	100.8%	88.3%	100.0%	100.0%	6.4	27.9%	97.1%	2	0		CSW fill rate an accepted risk due to redeployment to other areas. 4 redeployed and 2 short notice sickness unfilled.	81,245	82,569	-1,324
MAIDSTONE	Coronary Care Unit (CCU)	73.3%	N/A	100.0%	N/A	0.0	52.0%	100.0%	0	0		Low RN fill rate a considered & accepted risk, as unit is co-located on Culpepper Ward. Acuity and dependence of both CCU and Culpepper allowed for cross-cover during shift.	101,670	109,057	-7,387
MAIDSTONE	Culpepper	100.0%	100.0%	100.0%	100.0%	0.0	60.0%	95.2%	1	0					
MAIDSTONE	John Day	91.6%	97.5%	98.9%	98.3%	7.3	29.0%	100.0%	5	2			154,822	145,558	9,264
MAIDSTONE	Intensive Treatment Unit (ITU)	93.3%	95.5%	92.5%	N/A	28.4	50.0%	100.0%	0	0			166,871	160,401	6,470
MAIDSTONE	Pye Oliver	94.7%	93.3%	99.2%	105.3%	6.6	10.5%	100.0%	5	0			115,884	121,963	-6,079
MAIDSTONE	Chaucer	100.6%	96.8%	109.0%	98.9%	6.8	0.0%	0.0%	2	0			140,996	140,676	320
MAIDSTONE	Lord North	100.7%	88.3%	97.8%	96.8%	6.8	61.0%	100.0%	1	0		CSW fill rate equates to 7 days being short by 1 during the course of the month.	88,631	99,674	-11,043
MAIDSTONE	Mercer	105.0%	89.2%	98.9%	100.0%	6.1	14.3%	83.3%	6	1		Reduced fill rate for CSW an accepted risk.	98,103	108,403	-10,300
MAIDSTONE	Edith Cavell (MOU)	97.1%	100.0%	100.0%	106.7%	7.8	0.0%	0.0%	2	0			62,241	58,128	4,113
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	92.1%	100.8%	136.8%	95.7%	12.4	12.3%	90.6%	3	0		Trolley bay escalated over night throughout month.	118,585	129,714	-11,129
TWH	Stroke (W22)	86.1%	88.7%	96.7%	100.0%	9.5	50.0%	100.0%	7	0		Running at least 1 nurse short per shift throughout the month. Minimal impact on patient care, as risk mitigated during the day by the Stroke CNS.	182,359	113,967	68,392
TWH	Coronary Care Unit (CCU)	96.7%	160.0%	97.8%	N/A	12.5	76.2%	96.9%	1	0		CSW rate appears increased, as this included EU nurses awaiting NMC PIN.	59,970	63,883	-3,913
TWH	Gynaecology	96.6%	100.0%	100.0%	100.0%	7.5	17.5%	100.0%	0	0			65,125	66,947	-1,822
TWH	Intensive Treatment Unit (ITU)	100.8%	100.0%	100.8%	N/A	26.6	50.0%	100.0%	0	1			179,173	190,767	-11,594
TWH	Medical Assessment Unit	94.6%	97.3%	130.0%	190.0%	6.0	7.5%	100.0%	7	0		Ambulatory Bay escalated throughout the month.	166,180	202,532	-36,352
TWH	SAU	108.3%	81.7%	105.6%	98.3%	9.8	0.0%	0.0%	0	0		Priority given to covering night, as day shift mitigated with the presence of the Surgical Coordinator Nurse	87,700	93,585	-5,885
TWH	Ward 32	91.7%	83.3%	100.0%	90.0%	3.6	1.9%	100.0%	0	1		Fill rate acceptable as cross-cover provided by The Wells Suite as/when required.	120,132	132,860	-12,728
TWH	Ward 10	95.7%	120.8%	100.8%	218.3%	8.4	6.4%	100.0%	3	1		6 patients with significant care needs including both high acuity and high dependency . A number of patients with high risk of falls. All patients reviewed daily with supporting documented assessment of needs.	122,968	141,932	-18,964
TWH	Ward 11	98.1%	105.6%	96.7%	125.0%	7.1	10.6%	100.0%	4	0		1 patient needing enhanced care for 7 nights. Additional support required towards the end of the month as a number of patients with D&V symptoms	125,797	125,830	-33
TWH	Ward 12	91.6%	101.1%	96.7%	108.3%	6.4	6.1%	100.0%	16	1		3 patients at very high risk of falls. Of which one has significant behavioural challenges as a result of a previous brain injury.	118,381	115,879	2,502
TWH	Ward 20	108.1%	115.8%	114.2%	102.2%	7.4	16.0%	100.0%	7	1		Cohort nursing implemented/required throughout the month.	126,166	152,436	-26,270
TWH	Ward 21	111.7%	86.7%	89.3%	128.3%	6.6	32.4%	100.0%	5	0		Night CSW fill rate includes RN awaiting NMC PIN.	129,538	134,571	-5,033
TWH	Ward 2	83.9%	91.9%	94.4%	108.6%	6.5	0.0%	0.0%	4	0		RN shifts not filled by Bank. Accepted risk.	102,242	112,262	-10,020
TWH	Ward 30	82.6%	118.5%	97.5%	101.1%	7.1	7.9%	50.0%	4	0		RN:CSW ratio shift an accepted risk.	119,526	124,090	-4,564
TWH	Ward 31	95.0%	96.5%	95.8%	96.7%	7.2	22.6%	91.7%	5	3			124,656	126,315	-1,659
Crowborough	Birth Centre	100.0%	100.0%	100.0%	100.0%	-	0.0%	0.0%	0	0			86,692	61,787	24,905
TWH	Ante-Natal	98.3%	93.3%	98.3%	80.0%	-	7.6%	99.0%	0	0		Reduced fill rate for CSW across maternity an accepted risk, which mitigated by the movement of support staff from maternity day unit and maternity triage as required.	629,885	642,181	-12,296
TWH	Delivery Suite	97.0%	88.3%	91.5%	95.0%	-			1	0					
TWH	Post-Natal	99.3%	87.8%	100.0%	98.9%	-			0	0					
TWH	Gynae Triage	96.7%	93.3%	100.0%	93.3%	-	17.5%	100.0%	0	0			12,408	11,121	1,287
TWH	Hedgehog	104.4%	64.2%	96.1%	118.3%	7.5	14.0%	93.3%	0	0		Additional capacity open on Woodlands, some vacancy in support worker cohort. Efforts made to ensure adequate cover for night. Sufficient RN	213,110	209,499	3,611
TWH	Birth Centre	100.0%	96.7%	100.0%	90.0%	-			0	0			62,136	61,702	434
TWH	Neonatal Unit	108.9%	63.3%	106.7%	73.3%	12.8			0	0		Fill rate for support workers is low due to unscheduled absence. Given skill mix and acuity of patients this was an accepted risk. Support from main paeds was available if required.	166,944	153,283	13,661
MAIDSTONE	MSSU	117.3%	79.6%	91.3%	N/A	17.9	0.0%	0.0%	0	0		Additional Saturday lists.	43,161	46,215	-3,054
TWH	Peal	90.1%	112.9%	96.7%	N/A	6.8	12.2%	100.0%	1	0		7 bed days, 2 sickness uncovered, CSW fill rate equates to 5 shifts where RN time out was supported by CSW	87,097	74,684	12,413
TWH	SSSU	104.5%	68.2%	N/A	N/A	-	0.0%	0.0%	0	0		low fill rate for CSW an accepted risk, mitigated with colocation to SAU.	23,262	19,163	4,099
MAIDSTONE	Whatman	94.5%	78.2%	108.8%	78.3%	4.6	0.0%	0.0%	10	0		Newly established ward (previously escalation) with merged staff from Romney. CSW fill rate an accepted risk Ward supported by the Ward Manager from Mercer.	134,027	70,793	63,234
MAIDSTONE	A&E	96.7	93.3	99.5	51.8		18.0%	91.0%	3	0		CSW fill rate an accepted risk.	197,496	209,521	-12,025
TWH	A&E	115.0%	95.6%	105.3%	96.7%		23.9%	93.8%	5	0		Bays J-M escalated overnight on 12 occasions	294,412	296,069	-1,657
												Total Established Wards	5,139,420	5,165,000	(25,580)
												Additional Capacity beds	41,453	69,042	-27,589
												Other associated nursing costs	3,010,702	2,678,447	332,255
												Total	8,191,575	7,912,489	279,086

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-12	Review of clinical outcomes	Medical Director

It was agreed at the Quality & Safety Committee in September 2014 that an annual report should be submitted to the Trust Board outlining the process for reviewing clinical outcomes and notifying the Board of any outliers of concern. The Trust Board received the first such report in June 2015.

Which Committees have reviewed the information prior to Board submission?

- 'main' Quality Committee, 06/07/16

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

Report on clinical outcomes.

Following on from a Quality and Safety committee deep dive in September 2014, it has been suggested that an annual report should be presented to the board (as happened in June 2015) outlining the process for reviewing clinical outcomes and notifying the Board of any outliers of concern.

It is intended that this report should be considered by the Quality committee first, and then taken to the Board for its deliberation.

Summary of last year's Board report

- An outline of the different aspects of "surveillance" of outcomes has not changed in the past year and that information is not repeated here
- The issues of concern from last year are repeated and an update given.

National Joint Registry

- Two of the surgeons employed within the Trust had higher than expected revision rates for primary hip replacements. This was communicated to the Trust in November 2014, though the Trust was aware of this likelihood over a year earlier. The reasons for this and the actions taken will be discussed at the Board.
    - This area of concern has remained an area with greater scrutiny, particularly following the commencement of Professor Briggs' work on GIRFT (getting it right first time), which I will discuss at meeting

National hip Fracture Database

- In December 2014, the Trust received notification from the Dr Foster unit at Imperial informing us of a higher than expected mortality related to patients admitted with a fractured neck of femur. The directorate had been aware of this issue from internal scrutiny of our mortality and the Chief Nurse and The Medical Director facilitated a multidisciplinary meeting to formulate plans to improve the pathway and care of such patients. An audit of all of the deaths for a 12 month period were analysed and conclusions drawn.
    - We are at present in a much improved position with regard to this database.

Cerebrovascular Disease

- Patients with Cerebrovascular disease have demonstrated a higher than expected mortality within the Trust. Work is being done to improve our stroke care. Analysis of our data shows that our admitted patients with cerebrovascular disease have a raised age compared to the national average.
    - See following report

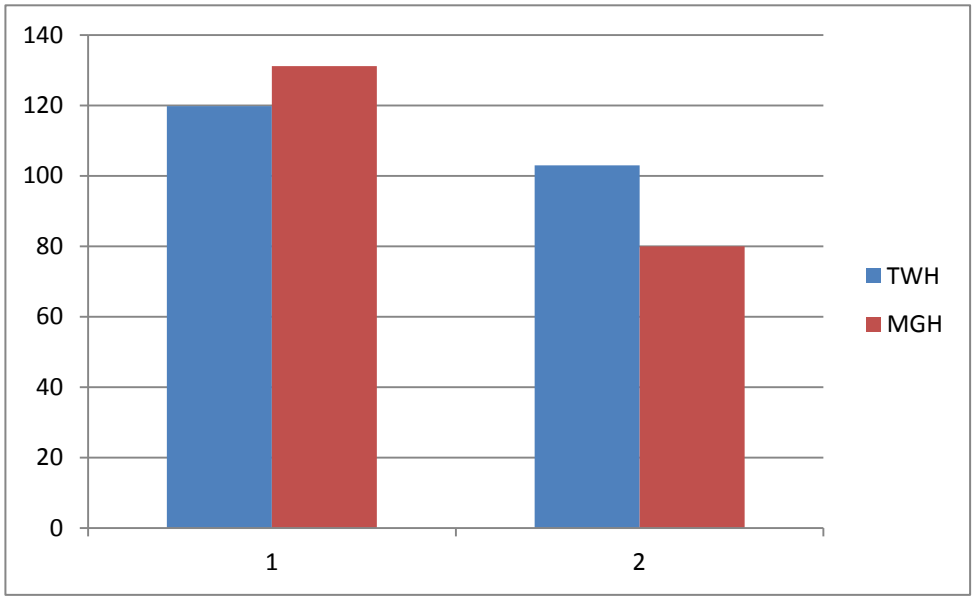
Vascular surgery

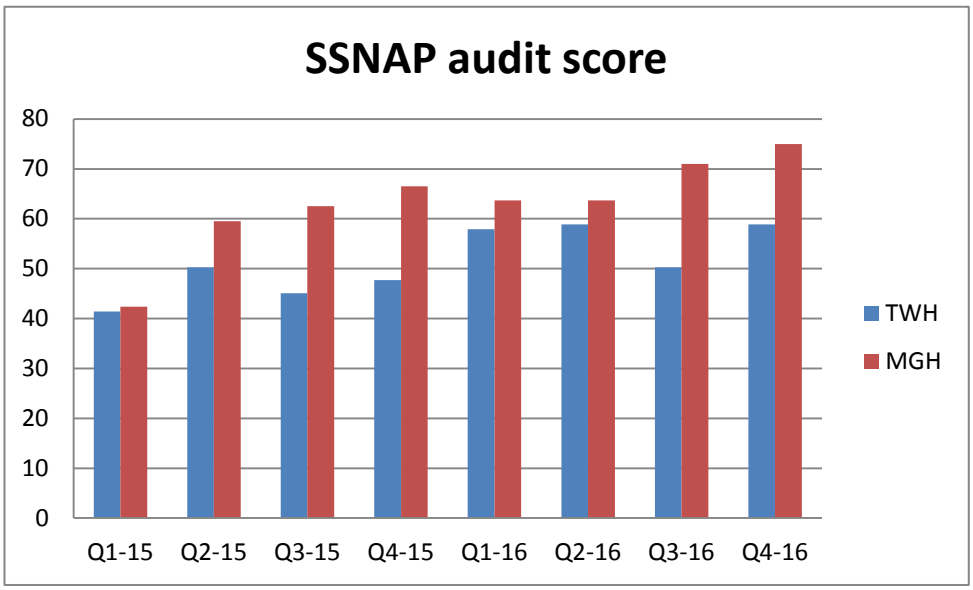
- As can be seen on the attachment, the Trust continues to provide some Carotid endarterectomy operations to patients. We are not an outlier – The Appendix demonstrates the variability in outcomes nationally and shows the figures for the South East Coast region.
    - This no longer occurs in our trust

Stroke mortality

The issues surrounding Stroke care have been discussed in an ongoing fashion at the Quality committee and also at the Board for the past couple of years. As stated last year, there was an observation that there was an increased mortality in these patients treated within the trust and it was seen that we had an increased number of patients aged over 85 years of age.

