TRUST BOARD MEETING

Formal meeting, which is open to members of the public (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

9.45am – c.12.30pm THURSDAY 27TH SEPTEMBER 2018

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
9-1	To receive apologies for absence	Chair of the Trust Board	Verbal
9-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
9-3	Minutes of the Part 1 meeting of 26th July 2018	Chair of the Trust Board	1
9-4	To note progress with previous actions	Chair of the Trust Board	2
9-5	Safety moment	Chief Nurse / Medical Director	Verbal
9-6	Report from the Chair of the Trust Board	Chair of the Trust Board	3
9-7	Report from the Chief Executive	Chief Executive	4
	Staff experience		
9-8	Apprenticeships	Work Experience and Apprenticeship Co-ordinator / Sr Nurse (Practice Development)	Verbal
9-9	Integrated Performance Report for August 2018 ▪ Effectiveness / Responsiveness (incl. performance on the Referral to Treatment (RTT) waiting time targets) ▪ Safe / Effectiveness / Caring (incl. planned and actual ward staffing for June 2018) ▪ Safe / Effectiveness (incl. mortality) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce)	Chief Executive Chief Operating Officer Chief Nurse Medical Director Dir. of Infection Prev. and Control Chief Finance Officer Director of Workforce	5
9-10	Performance on the 62-day Cancer waiting time target	Chief Operating Officer	6
9-11	Update from the Best Care Programme Board	Chief Executive	7
9-12	Review of the Board Assurance Framework 2018/19	Trust Secretary	8
	Quality items		
9-13	Quarterly mortality data	Medical Director	9
	Planning and strategy		
9-14	Review and approval of final proposals for developing a clinically led organisation	Chief Executive	10
	Assurance and policy		
9-15	Responsible Officer's Annual Report 2017/18	Medical Director	11
9-16	Health & Safety Annual Report, 2017/18 (incl. agreement of the 2018/19 programme and Board annual refresher training on Health & Safety, Fire safety, and Moving & Handling)	Chief Operating Officer / Risk and Compliance Manager	12
9-17	Ratification of Health & Safety Policy and Procedure	Chief Operating Officer / Risk and Compliance Manager	13
9-18	Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment	Chief Operating Officer	14
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
9-19	Workforce Committee, 26/07/18 (incl. quarterly report from the Guardian of Safe Working Hours)	Committee Chair	15
9-20	Quality Committee, 07/08/18 & 12/09/18	Committee Chair	16
9-21	Audit and Governance Committee, 08/08/18 (incl. the Annual Audit Letter for 2017/18)	Committee Chair	17
9-22	Finance and Performance Committee, 16/08/18, 30/08/18 (incl. quarterly progress update on Procurement Transformation Plan) and 25/09/18	Committee Chair	18 & 19 (to follow)
9-23	Patient Experience Committee, 05/09/18	Committee Chair	20
9-24	Trust Management Executive (TME), 19/09/18	Committee Chair	21
9-25	**To consider any other business**		
9-26	**To receive any questions from members of the public**		
9-27	To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest	Chair of the Trust Board	Verbal
	Date of next meeting: 25th October 2018, 10am, Pentecost/South Rooms, Academic Centre, Maidstone Hospital		

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 26TH JULY 2018, 10A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Tim Livett	Non-Executive Director	(TL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive	(MS)
In attendance:	Kelly-Ann Cushman	Matron, Trauma and Orthopaedics (for item 7-8)	(KC)
	Hannah Ferris	Deputy Director of Finance (Financial Performance)	(HF)
	Neil Griffiths	Associate Non-Executive Director	(NG)
	Simon Hart	Director of Workforce	(SH)
	Sharon Hayes	Junior Sister, Orthopaedics (for item 7-8)	(Sha)
	Alison Jupp	Named Nurse Safeguarding Children (for items 7-12 and 7-13)	(AJ)
	Sara Mumford	Director of Infection Prevention and Control (from item 7-6)	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Joanna Woodman	Patient of the Trust (for item 7-8)	(JW)
Observing:	Chhaya Patankar	Consultant, Paediatrics	(CP)
	Sarah Turner	Interim Associate Director of Operations, Surgery and Critical Care	(ST)

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

7-1 To receive apologies for absence

Apologies were received from Nazeya Hussain (NH), Non-Executive Director; and Steve Orpin (SO), Chief Finance Officer (although it was noted that HF was attending in SO's place). It was also noted that Selina Gerard-Sharp (SGS), NExT Director, would not be in attendance.

7-2 To declare interests relevant to agenda items

No interests were declared.

7-3 Minutes of the 'Part 1' meeting of 28th June 2018

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

7-4 To note progress with previous actions

The circulated report (Attachment 2) was noted. The following actions were discussed in detail:

- **5-23 ("Investigate the issues raised by the Chair of the Quality Committee following her attendance at the Emergency Department / Trauma simulation training")**. PM reported that he had recently attended the Trust's Quality Improvement Projects Awards ceremony with MC, and one of the projects featured had focused on the huddle that had been implemented in relation to the peri-arrest team. PM added that the lead for that project had agreed to establish a similar arrangement for the Trauma team, although other ideas were also being considered for the Trauma team, so further work was involved. DH therefore proposed that action 5-23 be

closed, but that a new action be agreed, for PM provide an update on the new plans in 3 months. This was agreed.

Action: Provide an update to the Trust Board in October 2018 on progress with the plans to apply the improvements to the functioning of the peri-arrest team to the Trauma team (Medical Director, October 2018)

- **6-5 ("Arrange for Trust Board Members and representatives from Healthwatch Kent to be included in the consultation for the revised Consent to treatment policy and procedure").** PM confirmed that Healthwatch Kent would be included in the consultation. It was therefore agreed to close the action.

7-5 Safety moment

COB reported that the month's theme was learning disability and highlighted the following points:

- There had been a focus on the provision of accessible information, and in particular on compliance with the Accessible Information Standard
- The use of 'patient passports' had been promoted, to enable staff to understand the specific needs of patients
- Staff had also been reminded about the national Learning Disabilities Mortality Review programme (LeDeR), which included a requirement to notify the deaths of any patient with a learning disability. The Trust had 3 staff who were trained to investigate to LeDeR standards, and such staff were currently investigating 2 incidents at other organisations (as staff would not investigate such incidents at their own Trusts)

7-6 Report from the Chair of the Trust Board

DH referred to Attachment 3 and highlighted the following points:

- He had attended NHS Providers' Governance Conference and there had been some useful discussion regarding the governance across areas, including Sustainability and Transformation Partnerships (STPs). DH and MS had also met with staff from the Kent and Medway STP to discuss governance and it was expected that some changes would be made to the STP Programme Board in the future
- The early feedback arising from the opening of the Marks and Spencer retail outlet at Maidstone Hospital (MH) had been positive. There had been a slight delay with the development due to the need to allay the concerns that the League of Friends of the Maidstone Hospital had in relation to the potential adverse effect on the profit of their own retail outlet
- The report provided details of the outcome of the 2 Advisory Appointments Committee (AAC) panels that had been held. A further panel had been held on 25/07/18 and the outcome would be reported to the next Trust Board meeting

PM noted that Dr Davies, one of the newly appointed Consultant Radiologists, was male, and should not therefore have been listed as "Joanne". The error was acknowledged.

Action: Notify the Medical Staffing team of the gender allocation error for one of the newly appointed Consultant Radiologists that included in the "Report from the Chair of the Trust Board" submitted to the Trust Board on 26/07/18 (Trust Secretary, July 2018)

7-7 Report from the Chief Executive

MS referred to Attachment 4 and highlighted the following points:

- A new Secretary of State for Health and Social Care, Matt Hancock, had been appointed
- MS had sat on the appointment panel for the new Dean of the Kent and Medway Medical School
- Louise Ashley had been confirmed as the new Chief Executive of Dartford and Gravesham NHS Trust (DGT)
- The Chief Executive of Medway NHS Foundation Trust (MFT), Lesley Dwyer, would be returning to Australia in the autumn
- The Trust had made successful appointments to the Chief Operating Officer and Director of Strategy, Planning and Partnerships posts. The former (Sean Briggs) would start on 26/11/18 whilst the latter (Amanjit Jhund) would start on 01/10/18

Patient experience

7-8 A patient's experience of the Trust's services

DH and COB welcomed JW to the meeting and invited her to recount her experiences with the Trust. JW duly reported the following points:

- JW had had undergone a double hip replacement at the Maidstone Orthopaedic Unit (MOU) on 26/07/17 i.e. 1 year ago that day. JW regarded that date as being the start of her getting her life back, as she had been unable to walk before the operation. JW would be forever in the MOU's debt and the staff on the Unit would always be in her heart
- JW had experienced pain in her legs as a child, and she eventually acknowledged that she was destined to have hip replacements, based on the experiences of her mother
- An x-ray in 2016, when JW was 51, revealed that both her hips were in a degenerative state. JW declined her GP's offer of stronger pain medication, as she had severe mobility problems, including being unable to dress herself. JW was therefore referred to the Trust, and she saw Dr Ravikumar on 24/11/16. Dr Ravikumar confirmed that JW required a double hip replacement
- After 3 pre-operative assessments, JW was admitted to the MOU for her operation, which was the first operation JW had ever had
- The outcome from the operation had given JW her life back, and she could not thank the NHS enough. From the moment JW entered the MOU, she experienced warm, caring professionals that completely put her at ease
- JW was the last patient on that day's Theatre list. A Nurse named Zoe Boakes looked after JW fantastically, as did all of the staff on the Unit, including the person who applied JW's surgical stockings
- JW visited the MOU whenever she was at MH to express her gratitude to the staff, which JW felt was important, particularly given the criticism that was often directed towards the NHS
- JW's GP had originally stated that she needed to be aged at least 60 to be eligible for hip replacements, and if JW had to wait until that age, she would have been in a wheelchair. JW in fact had to use a wheelchair in the week before her operation
- JW received a spinal anaesthetic for the procedure, but experienced no bruises from the insertion of the associated cannula
- Dr Ravikumar stated after the operation that he did not know how JW had managed, given the degeneration in JW's hips
- JW was admitted on 26/07/17 and was discharged on 31/07/17, which was as a result of the support provided by the staff (as well as the other patients on the Unit)
- The Therapy Assisted Discharge Service (TADS) team then visited JW at her home
- JW had recently been on holiday, and had been able to lie down on a sunbed for the first time in a long time (something which JW had previously been unable to do)

PM thanked JW for giving her story, and acknowledged the good care she had received. JW added that her aftercare had been fantastic, including Physiotherapy, which she had embraced. PM noted that JW had experienced an 8-month wait for her operation, and asked how she had felt during those 8 months. JW stated that she had initially been told that the operation would take place in 3 to 4 months, but JW's pre-operative assessment showed she had too much Thyroxine in her blood (for which JW had now been given an appointment with an Endocrinologist). JW continued that the wait had been difficult, and she had experienced pain during that time, as well as being given conflicting information as to whether the Thyroxine would delay the operation. JW noted that she was not however angered by the wait, as she understood that other patients had been prioritised. PM acknowledged the disparity between the original estimated date of the operation and the actual date, and the conflicting communication regarding the possible impact of the Thyroxine.