The directorate has been working towards increasing the quality of care that we are able to provide to patients who present with Stroke. This has been discussed at various meetings over the past year and we have observed an improvement in the SSNAP audit scores for the Trust. The next two figures show the past two years performance. The first figure shows the SMR for each site over the past two years (with some deficit in data) and the second shows the sites' SSNAP data.





On 25th May 2016, I received notification from Professor Rudd (National Clinical Director for Stroke) that Maidstone Hospital was an outlier for patients with stroke. We asked Dr Foster to look into this data in an objective way and their report is attached.

In addition, there is an audit underway looking into the deaths that have occurred and so far, the preliminary results are:-

- There appears to have been a lack of accurate reporting of depressed conscious level in Stroke patients at MGH, generally underestimating the severity of stroke.
- There are an increased number of patients aged over 85 years.

The Dr Foster report is attached, but I wish to highlight the following issues.

- The crude mortality has decreased from 18.82% to 15.36%, from 2014/5 to 2015/6 (compared to a much lower decrease nationally (0.43%).
- The SMR has decreased from 125 to 91 over the same time period.
- There was a higher number of patients who died with a primary diagnosis of stroke who were older than 85 years.

MORTALITY SUMMARY REPORT OF STROKE ANALYSIS

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Report Date	1st June 2016
Classification	**CONFIDENTIAL**
Healthcare Intelligence Specialist	Penny Booysen
Contact details	m: 07500 797825 e: penny.booysen@drfoster.com
Prepared by	Penny Booysen

BACKGROUND

Following on from the alert raised by the Royal College of Physicians on the 25th May 2016, the following analysis was conducted to review the findings and explore any improvements/changes since that period. The intention of the report will be to present 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.

METHODOLOGY

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and Summary Hospital-level Mortality Indicator (SHMI) and analysed in Quality Investigator, PPMv6 and mortality comparator, in-hospital mortality was examined for all inpatient Stroke admissions to Maidstone and Tunbridge Wells NHS Trust (MTW) for the time period April 14 to March 15 and April 15 to Feb 16, which includes the latest HES data available.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including November 2015 (unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

*The methodology used by the Royal College of Physicians in the report differs from the Dr Foster methodology in a number of areas however certain themes, trend sand patterns can be explored.

REVIEW OF DATA FOR STROKE DATA

- This period shows that MTW was an outlier for Stroke Mortality for the period April 14 to March 15. The funnel plot (fig1.0) shows that MTW sits outside the 95% confidence intervals for that time period however remain within the 99.8% control limits. There is 12 other Trusts Nationally which sits outside this 95% confidence interval.
- If the time period where analysed for the time period April 15 to Feb 16 (latest data available), (fig.2.0) it can be seen that MTW have a much improved position on the funnel plot and now sit within the 95% confidence intervals and have a relative risk of below 100.

FIG.1.0: NATIONAL PEER COMPARISON FOR STROKE DIAGNOSIS APRIL 14 TO MAR 15

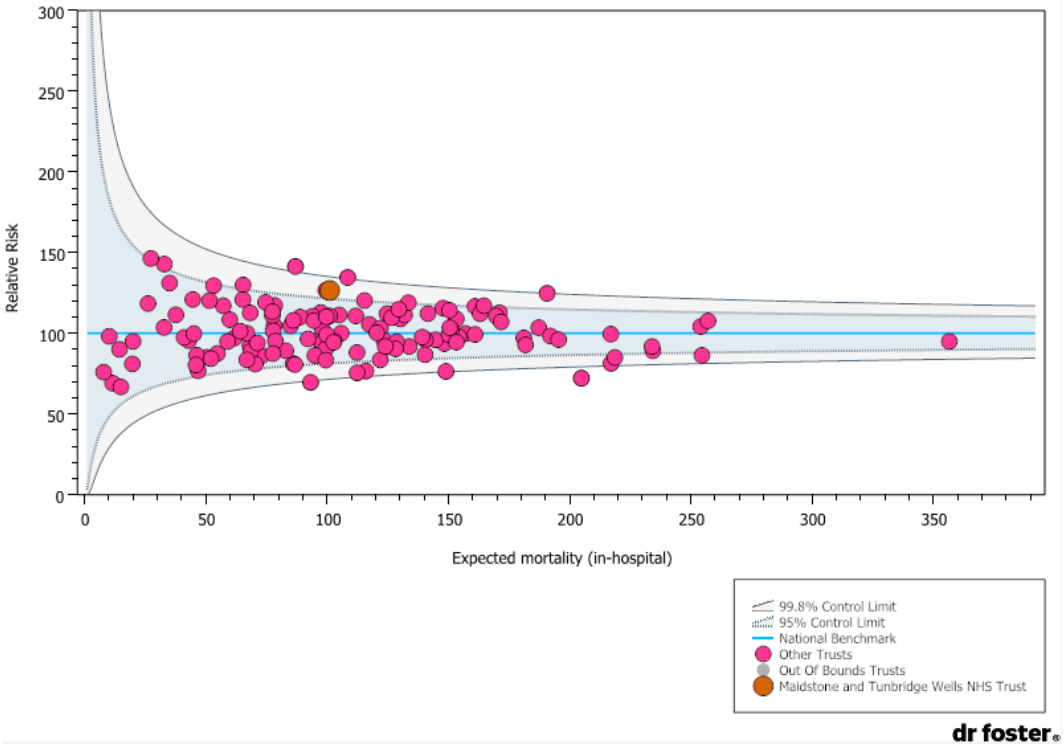
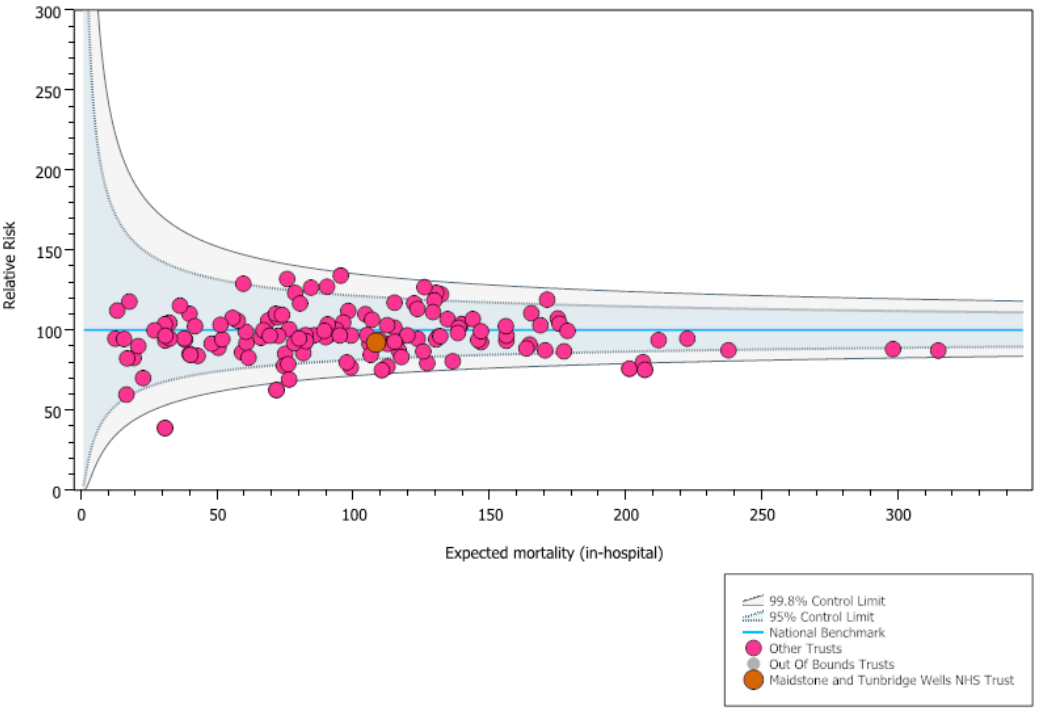


FIG.2.0: NATIONAL PEER COMPARISON FOR STROKE DIAGNOSIS APRIL 15 TO FEB16



- Fig.3.0 below shows that the crude mortality rate has decreased in Stroke from 18.82% in April 14 – Mar 15 to 15.36% in April 15 to Feb 16. This is a 3.46% decrease. Nationally the variance shows a 0.43% decrease and within the South East Coast Peer group there is a 0.1% decrease. The SMR for MTW has also decreased from 125.1 and being statistically higher than expected to 91.37 and 'as expected'. The overall number of deaths between each year analysed has decreased by 28, from 128 to 100.

FIG.3.0: TABLE OF OVERALL FIGURES YEAR COMPARISONS

	MTW	Peers	National
Apr14-Mar15			
Crude mortality rate	18.82%	16.99%	16.65%
SMR	125.1	100.75	102.31
Number of deaths	128	813	15059
Number of expected deaths	102.32	806.91	14956.33
Apr15-Feb16			
Crude mortality rate	15.36%	16.89%	16.22%
Crude variance	3.46%	0.10%	0.43%
SMR	91.37	98.15	96.96
Number of deaths	100	719	13214
Number of expected deaths	109.44	732.54	13628.87

- The rolling 12 months graph (fig.4.0& Fig.6.) shows each point on the graph plotted with 12 months data to show a true trend. In these graphs it can be seen the trend in April 14 to Mar 15 which was an upward trajectory has decreased and is now a downward trajectory. Fig. 5.0 and Fig. 7.0 may help explain this in that it can be noted that in Nov 15 a change in practice either pathway management or coding has led to a reversal of the observed and expected crude rate %. This has been maintained now for remaining 3 data points available.

FIG.4.0: ROLLING 12 MONTH STROKE SMR APRIL 14 TO MAR 15

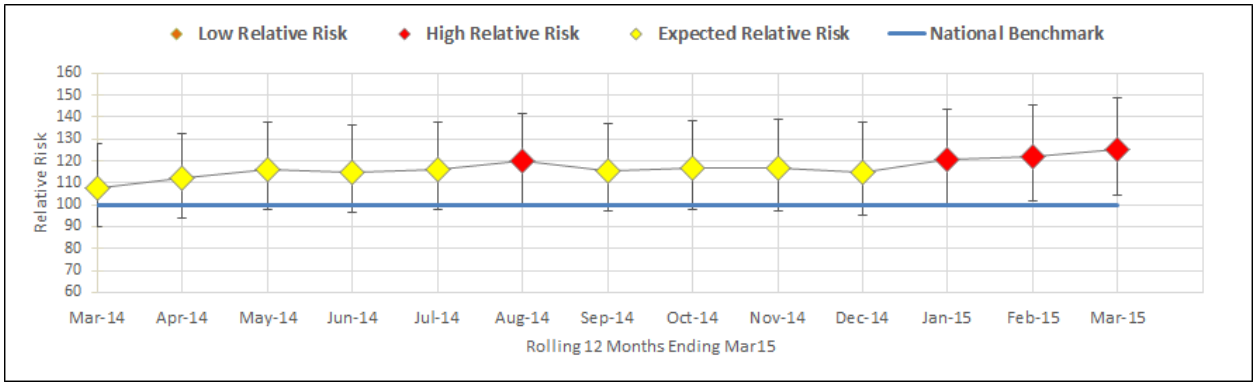


FIG.5.0: CRUDE MORTALITY RATES APRIL 14 TO MAR 15

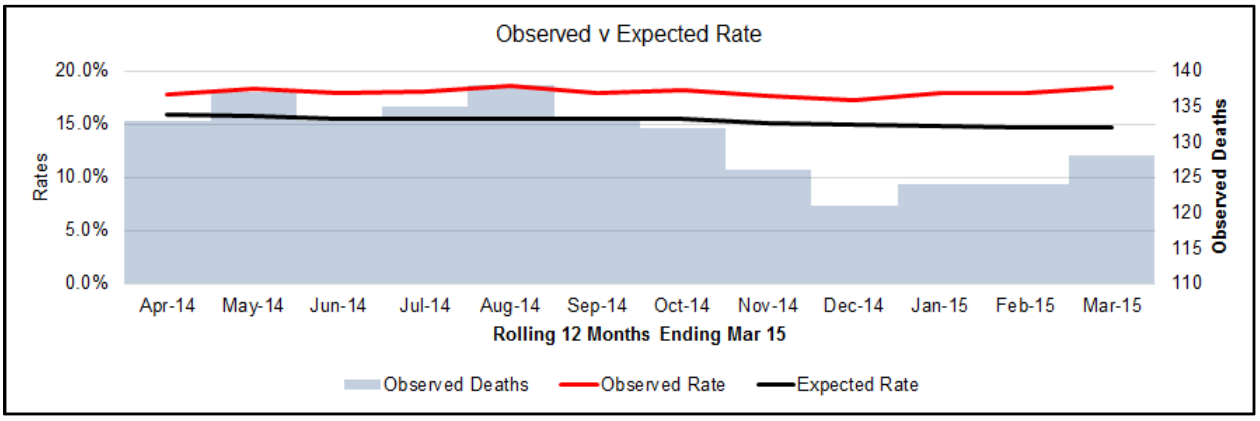


FIG.6.0: ROLLING 12 MONTH STROKE SMR APRIL 15 TO FEB 16

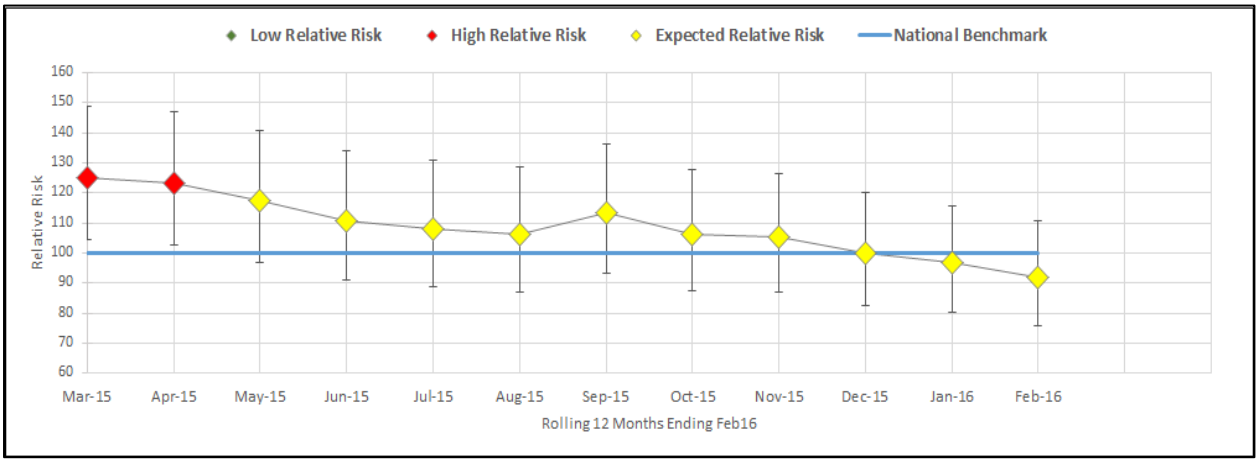
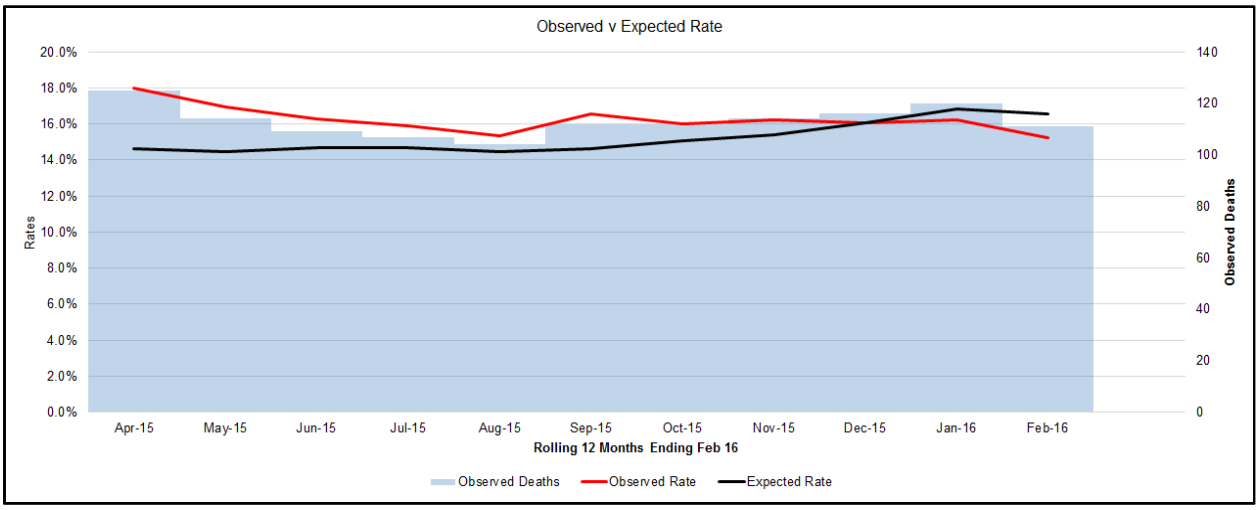


FIG.7.0: CRUDE MORTALITY RATES APRIL 15 TO FEB 15



*The Length of Stay (fig.8.0) analysis and readmission figures (fig.9.0) aid in triangulating not only the number of patients that died but the quality of the Stroke pathway at MTW.

- Overall the LoS at MTW has remained relatively static.
- The readmissions data however shows a general decrease in the number of readmissions within 30 days of discharge. Overall the rate has decreased from an average of 11.79% in the year April 14 to March 15 to 8.45% in the current FYTD. Of note is that the National readmission rate for Stroke within 30 days for the current FYTD is 8.15%.

FIG.8.0: LENGTH OF STAY ANALYSIS APRIL 14-FEB 16

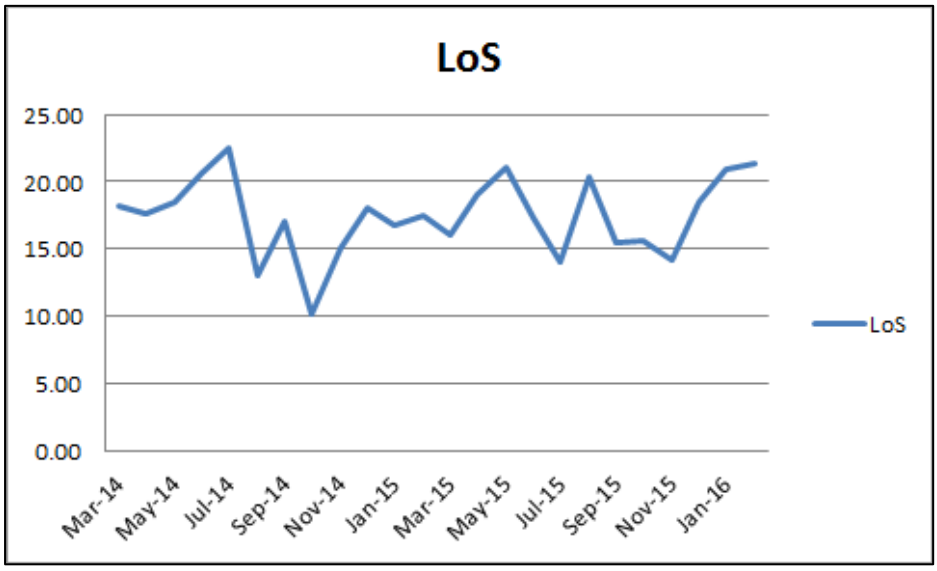
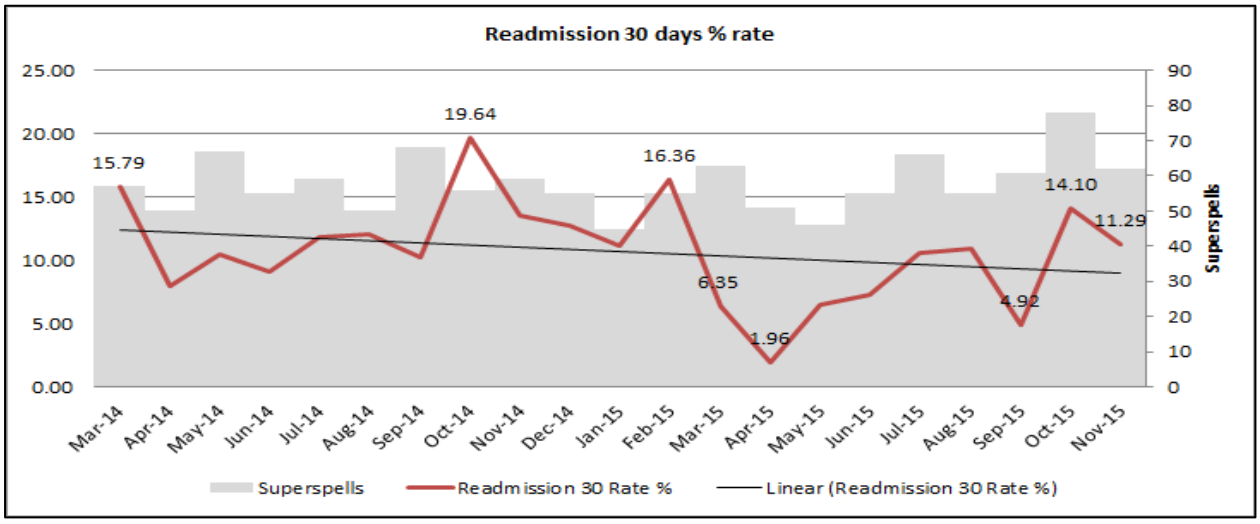


FIG.9.0: READMISSIONS RATE WITHIN 30 DAYS APRIL 14 TO DEC 15 (LATEST AVAILABLE DATA)



Case-Mix Analysis for Stroke

- The case-mix profile of 3 coefficients that are included in Dr Foster methodology show that MTW has a higher number of patients who died from a primary diagnosis of Stroke, during the period April 14 to Mar 15, aged over 85+.
- The co-morbidity scoring profile shows that MTW had an average number of comorbidities recorded in comparison to its peers in each score. This implies that the recording of comorbidities at MTW was in line with the trends of its peers for that time period, however if MTW had more complex patients than its peers, then this is not reflected in the coding.
- The social deprivation coefficients show that MTW has a high number of patients that died from Stroke admitted with a Deprivation score of Q1&Q2: Least deprived and below average compared to its peers.