COB then remarked that it was pleasing to hear the personalised approach that JW had encountered, noting that this was regrettably not always achieved with every patient. COB also welcomed hearing about JW's entire care experience, including her post-operative care.

DH thanked JW for attending to give her story.

7-9 Review of the Board Assurance Framework 2018/19 (incl. review of the key objectives)

KR referred to Attachment 5 and drew attention to the following points:

- This was the first time the populated Board Assurance Framework (BAF) had been submitted to the Trust Board in 2018/19
- The 10 key objectives had been approved by the Trust Board in May and June 2018, and summary RAG ratings of the Responsible Director's confidence that the objective would be achieved by the end of 2018/19 were shown on page 2, with detailed information on those ratings contained on page 3 onwards
- The format of the BAF was essentially unchanged from that used in 2017/18, but an additional "Does specific assurance exist on the data quality of the performance information?" section had been added, at the request of the Audit and Governance Committee
- When the key objectives were approved by the Board, it agreed that a review of the objectives should take place at Quarter 1. The Board was therefore asked to consider whether the objectives required amendment, or to confirm they were appropriate as stated
- Objectives 1 to 4 were reviewed at the Finance and Performance Committee on 24/07/18, and a challenge had been made as to whether the RAG rating for objective 2 ("To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway") should be amber. It had also been acknowledged that more external factors could be included in the "What could prevent this objective being achieved?" section

DH noted the review by the Finance and Performance Committee and asked whether the other Trust Board sub-committees undertook equivalent reviews for the relevant key objectives. KR confirmed that no equivalent BAF report was currently considered at the Workforce or Quality Committees but this could be scheduled if the Committee Chairs so wished. SP confirmed this was not necessary for the Workforce Committee as the key objectives were already covered in the Committee's routine business. DH noted that this would also apply to the Quality Committee.

SDu then queried whether the statement on page 3 that "Demand and capacity planning for 2017/18 …" should state "Demand and capacity planning for 2018/19…". KR confirmed that the reference should indeed have been to 2018/19.

DH then noted that all of the key objectives were covered within the Integrated Performance Report for July 2018, so suggested that detailed queries on the objectives be covered under item 7-10. This was agreed.

7-10 Integrated Performance Report for July 2018

MS referred to Attachment 6 and highlighted that he would advise the Trust Board to direct its attention towards performance in relation to the 18-week Referral to Treatment (RTT) target, the 62-day Cancer waiting time target, complaints response times, and finances.

Effectiveness / Responsiveness

AG then highlighted the following points:

- The A&E 4-hour waiting time target performance remained on target. Activity was still above plan but some improvements had been made in relation to Delayed Transfers of Care (DTOCs) and Length of Stay
- A technical issue had emerged from the Allscripts Patient Administration System (PAS) which meant that circa 1950 patients that had been excluded from the Patient Tracking List (PTL), and following validation, 921 patients had been added to the waiting list backlog
- There were some elective capacity issues in Surgery, due to gaps in Middle Grade i.e. Specialty and Associate Specialist (SAS) doctor rotas

DH referred to the "RTT Incomplete pathways" chart on page 6, and asked where the green-coloured bar would be without the aforementioned data issue. AG confirmed there would be a marginal difference.

NG asked whether the patients had been within the system, but just not reported. AG confirmed that the patients were within the PAS, but not on the PTL. EPM asked if the problem was considered to be an isolated issue. AG noted that another 'healthcheck' had been requested from Allscripts. MS added that it had also agreed to develop an RTT forecast, similar to a financial forecast, to enable a better understanding of the risks of delivery.

AG then continued and highlighted the following points:

- The 62-day Cancer waiting time target performance in May (as Cancer performance was reported 1 month behind) remained below trajectory. Several factors, including gaps in Junior Doctor rotas, had resulted in performance moving significantly away from trajectory. AG acknowledged that the impact of both rising referrals and reduced capacity should have been highlighted and addressed earlier, but gave assurance that remedial actions were being put in place to increase capacity, particularly in relation to triage and the diagnostic phase
- A comprehensive Recovery Plan had been developed in response to letters received from the Trust's regulators, and this was included in Attachment 6

AG then described key aspects of the Recovery Plan in detail, drawing attention to the main drivers for the reduced capacity and the measures being put in place to address these. AG added that the Plan incorporated actions already taken following a NHS Intensive Support Team (IST) 'critical friend review' earlier in the year.

SDu stated that the Recovery Plan appeared convincing, but asked what assurance could be given regarding the key issue affecting performance i.e. capacity. SDu also expressed concern that some of the actions could be regarded as aspirational, given the inability to recruit staff, and asked whether purchasing additional capacity was an option. AG replied that the key issue was to understand the future demand, via triage, and incorporating this into a demand profile for the next phase i.e. the diagnostic phase. SDu noted that patients faced an increased waiting time, and asked whether there was an opportunity to advise new patients in specific tumour groups that it may be beneficial if they were not treated at the Trust. AG confirmed that this option had not yet been considered, as the actions taken to date had focused on the relationship with primary care, to see if the demand could be managed by improving triage, and by GPs undertaking more triage. MS acknowledged the validity of SDu's query, and stated that the test for the Trust had to be whether the additional 500 slots needed each month could be identified, via internal means or outsourcing, no later than the end of August 2018. MS added that MFT and DGT were achieving their required 62-day Cancer waiting time target performance, but the Trust and East Kent Hospitals University NHS Foundation Trust (EKHUFT) were not.

MC stated that it was difficult to understand the relationship between the RAG ratings in the "IST Action Plan" within the Recovery Plan and the ratings in the BAF. MS explained that while good progress had been made in implementing the recommendations of the IST these actions did not address the fundamental mismatch between demand and capacity that had emerged since their visit. MS added that the IST would return to the Trust w/c 30/07/18 and would review the Trust's processes, and the management of the PTL. MS continued that he took assurance from the IST's last visit that the Trust understood what the issue was, and that the PTL was managed appropriately, but this question needed to continue to be asked.

NG asked whether the Recovery Plan was stating that the target would be achieved by the end of 2018/19. MS replied that he could not give such assurance, but explained that the focus in August should be on whether the additional diagnostic and treatment slots required each month had been identified, and whether the IST could give assurance on the processes. MS therefore suggested that this be the focus of the review at the Finance and Performance Committee meeting in August 2018. DH concurred.

Action: Arrange for the Finance and Performance Committee meeting in August to focus on providing assurance regarding the 62-day Cancer waiting time target (Trust Secretary / Chief Operating Officer, July 2018 onwards)

COB then highlighted the following points:

- The falls rate was below the target rate. The Trust's participation in NHSI's Patient falls improvement collaborative programme continued, and improvements were expected as a result

- The pressure ulcers rate was also below the target rate. New NHSI guidance had been published which asked for further information to be provided in relation to deep tissue injuries
- Analysis had been undertaken on the patients with dementia experiencing incidents, and this would inform future work
- The Friends and Family Test (FFT) response rate had improved from May, but this may reflect FFT forms from May (for which the response rate had been low) being included in June's data
- The Trust was still struggling to meet the complaints response rate target, but all services other than Women's had been able to achieve their improvement target, although this had not been reflected in the overall rate. Nine complaints had been subject to delays in the month, and the report contained the reasons. COB gave assurance that the Directorates were taking the issue seriously, and she expected an improved response rate to be reported to the September 2018 Trust Board meeting. The complaints categories were also listed in the report on page 45
- Serious Incident (SI) data included some SIs that had been downgraded by West Kent Clinical Commissioning Group, and the reporting of such incidents as SIs was likely to be related to the Trust SI Panel's desire to learn from all incidents

COB then referred to the planned and actual Ward staffing for June 2018 and noted that Ward 20 had been rated as amber on the Quality, Effectiveness & Safety Trigger (QuEST) tool scoring, with a score of 12. COB added that a quality review would be undertaken with the Ward team, to review a range of quality indicators, to determine whether any additional support was required. COB added that work was continuing to improve compliance with the QuEST tool.

Safe / Effectiveness (incl. Mortality)

PM then reported the following points:
- The Trust's Learning Disability Nurse was now involved in the Mortality Review work
- A mortality assurance audit would be carried out in August, which would review 10% of the cases that had been categorised as having "no concerns"
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) were stable

Safe (infection control)

SM then highlighted the following points:
- There had been no cases of MRSA bacteraemia in the month
- There had been 3 cases of Clostridium difficile, but this was not surprising, as cases often increased during hot weather
- The Trust's action plan included 3 projects on gram negative bloodstream infections
- The Infection Prevention and Control Committee had emphasised the need to renew the focus on compliance with 'bare below the elbows' processes
- A recent audit had showed that patients undergoing Endoscopic Retrograde Cholangio-Pancreatography (ERCP) had not received antibiotic prophylaxis, so actions had been taken to address this

Well-Led (finance)

HF then highlighted the following points:
- The plan for the month had been met, although not via the intended means. The plan for the Quarter had therefore also been achieved, so the receipt of Provider Sustainability Fund (PSF) monies for Quarter 1 had been assumed. However, pay was the main issue of concern
- Savings had been £0.1m adverse to plan, and the slippage was again related to pay
- The cash position was satisfactory at present, but this could be problematic later in the year
- There had been no significant changes within the capital programme
- The delivery of the overall plan was still forecast, but there were £11.3m of risks to delivery (although there were mitigations)

DH commended the achievement of the financial plan for the first Quarter, but emphasised that the plans for the other Quarters would be far more challenging to achieve. MS highlighted that the budgets for 2018/19 had essentially been set according to expenditure in 2017/18, adding that it was important to understand that the budgets had been set at a reasonable level.

SP asked whether the STP-related pay issues were concerned with changes in hours, or in pay rate, and asked how much of the planned changes relied on collective efforts across the STP. SH confirmed the STP-related issue concerned pay rate, and explained that it was proving very difficult to reduce the rates because Agencies were being firm on the rates they charged. SH added that the focus had therefore shifted to other means of reducing cost. SP asked whether other Trusts were experiencing similar issues. SH confirmed this was the case. DH added that the situation had confirmed that a sellers' market was in place, and it was not yet clear whether the 1500 doctors who had been unable to be appointed because of the restriction on the recruitment of Medical and Nursing staff through the Tier 2 visa route would make a difference to the situation.