FIG.10.0: AGE PROFILE

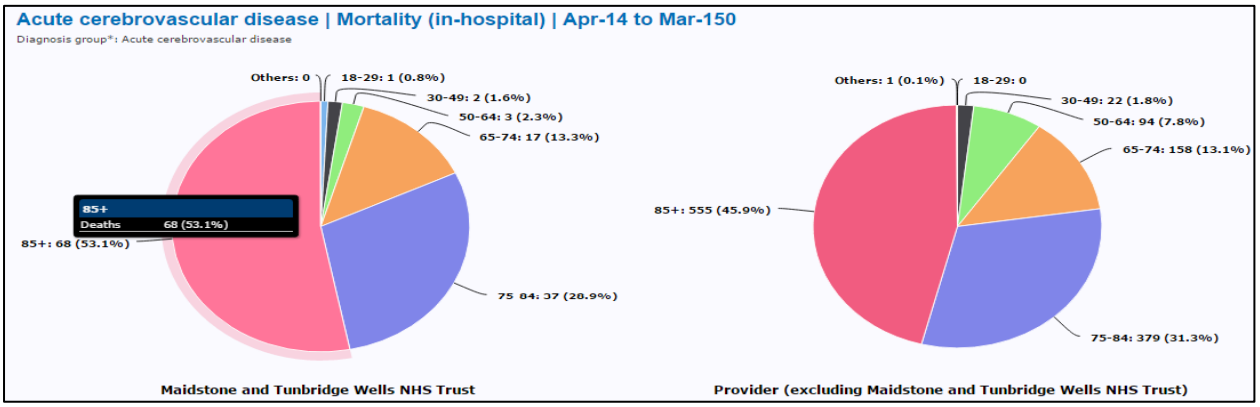


FIG.11.0: COMORBIDITY SCORE PROFILE

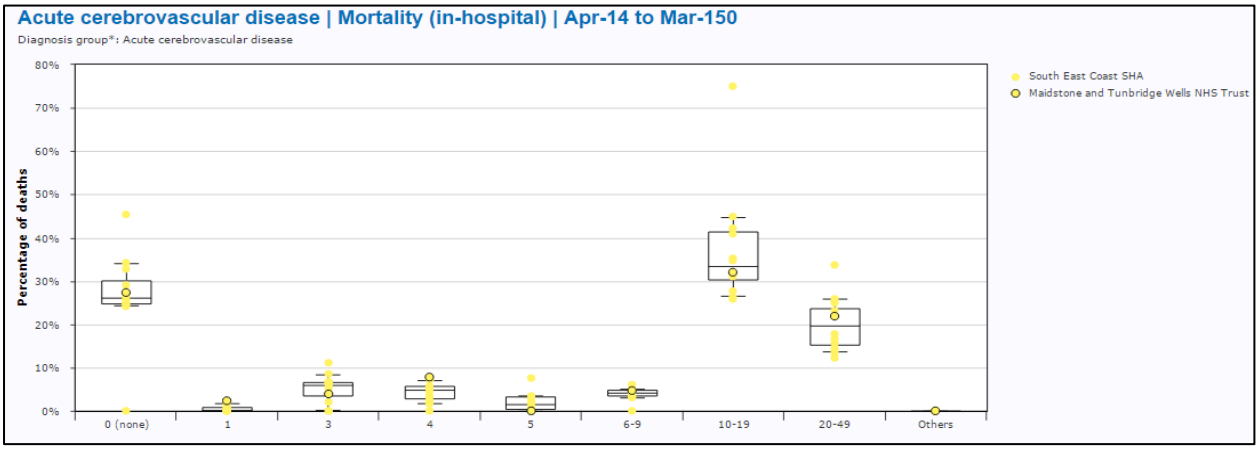
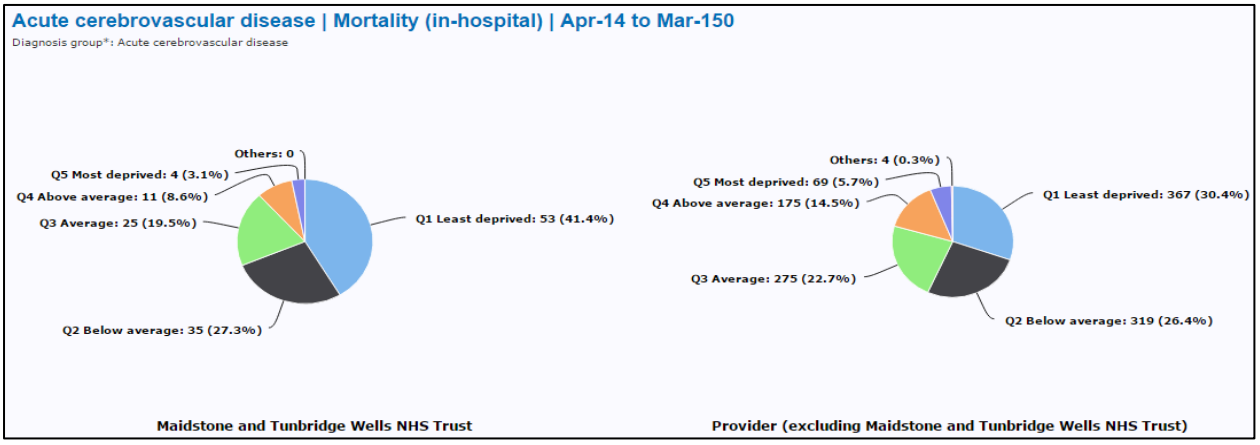


FIG.12.0: DEPRIVATION PROFILE



SHMI Data

- In the SHMI data for the period April 14 to Mar 15, it can be seen that MTW remained within the 95% confidence intervals for Stroke. (Fig.13.)
- If Stroke were analysed by crude rates for where a patient died, neither patients in-hospital nor post-discharge deaths were considered statistically significant with an overall rate of In-patients of 18.08% compared to Peers of 15.74% and Post-discharge (within 30 days) showing a crude rate of 2.87% against a peer rate of 2.73%. (Fig.14.0)
- Stroke split by in-hospital deaths against Post-discharge deaths shows that neither is statistically significant for the time period April 14 to Mar 15.
- The latest SHMI data period available is Oct 14 to Sept 15 and this reflects the improving picture we have seen in SMR for stroke in that the SHMI has improved from 116.8 for the period April 14 to Mar 15 to 108.73 for the period Oct 14 to Sept 15 (fig.15.0).

FIG.13.0: SHMI BY PROVIDER FOR STROKE ADMISSIONS APRIL 14 TO MAR15

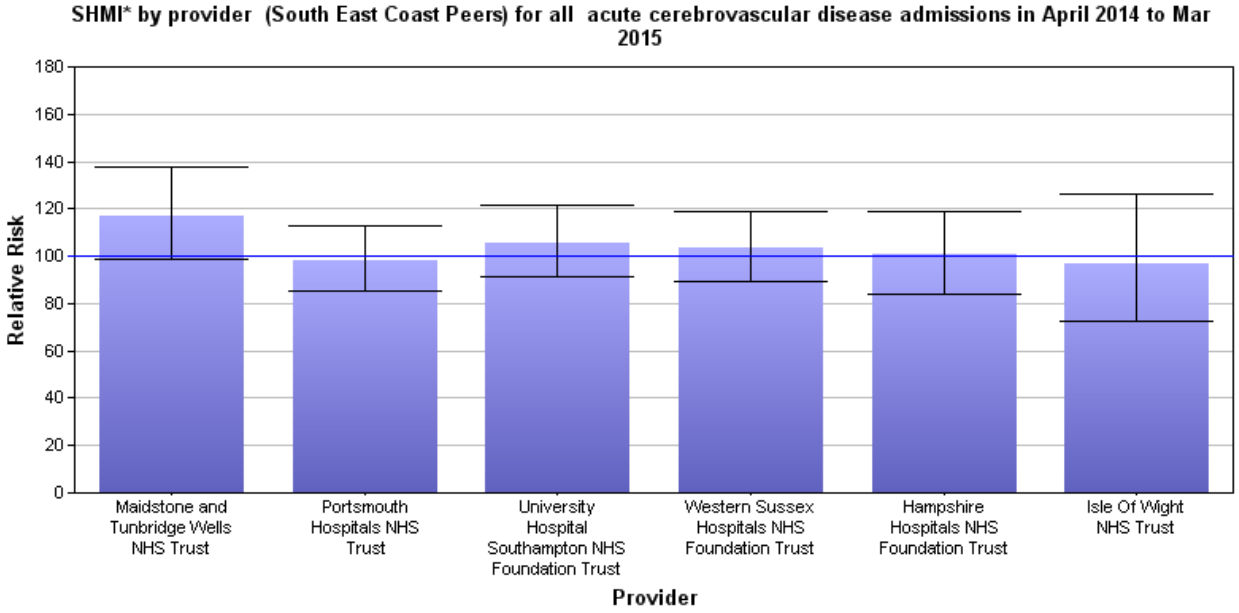


FIG.14.0: MORTALITY (CRUDE) RATE BY WHERE A PATIENT DIED VS SOUTH COAST PEERS APRIL 14 TO MAR 15

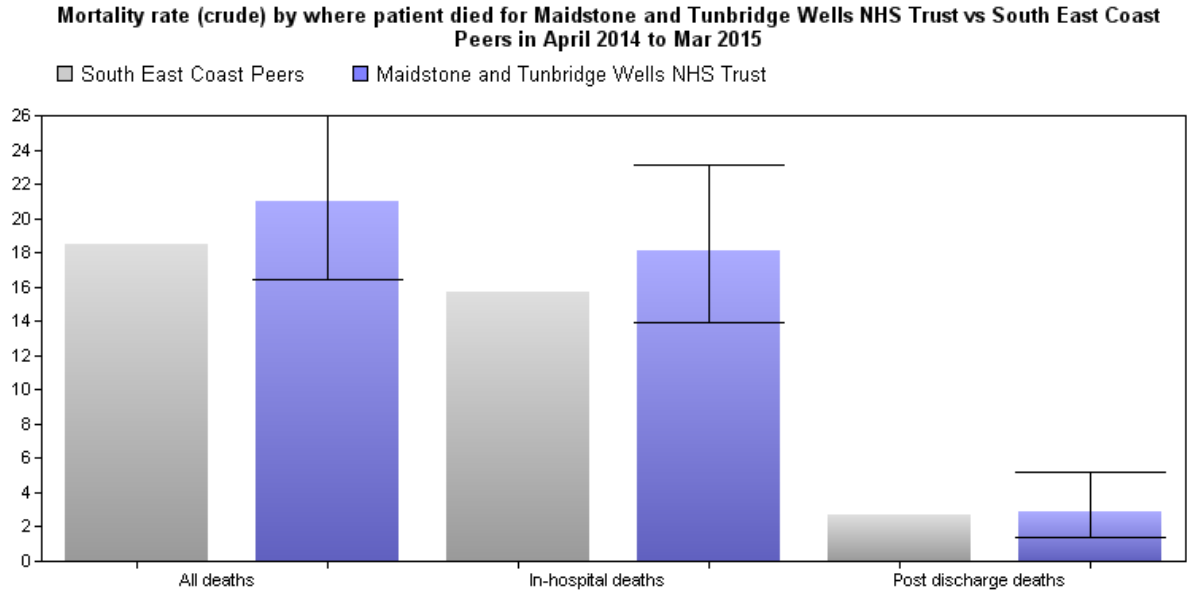


FIG.15.0: SHMI SPLIT BY HOSPITAL/ALL DEATHS BY CCS GROUP APRIL 14 TO MAR 15

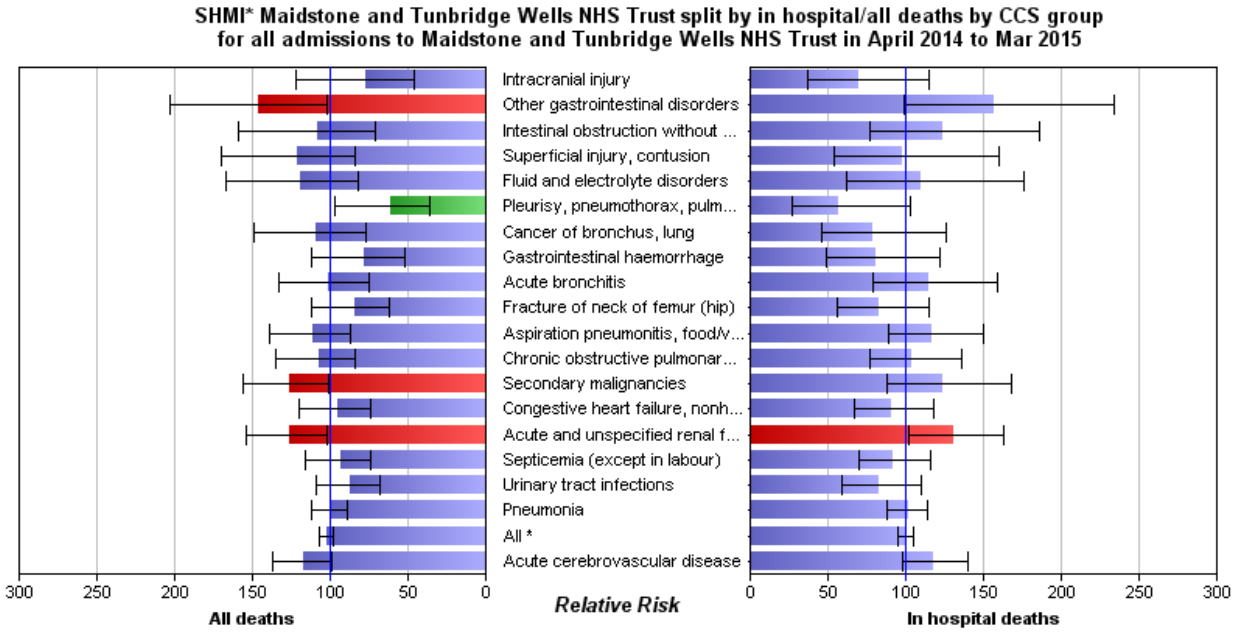
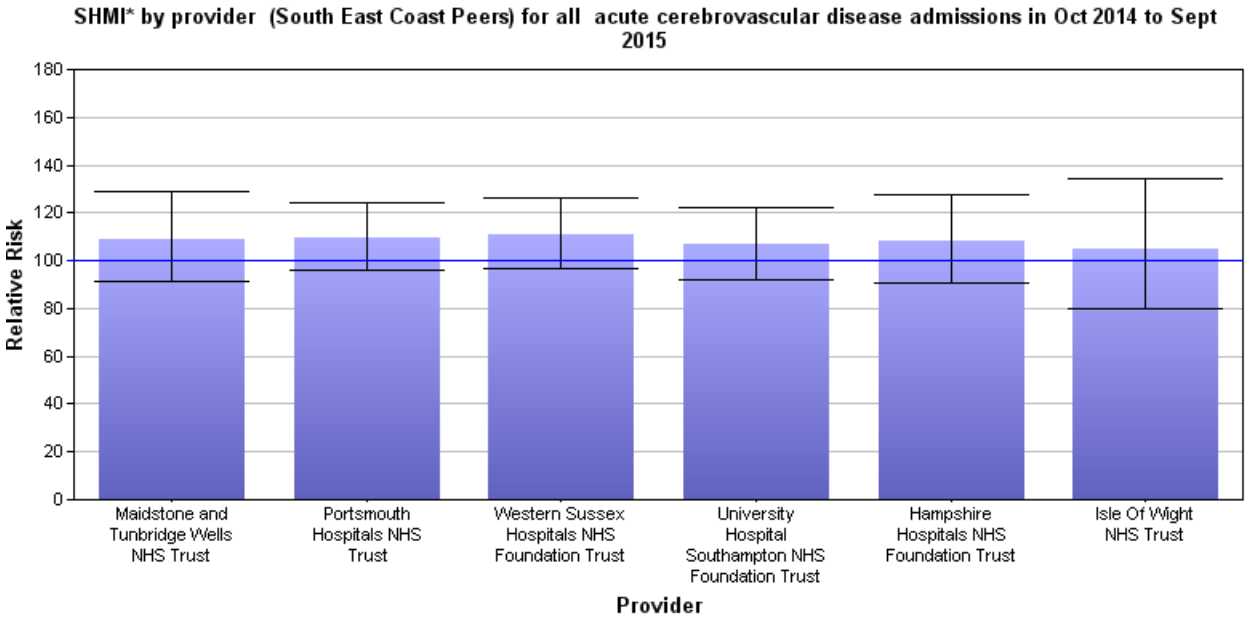