Well-led (workforce)

SH then reported the following points:
- Sickness absence had improved but this was to be expected during the summer
- The turnover rate had continued its downward trend
- The challenges to reduce vacancies remained, which affected the use of temporary staff
- Mandatory training remained satisfactory. The Trust's new e-learning system would be introduced in September, and would enable experts such as AJ to develop e-learning courses
- The staff FFT score was below that seen in the previous year, so further work was required (which would be considered at the Workforce Committee) to consider whether this related to the low response rate, or was indicative of a wider issue

7-11 Update from the Best Care Programme Board

MS referred to Attachment 7 and highlighted the following points:
- The last Best Care Programme Board meeting had focused on Best Patient Flow
- It had been good to establish the Best Care programme, but the expectations for delivery increased markedly over the next Quarter, so all workstreams needed to respond to this. In this context, a number of significant risks had been identified, and work was taking place with the relevant Senior Responsible Officers (SROs) to address these, which related to the schemes involving Estates and Facilities, patient flow, private patients, the Prime Provide contracts, and the workforce workstream (which had much earlier savings requirements)

DH echoed MS' sentiments, in that it had been beneficial to collate the large number of projects at the Trust in a more systematic way, and this should be commended, but delivery was now the overriding consideration.

Quality Items

7-12 Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)

DH welcomed AJ to the meeting. AJ referred to Attachment 8 and highlighted the following points:
- The Trust made more referrals than any other acute Trust in Kent, but AJ believed the level of referrals was appropriate
- An increasing number of children with mental health issues were being seen, and between 3 and 5 such children were admitted to Hedgehog Ward each week
- AJ was concerned that 16 and 17 year old patients were being treated in non-paediatric areas, as staff in those areas were not trained at Level 3 child safeguarding. A plan was in place to train more staff, although the training was only delivered by AJ, who had limited capacity
- AJ's role involved dealing with the effects of gang activity in West Kent, and of exploitation through 'county lines', and AJ worked closely with partner agencies on such issues
- 5 females had disclosed allegations of sexual assault in recent months, which was a very large number. AJ was again working with partner agencies to support the individuals
- The Child Protection - Information System, which was an initiative between Local Authorities and NHS Digital, went 'live' earlier in the year

COB added that safeguarding training continued to be discussed at the Safeguarding Committee. AJ elaborated that Level 3 training rates remained at circa 71% and work continued with staff to try

and increase the rate. AJ added that the Trust had the best level of training compliance in Kent, but this was still not at the required 85% level. DH asked whether online training was available. AJ confirmed that the Trust's new training system would enable Level 3 training to be provided online, but she was not yet convinced that such training would be sufficiently robust.

MS then noted that AJ had reported that the Care Quality Commission (CQC) recommendations regarding safeguarding children training would not be addressed until later in 2018, so asked whether the plans could be revisited, as the date AJ had referenced would be over a year since the CQC had inspected. AJ acknowledged the issue was a priority, and confirmed she was conscious that the CQC inspection had taken place in December 2017. MS asked what the position would be at the end of October 2018. AJ replied that a pragmatic approach would be taken, and COB added that some complexity was involved in determining exactly who needed to be trained. MS asked for confirmation that by the end of October 2018, every clinical area would have someone who had received Level 3 child safeguarding training, and that progress would have been made regarding the overall compliance with Level 3 training. AJ confirmed this was correct, but explained that in order to achieve the 85% target she would need to spend all her time delivering training, so a pragmatic approach had been taken.

DH asked for further comment about the patients who were aged 16 and 17. AJ confirmed that the Children Act 1989 defined children as those aged up to 18, but there was a requirement for 16 and 17 year old patients to be treated in an age-appropriate area, and there were insufficient beds on Hedgehog Ward to accommodate all the Trust's 16 and 17 year old patients, whilst there was no dedicated adolescent Ward. DH asked whether the absence of an adolescent Ward was a clinical issue or buildings-related issue. AJ replied that it was mainly a buildings-related issue. COB confirmed that such a Ward was aspirational and AJ confirmed that an adolescent unit would treat patients aged 14 to 17.

COB then concluded by thanking AJ for her work, drawing particular attention to the good working relationship that AJ had developed with the Local Authority.

7-13 Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)

COB referred to Attachment 9 and highlighted the following points:

- Karen Davies (KD), the Trust's Matron, Safeguarding Adults, would have attended the meeting, but was unable to do so
- The Trust reported a lot of Kent Adult Safeguarding Alert Forms (KASAFs) and there had been consideration as to whether the Trust's threshold for reporting was appropriate. However, this had been confirmed
- A number of alleged assaults had been made, which had been thoroughly investigated, and the learning had been included in the Annual Report
- Training was a large aspect of the KD's work
- KD and AJ worked closely together on the Prevent programme, the application of the Mental Capacity Act (MCA) for 16 and 17 year old patients, and domestic violence issues
- The Report contained the priorities for 2018/19 which aligned with Best Care and Best Quality programme. KD was also working with one of Named Doctors, but more Medical support was required
- The Report acknowledged the further work required to strengthen the Safeguarding Adults team, which currently comprised KD and a Learning Disability Hospital Liaison Nurse

PM added that the consent to treatment process was very robust, and involved multiple partners within and outside the Trust, but there was still much to do to support clinicians in understanding MCA-related issues. PM therefore supported the strengthening of the Safeguarding Adults team.

COB noted PM's comments regarding the MCA, and added that the fact that the training target for MCA had been met, but challenges with the application of the issues by clinical staff remained, illustrated that the provision of training did not always guarantee staff's adherence to the required practice.

MC then noted that COB had alluded to the seriousness of the alleged assaults, but asked whether there had been acknowledgement of the pressure felt by staff, if this had been a factor in the incidents, and the need to support staff to prevent future occurrences. COB gave assurance that staff involved in such incidents had been supported, and debriefing sessions had been held to learn lessons. COB also noted that the Local Authority lead had been involved in the investigation of SIs and KASAFs.

Assurance and policy

7-14 Estates and Facilities Annual Report 2017/18

AG referred to Attachment 10 and highlighted the following points:
- Page 4 of 31 showed the "Our year in numbers", which gave a good summary
- The report also provided details of the Premises Assurance Model, and no issues had been identified as "inadequate"
- Over 12,000 LED lights had been installed, which led to savings of circa £400k
- The outcome of the fire compliance audit was still awaited

SP commended the report and referred to the "Model Hospital" section on page 15, noting that this related to the discussions that had been taking place in recent 'Part 2' Trust Board meetings. SP asked if the issues could be discussed further at the 'Part 2' meeting scheduled for later that day. DH confirmed this would be acceptable.

EPM then asked about financial performance. AG noted that the Directorate's financial plan included the disposal of residential accommodation that had not occurred, which had created a pressure, but overall, the performance was as expected.

DH asked for confirmation that the majority of backlog maintenance was at MH, given the PFI arrangements at Tunbridge Wells Hospital. AG confirmed this was the case.

7-15 Bribery Act - Statement of Support

HF referred to Attachment 11 and reported that the Trust Board was being asked to give a one-time commitment, which would then be used to cascade the key message to staff.

The Trust Board agreed to support the Bribery Act - Statement of Support as circulated.

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

7-16 Quality Committee, 04/07/18

SP referred to Attachment 12 and confirmed there was nothing he particularly wanted to highlight.

7-17 Patient Experience Committee, 05/07/18 (incl. proposed amendment to Terms of Reference)

MC referred to Attachment 13 and reported the following points:
- A longstanding member of the Committee, Heather Thompson, from the seAp advocacy service, had recently passed away. The Trust had been represented at the service
- The Deputy Chief Nurse, John Kennedy, had been thanked for his contribution, given his impending retirement
- The Committee's Terms of Reference had been reviewed and some changes had been agreed, including the quorum requirements
- Committee members had been positive about the intention to change the way the Committee operated

The updated Terms of Reference for the Patient Experience Committee were approved as circulated.

7-18 Trust Management Executive (TME), 18/07/18

MS referred to Attachment 14 and invited questions or comments. None were received.

7-19 Finance and Performance Committee, 24/07/18

TL referred to Attachment 15 and highlighted that there had been a significant focus on financial and operational performance, and a presentation had been received on the revised IT Strategy, for which it was noted that further work was required. KR added that revised Terms of Reference for the Committee had been agreed and these had been submitted for approval within Attachment 15.

The revised Terms of Reference for the Finance and Performance Committee were approved as submitted.

7-20 To consider any other business

SDu reported that she had recently needed to attend the Emergency Department as a patient, and had been treated extremely well and had a successful follow up, but when SDu was told that she was being transferred to the Clinical Decisions Unit (CDU), this caused anxiety as she initially thought this meant she would be admitted, which turned out not to be the case. SDu therefore queried whether it was possible to adapt the process, to prevent moving patients who were at risk of breaching the 4-hour waiting time target to the CDU, particularly given the state of the CDU's fabric. DH proposed that the issues raised by SDu be considered outside the meeting. This was agreed.

Action: Consider a response to the issues raised by the Chair of the Quality Committee at the Trust Board on 26/07/18 in relation to the Clinical Decisions Unit (CDU) (Chief Operating Officer, July 2018 onwards)

SDu also noted that she had been asked to complete the FFT twice, and she had been surprised to see that the Trust had a paper-based FFT system, as she understood that other organisations, including DGT, had tablet-based systems. SDu therefore asked whether it was possible to introduce a tablet-based system at the Trust. COB replied that a non-paper-based solution had been explored, but had been a challenge to implement. MS stated that he had not appreciated that that the Trust's FFT process was paper-based, and proposed that the issue be reconsidered. This was agreed.

Action: Reconsider the feasibility of introducing a tablet-based Friends and Family Test system at the Trust (Chief Nurse, July 2018 onwards)

7-21 To receive any questions from members of the public

No questions were posed.

7-22 To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
7-20a (July 18)	Consider a response to the issues raised by the Chair of the Quality Committee at the Trust Board on 26/07/18 in relation to the Clinical Decisions Unit (CDU)	Chief Operating Officer	July 2018 onwards	A verbal update will be given at the Trust Board meeting on 27/09/18
7-20b (July 18)	Reconsider the feasibility of introducing a tablet-based Friends and Family Test system at the Trust	Chief Nurse	July 2018 onwards	A verbal update will be given at the Trust Board meeting on 27/09/18

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-10 (July 18)	Arrange for the Finance and Performance Committee meeting in August to focus on providing assurance regarding the 62-day Cancer waiting time target	Trust Secretary / Chief Operating Officer	July 2018 onwards	An extraordinary Finance and Performance Committee meeting was held on 16/08/18 that focused on performance on the 62-day Cancer waiting time, Referral to Treatment (RTT), and A&E 4-hour waiting time targets

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
7-4 (July 18)	Provide an update to the Trust Board in October 2018 on progress with the plans to apply the improvements to the functioning of the peri-arrest team to the Trauma team	Medical Director	October 2018	An update will be given to the October 2018 Trust Board (as part of the 'actions log')

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

Trust Board meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-6 Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant Appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and 2 other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

New substantive Consultant appointments				
Start date	**Title**	**First name**	**Surname**	**Department**
27/08/2018	Dr	Natalie	Williams (Heeney – preferred name)	Haematology
TBC	Dr	Ying Yiing	Lou	Obs & Gynae
TBC	Dr	Iain	Mckay-Davies	ENT
30/07/2018	Dr	Nisha	Krishnan	Obs & Gynae

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

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

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

Trust Board meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-7 Report from the Chief Executive Chief Executive

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

1. It has been officially recommended that one of three new Hyper Acute Stroke Units (HASUs) planned for Kent and Medway is based at Maidstone Hospital as part of proposals to improve outcomes for stroke patients throughout the county.