FIG. 15.0: SHMI FOR STROKE OCT 14 TO SEPT 15



Summary

Overall it can be demonstrated that MTW were outliers for Stroke in April 14 to Mar 15. However it is evident that a number of changes have occurred within the Trust which has led to an overall decrease and in fact reversal of this trend, with the Trust now showing overall improved Stroke data. MTW now remains well within the funnel plot and if this trend, noted in the crude mortality rates, continues may soon be below expected. Overall the LoS data shows that LoS remains stable whilst the readmission rate has decreased demonstrating that potentially the quality of care has improved and patients are not being discharged sooner than expected and of the patients that are discharged the number that are being readmitted within 30 days is decreasing. The overall case-mix analysis shows that MTW differs from its' peers in that the Trust has a higher proportion of patients aged over 85+ and also record patients from a more deprived social deprivation that its' peers. The SHMI data also reflects and improving picture with the overall SHMI for Stroke mortality, whilst remaining 'as expected', decreasing from 116.8 to 108.73 for the latest time period Oct 14 to Sept15.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting –July 2016

7-13 Safeguarding Children's Report Chief Nurse

The Trust is required to produce an annual Safeguarding Children's report, which should have oversight by a committee of the Board and cover the key elements of safeguarding including the provision of policies, procedures, training and safeguarding alerts.

The full report was presented to and discussed by TME in May 2016 and Quality Committee in June 2016 and covered the period April 2015 – April 2016 and below is a summary providing the board with the key information for assurance:

The report provides assurance that statutory requirements are met, particularly in relation to the following declaration as requested by the Department of Health:

- The organisation meets the statutory requirements in relation to the Disclosure and Barring Service (DBS) checks
- Child protection policies are up to date
- Staff have undertaken safeguarding training
- Designated and/or named professionals are clear about their role and have sufficient time and support to undertake it
- There is a Board level Executive Director for Safeguarding. The Board reviews safeguarding across the organisation at least once a year to assure it that safeguarding systems and processes are working.

Safeguarding Children's Report Summary:

The Safeguarding Children Committee forms an integral part of the governance system and is chaired by the Chief Nurse. Membership of the committee includes the Head of Midwifery, Women, Children and Sexual Health Services, Named Doctor, Named Nurse, Named Midwife, A/E Safeguarding Lead, Matron for Paediatrics, West Kent Lead Nurse for Children's Safeguarding and Lead for Learning and Development.
The Named Nurse is supported by two Safeguarding Children Nurses, a deputy named midwife for safeguarding, and a perinatal mental health nurse working with her.
The Trust supports staff in the identification and management of issues relating to Safeguarding Children.
The child's welfare is seen as paramount and staff ensure the child's safety is their first consideration.
Staff are working collaboratively with other agencies involved in safeguarding children.

Mandatory training updates for Child Protection are attended initially at Trust Induction, then, are required every three years by all staff within the Trust. Levels of training encompass all National and Local guidance pertaining to content and competencies with specific reference to those most relevant to MTW.

The key developments and areas of focus this year have been as follows:

- Kent Safeguarding Children Board (KSCB) Child Sexual Exploitation self-assessment
- Ofsted inspections
- Coping with Crying pilot programme
- Early Help preventative services
- New and revised policies in relation to safeguarding children
- Flagging children with child protection plans

- Female Genital Mutilation
- Multiagency Maternity Hub
- Joint area targeted inspections

Areas of risk for ongoing monitoring and review

The Safeguarding Children Committee will continue to monitor compliance with training with particular focus on improving the compliance at level 3. This currently sits at 82%.Levels 1 & 2 are above 85%.
A focus on Multi-Agency working particularly with reference to the completion of referrals to social services by A/E staff.

Continuing to deliver the actions and recommendations as identified by the audits that have been undertaken throughput the last year.

Conclusion

Significant work has been done in the last year in relation to improving services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust, with our commissioners and Kent Safeguarding Children's Board. There is still work to do to further improve the standards but we are assured that we have the right people and systems in place.
The Safeguarding Children's Committee continues to report regularly to the Trust Clinical Governance Committee.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive; Quality Committee

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-14 Trust Board Members' hospital visits (23/04/16 – 14/07/16) Trust Secretary

"Board to Ward" visits, safety 'walkarounds' etc. are regarded as key governance tools[1] available to Board members. Such activity can aid understanding of the care and treatment provided by the Trust; and provide assurance to supplement the written and verbal information received at the Board and/or its sub-committees.

This quarterly report therefore provides details of the hospital visits reported as being undertaken by Trust Board Members between 23rd April 2016 and 14th July 2016 (the last report submitted to the Board in April 2016, covered visits up to 22nd April).

The report includes Ward/Department visits; involvement in Care Assurance Audits; and related activity, but does not claim to be a comprehensive record of such activity, as some Trust Board Members (most notably the Chief Executive, Chief Operating Officer, Chief Nurse, Medical Director, and Director of Infection Prevention and Control), visit Wards and other patient areas regularly, as part of their day-to-day responsibility for service delivery and the quality of care. It is not intended to capture all such routine visits within this report.

In addition, Board Members may have undertaken visits but not registered these with the Trust Management office (Board Members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Board Members to continue to undertake visits. Board Members are also invited to share any particular observations from their visits at the Board meeting.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

Information, and to encourage Board members to continue to undertake quality assurance activity

[1] See "The Intelligent Board 2010: Patient Experience" and "The Health NHS Board 2013"

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

Hospital visits undertaken by Board members, 23rd April to 14th July 2016

Trust Board Member	Areas registered with the Trust Secretary / Assistant Trust Secretary as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman of Trust Board (AJ)	▪ AMU (TW)	-
Chief Executive (GD)	-	-
Chief Nurse (AB)	▪ John Day Ward (MH) ▪ Ward 2 (TW) ▪ Ward 12 (TW) ▪ CDU (TW) ▪ A&E Paediatric (TW)	-
Chief Operating Officer (AG)	▪ A&E (MH) ▪ UMAU (MH) ▪ Mercer Ward (MH) ▪ Whatman Ward (MH)	-
Deputy Chief Executive (JL)	-	-
Director of Finance (SO)	▪ Therapies (MH)	-
Director of Infection Prevention and Control (SM)	▪ AMU (TW) ▪ John Day Ward (MH)	-
Director of Workforce (RH)	-	-
Medical Director (PS)	-	-
Non-Executive Director (KT)	▪ A&E (MH) with AG ▪ A&E (TW) ▪ A&E Paediatric (TW) ▪ Mercer Ward (MH) with AG ▪ UMAU (MH) with AG ▪ Whatman Ward (MH) with AG	-
Non-Executive Director (AK)	▪ AMU (TWH)	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	▪ AMU (TWH) ▪ A&E (TW) ▪ A&E Paediatric (TW) ▪ A&E (MH) ▪ Chaucer Ward (MH) ▪ Surgery/Anaesthetics Clinical governance meeting	-
Non-Executive Director (ST)	▪ AMU (TW)	-

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-16 Estates and Facilities Annual Report 2015/16 Chief Operating Officer

For the past 2 years, the Trust Board has received an Annual Report for Estates and Facilities.

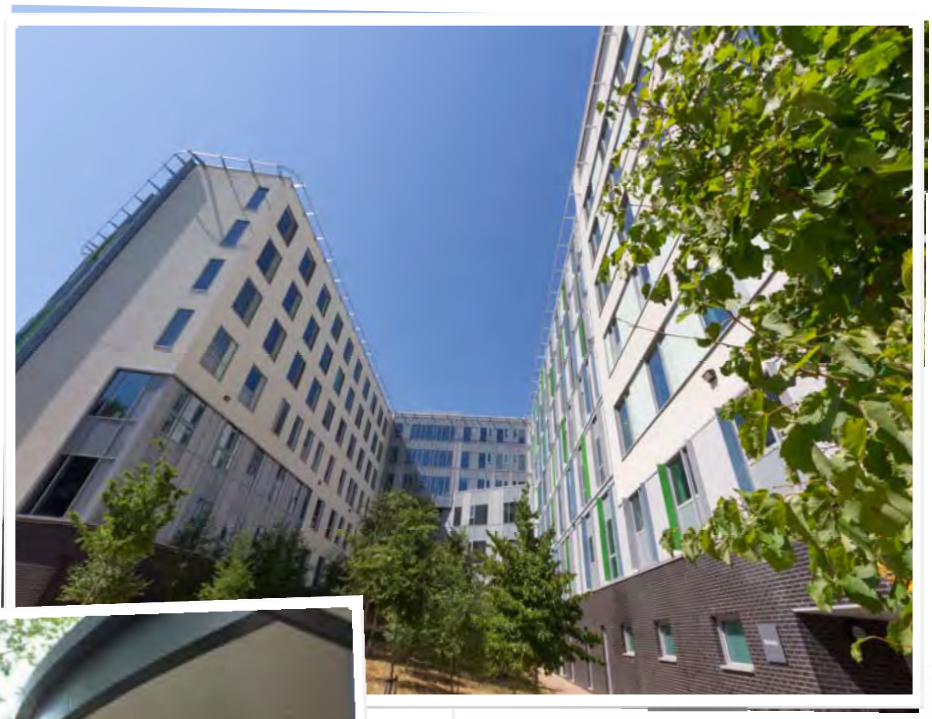
The enclosed report provides a broad perspective of the Estates, Capital and Facilities Management functions for the financial year 2015/16.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 13/07/16

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

Estates and Facilities Management Annual Report



Maidstone and Tunbridge Wells NHS
NHS Trust

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Estates and Facilities Management

Inside this year's Annual Report

The directorate is responsible for;

- Capital Building Projects
- Car Parking
- Cashier Service
- Catering
- Cleaning
- Decontamination
- EME
- Environment and Sustainability
- Estates Maintenance
- Fire Safety
- Laundry and Linen
- Main Reception
- Medical Devices
- Moving and Handling
- Non-emergency Patient Transport
- Pest Control
- Private Finance Initiative
- Portering
- Post
- Property Management
- Security
- Staff Residential Accommodation
- Transport
- Travel Planning
- Waste Managements
- Window Cleaning

Managing the Trust's Estate is a complex and diverse business.

Our role is to make sure that the land and property we invest in and manage for our patients, visitors and staff are sustainably worked, developed and enjoyed to deliver the best value over the long term.

At the heart of how we work is an astute, considered, collaborative approach that helps us create success for our service and those we provide it for.

Key Highlights

Annual Staff Star Awards:

- RESPECT: Winners – Security Team
- DELIVERY: Runners up – Capital Projects Team

Accreditations achieved:

- ISO 14001: Environmental Management
- OHSAS 18001: Occupational Health and Safety Management
- ISO 22301: Business Continuity
- ISO 9001: Quality Management

Developments:

Tunbridge Wells
- New 38 bed Acute Medical Unit

Maidstone
- New 31 bed Respiratory Ward
- New Outpatient Phlebotomy Department

Our year in numbers

872,715 In-patient main meals requested	**3,775,481** Laundry and Linen pieces processed per annum for MTW	**50,212,307** kWh of Electricity and Gas Consumed
£7,430,000 Capital Investment for improving existing buildings	**130,030m^2** Gross internal floor area	**£995,000** Investment to reduce backlog maintenance
92 False Fire Alarm Activation	**23.83** Hectare Land Area	**£646,489** Risk Adjusted Backlog
624.1000 Waste Tonnes Volume	**£343,804** Income from Services provided to others	**60%** Of patient accommodation is single bedrooms

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Estates and Facilities Management

1 Introduction

This is the Estates and Facilities Management (EFM) annual report to update the committee with a broad perspective of the Estates, Capital and Facilities Management function and includes a review of the key developments and improvements achieved in the financial year 2015/16 and to look ahead to the planned areas of focus for the financial year 2016/17.

The figures and information included within this report are those reported for the annual Estates Return Information Collection (ERIC) submitted to the Department of Health.

2 Financial Overview

2.1 Financial Position - Revenue

2.1.1 The Directorate has a balanced business plan for 2016/17, with a proposed cost improvement programme (CIP) of 8% equating to approx. £2.6m. The savings are monitored on a fortnightly basis to ensure delivery and any risks that materialise during the year are managed and mitigated accordingly.

2.1.2 The Directorate completed 2015/16, as follows, which excludes the PFI unitary payment.

Annual Budget £	Year End £
24,045,645	27,763,198

2.2 Financial Position – Capital

2.2.1 The Estates Capital for the year was £995,000 for backlog maintenance and £7,430,000 for improving existing buildings.

2.3 Cost Pressures

The cost pressures to the Directorate which are service demand led included; Staff Residential Accommodation to meet the overseas recruitment drive for nurse; non-emergency patient transport service, extended winter escalation period, and postage.

2.3.1 Staff Residential Accommodation

Additional accommodation needed to be secured to meet the requirement driven by the overseas recruitment. Initial costs incurred through the legal agreements surrounding the

new leases. Nurses appointed at a lower agenda for change band entitled them to a reduction in the monthly rent payment.

2.3.2 Patient Transport

Private resource is used for inter-site patient transfers and used to mitigate the poor performance of the Kent and Medway Non-Emergency Patient Transport Service which was awarded to NSL by West Kent CCG. This contract ceased on 30 June 2016 and the new provider has now commenced.

3 Workforce

3.1 Awards and Recognition 2015

- **Respect Award**, Winner – Team: Security
- **Delivery Award,** Runner Up – Team: Estates Project Team for the TWH New Ward

3.2 Accreditations

Within the year the Directorate became one of the first NHS Trusts to achieve the following internationally recognised standards;

- ISO 14001: Environmental Management
- ISO 22301: Business Continuity
- BS OHSAS 18001: Occupational Health and Safety Management

4 Estate Strategy and Capital Development Projects

4.1 Refreshing the Estate

4.1.1 The Estate development team are working collaboratively with colleagues to develop a joint approach to estate strategy planning.

4.1.2 The Estate Strategy previously agreed by the Trust Board plans until 2017. The new Trust Five Year Strategy is being reviewed and the Estate Strategy revised to incorporate the strategic direction and plan to indicate the sequencing of investments required over the next 3-5 years.

4.2 Capital Projects

4.2.1 Projects Approved

Instruction to proceed with the Capital programme was given in August 2015 and through the concentrated period of seven months; the Capital Project team have delivered the following projects within the initial £2,597,000 allocation;

- John Day/Jonathan Saunders ward reconfiguration
- Maidstone Main Entrance Refurbishment Completion
- TWH AAU completion
- Waste cupboard compliance completed
- Maidstone Admissions Unit
- Maidstone Outpatients

4.2.2 In-year Project

Post commencement of the financial year and following high level strategic review of the Trust inpatient activity, agreement was reached to develop a new acute medical unit at Tunbridge Wells Hospital to improve emergency patient flow through the Trust and enhance standards of care for patients.

The development incorporated the relocation of 400 office based staff, strip out of offices and on-call rooms and the redevelopment of the area to create a new 38-bed ward, consisting of two single rooms and nine 4-bed bays that will act as a central hub for handling A&E patients and receiving urgent GP medical referrals.

The programme of works from initial concept to commission was completed within 48 weeks and cost £4,833,000.

4.2.3 Backlog maintenance

Backlog maintenance is capital investment in the building and equipment in the estate to ensure the Trust remains compliant to Health and Safety and legislation.

The estates department has delivered backlog maintenance at Maidstone Hospital worth £995k including;

- Plate Heat Exchangers
- Fire Dampers
- Replacement of oil distribution pipework
- Roof improvements & flooring works
- Hot water flow
- Chiller replacement
- L1 Fire Alarm replacement
- Outpatient Kitchen refurbishment

5 Operational Productivity and Performance in English NHS acute hospitals: Unwarranted Variations, by Lord Carter of Coles

Recommendation 6 of the report states;

All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

Delivered by:

a) Ensuring every trust has a strategic estates and facilities plan in place, including in the short term, a cost reduction plan for 2016-17 based on the benchmarks, and in the longer term (by April 2017), a plan for investment and reconfiguration where appropriate for their whole estates, taking into account the trust's future service requirements;

b) Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems, funded through a new Department of Health (invest to save energy efficiency fund' set up by April 2017, working in partnership with Salix (who provide interest free capital loans) and other partners, to help trusts deliver the opportunities for reduced energy consumption;

c) HSCIC and trusts should ensure better data accuracy by improving the governance and assurance of the ERIC data in time for the 2015-16 returns due in July 2016 with trust Finance Directors ensuring the financial ledger and ERIC reported costs are aligned by July 2016; and,

d) Ensuring estates and facilities costs are embedded into trusts' patient costing and service line reporting systems, which will be monitored by NHS Improvement.

The directorate are working towards or have exceeded these recommendations by;

Target		Progress
35% non-clinical floor space	✓	31% Maidstone
	✓	30%Tunbridge Wells
Strategic E&F plan in place	✓	Existing Board approved plan dated to 2017
Cost reduction Plan	✓	The directorate has identified its savings to meet the 2016/17 efficiency savings target and have implemented a number of schemes and reviews on the three key areas identified in the Estates and Facilities Efficiency Programme Dashboard for MTW as being in the upper quartile of costs when compared to other large acute trusts.
Energy Saving Scheme	✓	EPC Business Case prepared
Data governance and assurance	✓	Finance Manager assistance in preparation of ERIC submission and agreed with Director of Finance
Service Line Reporting	✓	E&F service line reporting already included, however, a full schedule of accommodation is being completed to align specific room data to clinical directorate

A copy of the MTW NHS Estates and Facilities Dashboard for 2014-15 is attached in Appendix A.

6 Directorate Activity and Operational Performance

During 2015/16 operational progress included:

6.1 Estates

6.1.1 Energy Performance contract (EPC)

During 2015/16 a procurement process was completed to appoint an EPC partner. The successful bidder has now completed the investment grade audit and the business case has been prepared for submission through the Trust Governance Structure, to seek agreement to apply for an interest free loan from SALIX, inline with the Lord Carter of Coles

recommendations. This business case identifies a capital investment of £4.2m to achieve guaranteed revenue savings of circa. £1m per annum, managed under a 15 year contract.

6.1.2 Service Provision

Historically, the estates maintenance department have had a presence onsite during normal office hours and an out of hours on-call service. To improve productivity and performance, following consultation, the department now provides a 24 hour seven day week onsite service. This has improved the completion of planned maintenance activity.

6.2 Facilities

6.2.1 PLACE

The annual PLACE inspections were undertaken during May 2016, the confirmed and official results will be released during August 2016.

6.2.2 Non-Emergency Patient Transport Services (NEPTS)

The West Kent Clinical Commissioning Group (CCG) made the decision to move to one provider, to ensure a comprehensive and efficient service for patients across Kent and Medway. The NEPTS contract was awarded to NSL Care Services in January 2013 and went live throughout Kent and Medway on 1 July 2013. This contract expired on 30 June 2016 and the directorate has represented to the Trust in the multi-agency team to tender and commission the new service.

6.2.3 Annual Staff Star Awards 2015

This year the directorate provided the catering arrangements for the Trust's Annual Staff Star Awards.

6.3 Compliance with Standards and Regulations

6.3.1 Risk Register

The directorate is continuing to proactively manage its risk register with open risks reviewed by the Trust Risk Manager and Director of Estates and Facilities Management monthly. Where necessary red and amber items are escalated to the Trust risk register and Board Assurance Framework. There are currently four risks registered:

- Upgrade Fire Alarm System to L1 Standard
- Security issues Maidstone Hospital
- Lack of Statutory Compliance for Maidstone Hospital and Maidstone Residences
- Physical condition appraisal for Maidstone Hospital and Maidstone Residences

The last two entries have been on the risk register over two years and form part of an agreed long term strategy to be delivered through the capital programme.

6.3.2 Water Management

Following the receipt of an enforcement notice by the CQC Chief Inspector during the visit week commencing 13 October 2014, extensive work has been completed on water hygiene management which has been audited by CQC and the enforcement notice has been lifted.

7 Estates and Facilities Management Key Objectives for 2016/17

The Directorate Business Plan for 2016/17 identifies the following key objectives:

7.1 Project Management

- Complete the annual capital renewal program within the budget cycle and effectively spend funding received to reduce deferred maintenance.
- Develop and implement programs to reduce energy consumption.

7.2 Building

- To ensure compliance with Statute

7.3 Operational Management

- Audit and Monitoring of systems and processes
- Training and Development
- Achieve Financial balance

7.4 Support Services

- Recruitment
- Retention
- Establishment
- Work with the CCGs to ensure a smooth transition and mobilisation of the new Patient Transport provider.

Jeanette Rooke
Director, Estates and Facilities Management
7th July 2016

Appendix A – MTW Estates and Facilities Dashboard 2014-15

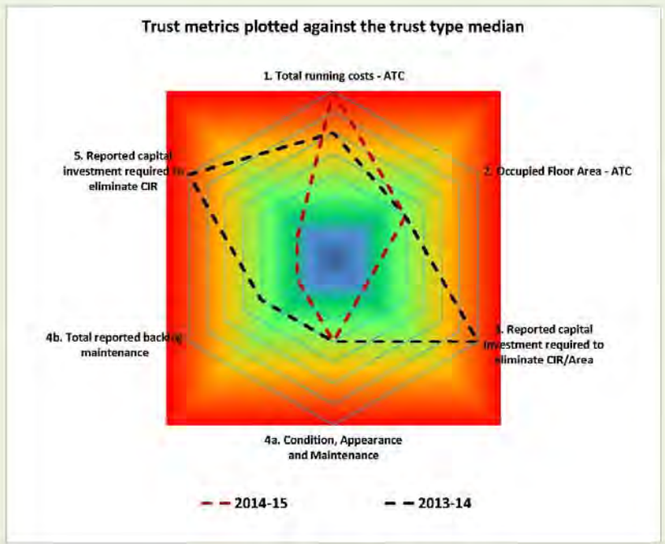
NHS ESTATES AND FACILITIES DASHBOARD 2014-15

CODE	RWF	TRUST NAME	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

TRUST OVERVIEW

Organisation type	ACUTE - LARGE
Commissioning region	SOUTH OF ENGLAND

		2014-15	2013-14
Total occupied floor area	m2	125,011	128,655
Total estates and facilities running costs	£	58,186,036	49,611,393
Potential total E & F running cost saving by moving to the trust type median	£	13,491,499	8,077,393
Potential targeted E & F running cost savings from individual cost elements	£	4,823,679	4,132,866
Potential cost savings from improved utilisation of space	£	To be confirmed	
% of occupied floor area operated under a PFI contract	%	51%	not collected
% of occupied floor area under direct NHS management	%	49%	not collected
E & F running cost of floor area operated under a PFI contract	£/m2	402.98	not collected
E & F running cost of floor area under direct NHS management	£/m2	529.97	not collected



METRICS SCORING METHODOLOGY	
Quartile 1	Blue
Quartile 2	Green
Quartile 3	Amber
Quartile 4	Red

METRICS SOURCED FROM NATIONAL DATA

Domain 1 - Efficiency - Cost		TRUST METRIC 2014-15	Trend	2013-14	2014-15 QUARTILES FOR ACUTE - LARGE Lowest	Lower Quartile	Median	Upper Quartile	Highest
Total estates and facilities running costs / ATC	£ 1,000 / ATC	145.28	↑	119.52	61.38	86.25	119.27	137.65	261.84
Total estates and facilities running costs / area	£ / m2	465.45	↑	385.62	181.09	267.45	357.52	434.90	836.92
Total Hard Facilities Management costs - ATC	£ 1,000 / ATC	51.07	↓	67.94	9.38	20.40	27.25	36.37	107.76
Energy costs	£ / Units	0.11	→	0.11	0.04	0.05	0.06	0.07	0.11
Building and engineering maintenance costs	£ / m2	17.82	↑	13.89	3.16	15.63	24.34	37.36	83.20
Portering	£ / m2	18.62	n/a	not collected	4.86	13.39	15.55	18.82	38.27
Water and sewage costs	£ / m2	4.61	↓	4.66	2.12	3.14	3.80	4.65	7.57
Waste costs	£ / tonnes	344.48	↑	184.07	153.02	210.41	248.68	295.45	685.92
Total Soft Facilities Management costs - ATC	£ 1,000 / ATC	49.94	↓	51.58	28.71	38.62	43.55	50.33	71.07
Laundry and linen costs	£ / Item	0.31	↓	0.33	0.12	0.28	0.32	0.36	0.57
Food costs	£ / meal	3.83	↑	3.03	2.03	3.18	3.71	4.09	5.93
Cleaning costs	£ / m2	57.14	↑	51.87	11.93	34.58	38.17	45.57	67.65