   This is excellent news for MTW. It is a vote of confidence in our highly skilled stroke clinical teams, and in our ability to deliver state of the art services.

   In order to achieve the excellent outcomes we would all want for our loved ones 24/7, stroke teams will be drawn together from across Kent and Medway in three HASUs at Darent Valley, Maidstone and William Harvey hospitals.

   The scale of the development is such that we will effectively be creating a new service on the Maidstone Hospital site, building on the best of both our current units and hopefully welcoming colleagues from Medway too.

   This is a positive opportunity for MTW, and the NHS as a whole in Kent and Medway, to jointly develop clinically-led hyper acute stroke services for patients, that will enhance their experience and wellbeing for years to come.

   The recommendation to develop the HASUs requires final ratification at a public meeting of the Joint Committee of the Clinical Commissioning Groups on 10th January 2019, following approval of a Decision Making Business Case by NHSE and Joint Health Overview and Scrutiny Committee during December.

2. MTW remains absolutely focused on improving its cancer performance, and meeting national waiting time standards for more of its patients as quickly as possible. We recognise that longer waiting times for some of our patients to receive an all-clear diagnosis, or to start treatment, is unacceptable and this is being robustly addressed.

   A combination of a significant increase in the number of referrals and staffing challenges has, unfortunately, contributed to our move away from delivering the national standard.

   We are seeing over 20% more suspected cancer referrals now than this time last year. While the majority of these referrals are not resulting in a cancer diagnosis, we understand the need to both inform people that they do not have cancer, and treat those that do, in a timely way.

   We have implemented an action plan to improve our patient experience. We have increased the number of outpatient clinics, endoscopy sessions and radiology, CT and MRI slots, as well as speeding up the recruitment process for specialist doctors and clinical staff, to improve our performance, and to make sure our patients have access to the high quality treatment and care they need.

   As a consequence of these moves over 100 more patients a week are now being seen and are completing their main diagnostic test. Demand is such, however, that we need to, and will do, even more over the coming weeks and months to positively address this issue.

   We are also reviewing and monitoring, daily, each patient who has been on the cancer pathway for 40 or more days to ensure they are referred as quickly as possible for the next stage of their care and that they receive the most appropriate follow-up during this period.

   The conversations that our clinical leads are having are positive and are generating opportunities that can potentially set standards for other Trusts to follow in the future. This is encouraging and reflective of the clinically-led organisation we are creating at MTW.

3. MTW's commitment to cancer care is long, broad and extending all the time. I am pleased

to report that we have further strengthened our partnership working with Macmillan Cancer Support. Macmillan is `adopting' our treatment therapeutic radiographers as we become ever more integrated with this important organisation.

The move will open up further training opportunities for our staff and give them access to networks of like-minded professionals who are committed to continually improving the health and wellbeing of people who are living with cancer. Our staff will wear Macmillan badges with pride as a symbol of their commitment to excellence in cancer care.

We have also welcomed the National Clinical Director for Cancer, National Director for Cancer and National Cancer Programme Director to MTW to see first-hand our facilities and new linear accelerators. We have also highlighted the advanced roles we have developed in radiotherapy and the bespoke local training programmes that have been created for radiographers and physicists.

4. MTW is continuing to ready itself for the winter months. It is incredibly important for all of our patients that we are in the best possible position to keep our hospitals flowing when we experience peaks in demand.

We are commissioning additional care in the community to help more of our patients continue their recuperation at home once they are medically fit to leave our hospitals. This is good for patients who no longer need acute care, because it will support them at home where they want to be, and at the same time help us to see more of our patients who require emergency admission in a timely way.

To maintain safe services throughout the winter, and the best overall experience for our patients as a whole, it is also vitally important that our hospitals work seamlessly as a single point of care.

We have the benefit of two acute hospitals with excellent facilities. We can keep our patients safe again this winter by ensuring we share these facilities wherever they exist. For some patients this might mean having different stages of their care provided by both of our hospitals.

Part of our challenge this winter is to get much better at using all of our finite resources. To have empty hospital beds on one site, for instance, and patients waiting at another site for admission, is not good sense. While we must ensure that our patients continue to receive the specialist care they need in an emergency, in a timely way, we can achieve this more consistently for all of our admitted patients this winter, by moving some patients between our hospitals, following their acute treatment and step down in their care.

5. While the Kent and Medway Sustainability and Transformation Partnership (STP) has mainly focused this month on the acute stroke services consultation option appraisal, I am pleased to announce that Professor Chris Holland has been appointed as the Foundation Dean of the Kent & Medway Medical School. I can also report my own appointment as Chair of the STP Productivity Workstream. The STP is also going to appoint an independent Chairperson to work with Non-Executive Directors from across Kent and Medway.

I have asked our new Director of Strategy, Planning and Partnerships to provide an overview of the Trust's 2019/20 business planning process at the next Trust Board meeting and to explain how this is integrated with the long term plan for the NHS, the latter of which is outlined in the following briefing from NHSProviders.