Domain 2 - Effectiveness - Productivity		2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Occupied Floor Area - ATC	1,000 m2 / ATC	0.16	→	0.16	0.16	0.30	0.33	0.37	0.42
Amount of utilised space	%	100.0%	→	100.0%	76.2%	93.5%	96.4%	99.0%	100.0%
Amount of non-clinical space	%	44.7%	↓	46.3%	15.7%	36.7%	44.7%	48.7%	69.2%
Total income earned per area	£ / m2	3,237	↑	2,903	1,752	2,656	2,931	3,101	5,539
Estates and facilities staff sickness absence rate	%	6.2%	→	6.2%	0.0%	5.1%	5.4%	6.1%	7.3%
Amount of energy used	Units / m2	297.57	↓	287.53	263.18	388.11	447.92	503.36	903.38
Portering	Beds/WTE	7.39	n/a	not collected	6.38	7.92	9.66	11.30	25.33
Waste - ATC	ATC ratio*	3.37	↓	5.81	1.57	4.59	4.97	5.42	9.12
Laundry and linen - ATC	ATC ratio*	10.49	↓	12.14	4.06	8.30	9.46	10.67	13.61
Food service productivity	Meals / Beds / Day	3.22	↓	3.32	1.58	2.51	2.79	3.09	3.90
Cleaning productivity	m2/WTE	304	↑	271	328	538	613	706	2023

Domain 3 - Safety		2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Reported Critical Infrastructure Risk (CIR)/Area	£/m2	4.82	↓	109.77	3.76	14.87	39.45	113.40	324.35
Reported Critical Infrastructure Risk	£	604,248	↓	14,122,000	604,248	2,081,808	6,178,820	18,070,549	35,105,579
Fires recorded	No.	0	→	0	0	2	3	6	30
False Alarms	No.	6	↑	31	6	73	115	180	401
Number of people injured resulting from fire(s)	No.	0	→	0	0	0	0	0	1
Number of patients sustaining injuries during evacuation	No.	0	→	0	0	0	0	0	0

Domain 4a - Quality - Patient Environment		2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Condition, Appearance and Maintenance	%	90.24%	↓	93.23%	79.56%	85.64%	90.24%	93.23%	97.87%
Cleanliness	%	98.37%	↓	99.39%	91.86%	96.39%	97.69%	98.76%	99.74%
Food	%	91.52%	↑	79.61%	69.88%	83.68%	87.84%	91.16%	97.11%
Privacy, Dignity, Wellbeing	%	91.03%	↑	78.12%	66.13%	81.41%	84.77%	89.76%	95.33%
Condition, Appearance and Maintenance	%	90.24%	↓	93.23%	79.56%	85.64%	90.24%	93.23%	97.87%
Dementia	%	89.09%	n/a	not collected	47.88%	63.55%	70.52%	76.95%	95.41%

Domain 4b - Quality - Infrastructure		2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Total reported backlog maintenance	£/m2	24.41	↓	108.48	3.83	56.34	174.74	264.59	1,104.45
Amount of functionally suitable space	%	100.00%	↑	66.38%	40.81%	84.62%	94.30%	99.68%	100.00%
Single bedded rooms	%	60.6%	↓	67.4%	0.0%	22.9%	26.8%	30.7%	66.6%
CO2 emissions	kg/m2	53.6	↓	55.67	50.62	101.87	112.30	132.38	203.14

Domain 5 - Organisation Governance & Processes		2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Capital investment required to eliminate CIR	£	604,248	↓	14,122,000	604,248	2,081,808	6,178,820	18,070,549	35,105,579
Capital investment required to eliminate backlog	£	3,092,043	↓	17,853,000	671,957	9,521,743	24,064,900	37,816,082	153,895,626
Capital spend as % of NBV of land and buildings	%	0.8%	↓	3.1%	0.5%	2.2%	3.4%	5.9%	17.2%
Retail Income	£/m2	459.76	n/a	not collected	0.00	228.80	510.84	798.15	2975.84

Produced by: Estates and Facilities Management Efficiency Project Team, Department of Health
EFM National Programme Head: Pete Sellars
For further information please refer to the NHS Estates and Facilities Efficiency Dashboard Guidance document or contact the dedicated mailbox efmefficiencyteam@dh.gsi.gov.uk

Sources: ERIC 2014-15 and 2013-14, PLACE 2015 and 2014, Electronic Staff Records 2014-15 and 2013-14, Trust Financial Accounts 2014-15 and 2013-14
Version: 1.1 Produced: December 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2016

7-17	Summary report from Quality Committee, 06/07/16	Committee Chair (Non-Executive Director)

The Quality Committee met on 6th July 2016. It was 'main' meeting.

The key matters considered at the meeting were as follows:

- The **latest Stroke care performance** was reported. The report that was received is enclosed at Appendix 1, and has been included as a result of a previous request from the Board. It was agreed that in the light of the fact that The Queen Elizabeth The Queen Mother Hospital in Margate had managed to sustain improved performance on the Sentinel Stroke National Audit Programme (SSNAP), the staff at that hospital should be approached, to identify the reasons
- The Medical Director gave an update on compliance with the recommendations from the **NCEPOD report "Gastrointestinal Haemorrhage: Time to Get Control?"**, which highlighted the Trust's inability to comply with the recommendations in full at the present time, and provided the rationale for this. It was however agreed that information on the clinical outcomes of patients treated for a gastrointestinal (GI) bleed at the Trust should be reported to the 'main' Quality Committee.
- An update on the **latest situation regarding patient/visitor car parking** at the Trust was reported (this was an action from the previous meeting), and it was agreed to arrange for the Director of Estates and Facilities to provide an update on the latest situation regarding traffic flow signage at the main entrance to Maidstone Hospital
- The assurance report from the **Trust Clinical Governance Committee** was reviewed. The Chair of that Committee (the Medical Director) introduced the key issues, which included an acknowledgement that further work was required to ensure that the minutes from the Directorate Clinical Governance meetings were received & reported accurately; and notification of the ongoing work in response to a national patient safety alert regarding Invasive Procedures
- The Clinical Directors and/or Matrons were then invited to report any issues from the Directorate sections of the report. The key points reported were as follows:
  - **Recruitment** continued to be a challenge in a number of Directorates. However, in Paediatrics there were now no Band 5 Nursing vacancies, and a waiting list was in place (it was noted that it was not possible for such Nurses to work elsewhere in the Trust as such Nurses were only trained for Paediatric Nursing); whilst in Surgery, it was reported that there would be only 5 vacancies across all Wards by September 2016. In Pathology, it was noted that a Recruitment and Retention premium had now been agreed for Biomedical science Band 6 posts, which should address the recruitment problems for such posts
  - Acute Oncology Cancer of Unknown Primary (CUP) provision and the Anal Cancer Multidisciplinary Team (MDT) had been subject to recent **Peer Reviews**. Some issues had arisen, and the Directorate was responding to these
  - Action was continuing to aim to resolve the disruption caused by the **Baxter infusion pump consumables supply problems**
  - In the most recent **National Emergency Laparotomy Audit (NELA)** data, the Trust performed very well and was expected to improve further
  - In the latest quality data from the **Intensive Care National Audit & Research Centre (ICNARC)**, the Trust's sites were 4th and 5th best in the country for standardised mortality. It was agreed that the ICNARC data should be circulated to Committee members
  - A service improvement had been made to reduce the mean **waiting time for Lower limb Ultrasound scans**
- The summary report from the **Patient Experience Committee**, 16/06/16, was noted
- The Medical Director submitted a **"Review of clinical outcomes" report**, and stated that although there had been concerns, the Trust had responded well. The same report has also been submitted to the Trust Board in July
- The General Manager for Cancer and Haematology reported on the **outcome of the Cancer Summit meeting held in June 2016** (this was an action from the Trust Board in April). It was

noted that the Summit had been well-attended, and waiting time breaches had been reviewed against the new Cancer Access Policy. It was acknowledged that a number of operational issues needed to be addressed to achieve recovery, but assurance was given that such achievement would occur. It was agreed that a report on the latest situation regarding waiting time target performance should be submitted to the 'main' Quality Committee in Nov. 2016

- The Matron for Critical Care Outreach attended to present the **Critical Care Outreach Team Annual Report 2015/16** (this was an action from the Quality Committee 'deep dive' meeting into Critical Care in April 2016). The comprehensive report provided details of the work of the Team since its formation in October 2015, but the difficulty in providing strong evidence for the effectiveness of the Team was acknowledged. The Medical Director however rightly highlighted that the work undertaken by Professor Sir Bruce Keogh regarding mortality in several NHS Trusts had emphasised the importance of having a Critical Care Outreach service.
- An update on **Serious Incidents** (SIs) was given, and queries were raised regarding some of the cases
- The final report of the **External Audit of Quality Accounts 2015/16** was received, which gave an unqualified conclusion
- The unapproved minutes of the **Quality Committee 'deep dive' meeting**, 13/06/16 were noted
- The **Complaints Annual Report 2015/16** was reviewed, which included the following points:
  - The rate of complaints at the Trust remained below the national mean, but the Health & Social Care Information Centre (HSCIC) had changed its reporting process, so that a single complaint, which may have 3 elements, required each element to be counted separately (which accounted for the increase shown in the report)
  - A complaint that had received national media attention in 2014 had not been upheld, following review by the Parliamentary and Health Service Ombudsman
  - Any Department was now able to upload compliments via the Intranet
- The **Safeguarding Children Annual Report, 2015/16** was reviewed, which included the following points:
  - Much work had been undertaken regarding the sexual exploitation of children, as well as Female Genital Mutilation (FGM), which was subject to national focus
  - The ability to 'flag' children with child protection plans in place, regardless of where they were cared for across the country, was the subject of recent efforts, which involved the Trust's Director of Health Informatics
  - The 'Coping with Crying' education initiative would be implemented further
  - Compliance with Level 1 and 2 training was very good, but compliance with Level 3 training had been challenging, and was currently at 82.1%. However, this was considered to be good, given that the training was not mandatory. The Trust had not been able to achieve the intended 85% despite a series of actions being taken, but the Chief Nurse was confident this could be achieved
  - There had been no Serious Case Reviews occurring at the Trust

1. The Committee agreed that (in addition to any actions noted above):

- N/A (all actions are listed above)

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

- Under 'Any Other Business', the Chief Nurse from West Kent Clinical Commissioning Group (CCG) reported that the CCG had raised concerns at the level of Disclosure and Barring Scheme (DBS) checks undertaken at the Trust. In response, it was agreed that the latest situation regarding this matter should be reported to the Trust Board in July 2016

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Appendix 1: Update on Stroke care performance reported to 'main' Quality Cttee on 06/07/16

Maidstone and Tunbridge Wells NHS
NHS Trust

QUALITY COMMITTEE - JULY 2016

7-5	**UPDATE ON STROKE CARE PERFORMANCE**	**CLINICAL DIRECTOR, EMERGENCY AND MEDICAL SERVICES**

The enclosed report provides information on:

- Current stroke performance against national benchmarks
- Actions being taken to maintain and further improve standards

Reason for receipt at the Quality Committee (decision, discussion, information, assurance etc.)
Information and assurance

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing Stroke headlines was requested to replace the full paper. This is the seventh short headline paper to be presented to the Quality Committee.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP). The Trust continues to review its own targets to continue to drive improvements within stroke care, adhere to national standards and drive excellence in stroke care.

2.1 CT scan performed in under an hour:

- Data for scanning in May within 1 hour has continued to be very successful, all be it with a slight reduction with Tunbridge Wells Hospital (TWH) scanning 60.7% within the hour and Maidstone (MH) scanning 54.8%. The national average increased marginally from 47.4% to 48.4% with a SSNAP "A" Level continuing to requiring 48% of patients to be scanned within an hour. Both sites are significantly above this target and sustaining a high performance.
- 12 hour scanning also shows a static position with TWH scanning 96.4% within 12 hours and MH remaining consistent at 95.2%. National average has also marginally increased to 92.6%, with a Level A consisting of 95% of patients being scanned within 12 hours. Both sites have shown they are performing within the upper quartile for this target.
- SSNAP results covering data collected Jan – March 2016 showed that Maidstone continued to achieve a SSNAP Level A, with TWH dropping to a "B" with no clear cause, yet still a commendable outcome.

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- May data indicates that there was a slight reduction in thrombolysed patients at 7% compared to April data. Of these patients' thrombolysed at TWH 50% were thrombolysed within 60 minutes. This equated to 1/2 patients.
- At MH a static picture of 11.9% of patients were thrombolysed, which equated to 5 patients, 3 of whom achieved the 60 minute door to needle target, bringing the total to 60% of patient thrombolysed within an hour.
- SSNAP Results covering data from January – March 2016 showed that TWH have achieved a SSNAP Level "C" with Maidstone remaining static at a "D". Previous reports have continued to highlight that improvement within this domain is likely only to be seen by ensuring senior specialists receive the patients at the front door as outlined below within previous reports.
- Ensuring there are highly trained nurses available on the stroke bleep is paramount. Currently there are challenges regarding stroke nurse bleep holders due to the national shortages in nurses, with key individuals requiring further training to perform the role. It is not an option to train newly qualified nurses due to the skills required of the nurses. The higher skilled the nurse and stroke team the quicker the Door to Needle is likely to be, dependent upon complications and contra-indications. The release of a junior Dr from the stroke unit is also shown to be beneficial at Maidstone to attend A&E. Currently this is not in place at TWH due to the lack of availability of an extra junior on ward 22. By implementing this support to the junior nurses and forming a "stroke team" this would also likely help achieve the 4 hour to stroke unit target too (as long as the ring fenced beds are protected).

2.4 Proportion of Patients admitted to the stroke unit within four hours:

- May data within this performance indicator shows that MH admitted 51.2% of stroke patients to the stroke unit within 4 hours, which is a drop from the previous month. TWH achieved 35.7% which is a significant reduction since April's 65.4% and did not achieve the expected significant increase after stroke rehabilitation at Tonbridge cottage returned to main site at the end of March. This target is still heavily reliant on having a stroke ring fenced bed, ideally 2 for the best chance of achieving best practice tariff. It would also benefit the stroke pathway to allow the senior team on ASU to have control of ward 22 beds, so that they can move the patients from ASU to ward 22 and enables ring fenced beds to be freed on ASU. If beds on ward 22 are filled directly then there is little/no capacity for movement from ASU. The extra advantage would be for the allocation of an extra junior for Ward 22 to be released to attend A&E with the stroke nurse to mirror Maidstone's pathway and aid in achieving this target.
- SSNAP data for January - March 2016 resulted in the expected E level for TWH, with Maidstone remaining stable at a Level C.

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from May indicates specialist assessments were completed within 24 hours in 75% of cases at TWH due to 7 day consultant ward rounds and 61.9% at MH. The national average for this indicator is 79.1%. The indicator is heavily reliant upon a 7 day consultant service.

2.6: Current 80/90 Performance

The 80/90 data for the period 15/16 ended with a final YTD of 81.4% The new year 16/17 commencing April 2016 has reduced to current performance of 80.2%. However, this is expected to increase due to an anomaly in the data noted from the repatriation of patients in March 2016. If measures are put in 0place to achieve the 4 hour target, then the 80/90 should follow as long as they are not removed from the stroke unit.

2.7: CQUIN achievement for 15-16

- ***The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS). A working party has been formed to identify steps to assist in achieving the required outcome***.

3. Conclusion

Data has generally showed some improvements and stable performance. Work continues locally with site specific action plans and meetings taking place to improve performance and drive up standards of care. The Kent Stroke Review continues to progress, with both nursing and medical clinical leads in addition to a strategic representative attending the Clinical Reference group to represent the Trust. The Programme board have officially removed a 5 site option from the table and have asked the Clinical reference group to start modelling work on a 3 site option across Kent, including how this may be achieved, whether a step change is needed, while keeping 4 sites on the table as a potential option. The Lead stroke nurse and medical stroke lead are likely to hold meetings to inform staff as the programme director has asked that the information is dealt with sensitively.

Below is an update of Kent's SSNAP results for April – June 2015, July - September 2015, October – December 2015 and more recently January – March 2016 which is encouraging for benchmarking. This placed MH with a SSNAP Level B and the second highest performing, with TWH improving scoring to almost achieve a SSNAP "C" rating.

April – June 2015

- Queen Elizabeth SSNAP Level C (64.1 points)
- Maidstone SSNAP Level C (63.7 points)
- Darent Valley SSNAP Level C (62.3 points)
- William Harvey SSNAP Level C (60.8 points)
- TWH SSNAP Level D (57.9 points)

- Kent and Canterbury SSNAP Level D (47 points)
- Medway Maritime SSNAP Level D (43.7 points0

July – September 2015

- William Harvey SSNAP Level B (70.3 points)
- Queen Elizabeth SSNAP Level C (68.4 points)
- Maidstone SSNAP Level C (63.7 points)
- TWH SSNAP Level D (58.9 points)
- Darent Valley SSNAP Level D (57 points)
- Kent and Canterbury SSNAP Level D (55.6 points)
- Medway Maritime SSNAP Level D (46.5 point)

October – December 2015

- Queen Elizabeth Hospital SSNAP Level A (86 points)
- Maidstone Hospital SSNAP Level B (71 points)
- William Harvey Hospital SSNAP Level D (59.8 points)
- Kent and Canterbury Hospital SSNAP Level D (50.4 points)
- Tunbridge Wells Hospital SSNAP Level D (50.3 points)
- Medway Maritime Hospital SSNAP Level D (46.5 points)
- Darent Valley Hospital SSNAP Level D (37.6 points)

January – March 2016

- Queen Elizabeth Hospital SSNAP Level A (88 points)
- Maidstone Hospital SSNAP Level B (75 points)
- William Harvey Hospital SSNAP Level B (70 points)
- Tunbridge Wells Hospital SSNAP Level D (58.9)
- Kent and Canterbury Hospital SSNAP Level D (47.7 points)
- Medway Maritime Hospital SSNAP Level D (47.5)
- Darent Valley Hospital SSNAP Level D (41.5 points)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2016

7-18 Summary of the Trust Management Executive (TME) meeting, 13/07 Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Director of Infection Prevention and Control reported that there had been an in-year increase in cases of *C. difficile* within the Trust (11 cases in the year to date, against 18 for the full year, 2015/16), and called for robust implementation of infection control precautions and for all to play their part in challenging poor practice.
- The key issues highlighted via the **reports from the Clinical Directors (CD)** were as follows:
  - Staffing was again reported to be a concern for a number of Directorates
  - Trauma and Orthopaedics – It was reported that the Virtual Fracture Clinics (VFC) initiative had launched and should reduce pressure on fracture clinics. Recruitment was under way for: a new General Manager; an Assistant General Manager and 4 Physician Associates (PAs). Most elective work on 12/07/16 had been cancelled due to bed capacity. Completion of Electronic Discharge Notices (EDNs) remained an issue. It was hoped the appointment of PAs would improve this. EDN status would be included as part of the Length of Stay update to TME in September.
  - Women's and Sexual Health – Community births continued to increase (with birth centre and homebirths now at 16%). This was viewed as positive, but as having cost implications over time. There was discussion about surgery backlogs and the management of CEPOD / Emergency Surgery lists, which was to be resolved out of meeting. It was agreed to aim to increase Obs and Gynae consultant hours on the labour ward over the next 3 months, with associated consideration of the impact on anaesthetist cover.
  - Cancer and Haematology –There were continuing issues with Haematology clinic capacity and staffing. This had partly been addressed by staff grade support, but was likely to continue until August. Potential for a part-funded mobile chemo facility was being explored. A response and action plans had been agreed following a Peer Review for CUP and Anal MDM, which had raised serious concerns on certain issues.
  - Children's Services – There was an issue with inpatient bed capacity; the Woodlands Business Plan was awaiting approval. EDNs remained a challenge, but the backlog had been cleared and consultants were taking responsibility for the process. Action plans were in place to address high DNA levels and low new patient income. Workforce issues were in hand.
  - Critical Care – There was a continuing problem with theatre staffing, especially at TWH, but recruitment and retention work was underway to mitigate this and other areas of pressure. A new risk (health and safety) had been identified relating to Endoscopy Room 1, which would be addressed at programme board level. Delayed discharges from ITU remained a challenge, with potential cost implications re CQUIN targets. There was discussion about the financial implications of the current withdrawal of purple laparoscopic ports and it was agreed to address this as a cross-directorate issue. Workforce issues were in hand.
  - Diagnostics and Pharmacy – Staffing levels continued to impact histopathology turnaround times and there was also a substantial biopsy work load. Raliat Onatade (RO) had joined the Trust as Chief Pharmacist and had been tasked with reviewing the results of the recent Oncology Pharmacy QA inspection. Warning was given of up to 4 days of MRI maintenance downtime at MH from 25/07/16. More slots had been made available at TWH to mitigate detriment to patients. The results of a recent cervical screening peer review had been very positive. Plans to make MH the centre for primary HPV screening would require planning.
  - Acute and Emergency – ED attendances were very high across both sites (up 6% on 2015/16). This, combined with a high medical and nursing vacancy rate and considerable Datix workload, created a considerable challenge for the directorate. It was agreed that support was needed from across specialisms to alleviate these issues. Work continued to address high sickness and vacancy levels.

- Specialist Medicine - Turnover was above plan and, although some key vacancies had been filled, there was particular concern about Respiratory Medical capacity. Plans were in place to address this, including targeted recruitment.
- Surgery – Urology Pathways were currently under review and the appointment of a new urology consultant had been confirmed. Performance against the 62 day wait cancer target remained a challenge – following June's repeat Cancer Summit, the Trust was expected to achieve its trajectory by September. The directorate was contesting a claim by FY1s for uplift payments on the basis of weak evidence of non-compliance by the Trust.
- Head and Neck – This was the first Head and Neck report. Challenges with recruitment in certain areas were reported, along with some teething problems with E-Notes.

- The **performance for month 3**, 2016/17 was reported. Length of stay was noted as a sustained key issue. It was also noted that the Trust was not meeting the four hour access to a stroke bed due to lack of bed capacity. On the subject of Workforce, it was reported that the Trust had a clear mandate to implement the new Junior Doctor contract over a period of 18 months from November/December 2016. An update was also given on the year to date financial position. A discussion on the (financial) implications of clinical coding ensued, and a proposal to trial and monitor the effects of coding at consultant level, within a chosen speciality for a limited period, mooted.
- The latest position regarding **infection prevention and control**, included a report on the measures taken to address the increase (and suspected outbreak) of *C. difficile* within the Trust (also see Safety Moment) and a first cut update on the prescribing of Tazocin and Meropenem at consultant level.
- The report of the recent meetings of the **Trust Clinical Governance Committee** (a formal sub-committee of TME) was noted. News coverage of Sepsis in the media that day was noted.
- An update on the **Kent and Medway Sustainability and Transformation Plan** (STP) was given
- The Chief Operating Officer gave a verbal report on the scope of the work underpinning **winter & operational resilience plan** preparation, and included an invite to CDs to join a think-tank to finalise the plan to be considered at the TME meeting in September and implemented from 01/10/16.
- A **Project Closure Report on Crowborough Birthing Centre** was noted and the principle of completing an SOC for future development at the site, agreed.
- An update on the **implementation of the SAcP (replacement PAS+)** and details of proposed solutions to current disablers, and the basis for compensation, provided.
- An **Update on Chemotherapy e-prescribing** was reviewed, and a recap of the existing derogations and potential significant penalties given.
- The **Business Cases** that had been recently-approved by Executive exception process were noted.
- The **Business Cases** for: 2 x Ophthalmic Operating Microscopes; Automated Ultraviolet Environment Decontamination System (UVc) and the Capital Backlog Maintenance Programme were reviewed and approved.
- The latest version of the **Trust Risk Register** was reviewed, and further work in process, noted.
- Updates were received on the work of the TME's main **sub-committees** (Informatics Steering Group (incl. the prioritisation of proposed IT projects & an overview of IT system failures); Information Governance Committee; Clinical Operations & Delivery Committee; and the Policy Ratification Committee).
- The Committee reviewed the **Estates and Facilities Annual Report for 2015/16.**

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

Maidstone and Tunbridge Wells NHS
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Trust Board Meeting – July 2016

7-19	Summary report from Finance Committee, 18/07/16	Committee Chairman (Non-Executive Director)

The Finance Committee met on 18th July 2016.

1. **The key matters considered at the meeting were as follows:**
   - The "Safety Moment" noted the intention to make the "Safety Moments" at all Board and sub-committee meetings more structured
   - The month 3 financial performance for 2016/17 was reviewed, and there was considerable discussion about the need to create capacity for elective activity, the reasons for and the ways to minimise the impact of contractual penalties, and staffing levels. An updated financial forecast for the year was also reviewed, but it was noted that the forecast was for illustrative purposes, and would be subject to further review by the Executive Team
   - A report describing the actions taken / being taken to improve the Trust's liquidity position was reviewed, and the Committee was assured by the progress reported
   - The Deputy Director of Finance (Financial Governance) attended to present the Procurement Strategy for 2016-2019, which had been approved by the Trust Management Executive (TME) in June 2016. The Committee commended the Strategy as a document, but emphasised the importance of ensuring the Strategy was implemented in full
   - The Deputy Chief Executive submitted a 3-monthly update report on service tender submissions
   - The Head of the Programme Management Office (PMO) attended to give a presentation on the PMO's work. The presentation was well-received, and it was agreed that it would be beneficial if the "Focus area this year" chart presented was 'RAG' rated, to demonstrate progress in each of the areas listed. It was also agreed that the Chair of the Finance Committee would attend the workshop that was intended to be held by the PMO in early September to capture further ideas and prepare for the Trust's CIP/ESP plans for 2017/18
   - The financial aspects of the Risk Register were reviewed, and it was agreed that the Director of Finance should arrange for an additional risk to be added to the Register, focusing on the Trust's longer-term financial viability
   - A report on the post-project review of the work undertaken by Meridian Productivity Ltd was reviewed, and it was agreed that a further report, on the work being undertaken in relation to Medical productivity, should be submitted to the Finance Committee
   - The quarterly analysis of Consultancy use was received, the latest breaches of the external cap on the Agency staff pay rate were reported, along with the latest uses of the Trust Seal
2. **In addition the agreements referred to above, the Committee agreed that:**
   - The Chief Operating Officer should arrange for the current review of bed configuration/capacity to include consideration of the installation of a mobile/modular Day Case Unit, and then submit the outcome of that review to the 'Part 2' Trust Board meeting in September 2016
   - The Director of Finance would submit the detailed response to the recommendations from the Lord Carter-led operational productivity and performance review to the Trust Board in September 2016
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - It was agreed that the outcome of the current review of bed configuration/capacity should be submitted to the 'Part 2' Trust Board meeting in September 2016
   - It was agreed that the detailed response to the recommendations from the Lord Carter-led operational productivity and performance review should be submitted to the Trust Board in September 2016

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

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