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

on the day BRIEFING

NHS Providers

Developing the long term plan for the NHS

Today NHS England and NHS Improvement have published a document on developing the long term plan for the NHS. This briefing summarises the document; outlines what we know about the plan; our view on the process and development of the plan; and how we plan to engage in its development.

As ever, we welcome member thoughts or input on this and anything in the wider briefing. Please contact Chris Hopson, Chief Executive (chris.hopson@nhsproviders.org) or Amber Jabbal, Head of Policy (amber.jabbal@nhsproviders.org) with any feedback.

Overview of the five and ten year plans

In March, the Prime Minister committed to a "sustainable long term plan" for the NHS backed by "a multiyear funding settlement". She expanded on this in June, confirming a new funding settlement for the NHS of an average of 3.4% real terms increase over the next five years. Mrs May also tasked the NHS with producing a 10 year plan in return for the increase in funding, setting out how the service intends to deliver major improvements. The timing of the plan's publication is expected to coincide with the autumn Budget, where the funding uplift, and how it will be funded, will be formally set out. Further detail is set out in the next section.

The government's priorities and tests for the plan

The Prime Minister set a number of priorities for the 10 year plan. They include:

- "getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care
- transforming cancer care so that patient outcomes move towards the very best in Europe
- better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- better integration of health and social care, so that care does not suffer when patients are moved between systems
- focusing on the prevention of ill-health, so people live longer, healthier lives"

The government also set the NHS five financial tests to show how the service will put the service onto a more sustainable footing. Those tests are:

1. "improving productivity and efficiency
2. eliminating provider deficits
3. reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live
4. getting much better at managing demand effectively
5. making better use of capital investment"

The former and current secretaries of state for health and social care, as well as Simon Stevens and Ian Dalton, have also set out their priorities for the plan. The new Secretary of State implied to the Health and Care Select Committee that he would be formally consulting on his priorities in September. These can all be found in the appendix of this briefing. There is an interesting task to reconcile all these different priorities and ensure they fit within a financial envelope that barely keeps up with cost and demand pressures. It will also be interesting to see how much the new Secretary of State wants to be involved in the detailed creation of the plan.

Delivery plan

A delivery plan to underpin the first few years of the 10 year strategic plan, is also being developed. It is not clear how separate this will be from the 10 year plan and how it will relate to the planning guidance that we believe the arms lengths bodies currently want to publish in late September. This September timeline would echo the 2017/18 planning guidance timetable which gave trusts the chance to complete draft plans before Christmas, rather than the 2018/19 timetable where trusts were still finalising plans in July.

NHS Improvement chief executive, Ian Dalton, in his first interview with the *Health Service Journal* identified a number of issues that he wanted to address through this planning guidance/delivery plan including include:

- Productivity levels – providers are likely to be expected to achieve more than last year, with Mr Dalton highlighting GIRFT as well as "transformation projects, and further cuts to agency, procurement, back office and corporate costs" as further savings opportunities
- Sector deficit – the national bodies may have to consider writing off some of the trust sector's debts
- Control totals – these will be replaced with a new financial architecture from April 2019, with Mr Dalton commenting that the current approach to control totals encourages non-recurrent savings rather than a focus on underlying financial sustainability
- Fines and sanctions – these are likely to be reviewed (including the marginal rate for emergency care)
- Tariff – the gap between tariff prices and costs of provision needs to be addressed
- Provider Sustainability Fund – will be reviewed as "the distributional effects of that have again not necessarily been equal across the system"

Simon Stevens, in his interview with the *Health Service Journal* also said that they are planning to publish a plan covering three financial years from 2019/20 to 2021/22 in September, for this to be confirmed in November. This would include three years of firm clinical commissioning group allocations and two years indicatively. He also suggested that there would be a "wholesale shift" in NHS funding rules, including the payment system, and the end of "sustainability funding".

We would also expect the planning guidance/delivery plan to be clear about detailed sector level demand assumptions, operational performance levels and recovery trajectories and financial expectations. In other

words, on current plans, members are likely to know much of the detail of what they will be required to deliver over the next few years, in September, before the final 10 year plan is published in November.

What do we know about the 10 year plan?

Working groups

The ALB plan to secure wider engagement into the 10 year plan focuses on creating a number of working groups, covering the priorities set out by the government. Each working group is expected to have a lead from an arm's length body (predominantly NHS England or NHS Improvement), and in the majority of cases a provider CEO representative. A number of these working groups and their leads have been confirmed (outlined below, and grouped by themes).

We also expect there to be groups covering key issues such as: financial architecture; transformation, productivity and efficiency; and legislation. We have been told privately that different consultation mechanisms will be used for this work.

Life course programmes

- **Prevention and Personal Responsibility**
  Duncan Selbie, Dr Neil Churchill, Dr Vin Diwaker, Dr Amanda Doyle
- **Healthy Childhood and Maternal Health**
  Sarah-Jane Marsh, Professor Russell Viner, Professor Jacqueline Dunkley-Bent, Dr Matthew Jolly
- **Integrated and Personalised Care for People with Long Term Conditions and the Frail Elderly (including Dementia)**
  Caroline Abrahams, Julian Hartley, Martin Vernon, Matthew Winn

Clinical priorities

- **Cancer**
  Cally Palmer, Lynda Thomas, Paula Head
- **Cardiovascular and respiratory**
  Professor Stephen Powis, Professor Mike Morgan, Simon Gillespie, Juliet Bouverie
- **Learning Disability and Autism**
  Ray James, Dr Jean O'Hara, Rob Webster
- **Mental Health**
  Claire Murdoch, Paul Farmer, Sheena Cumiskey

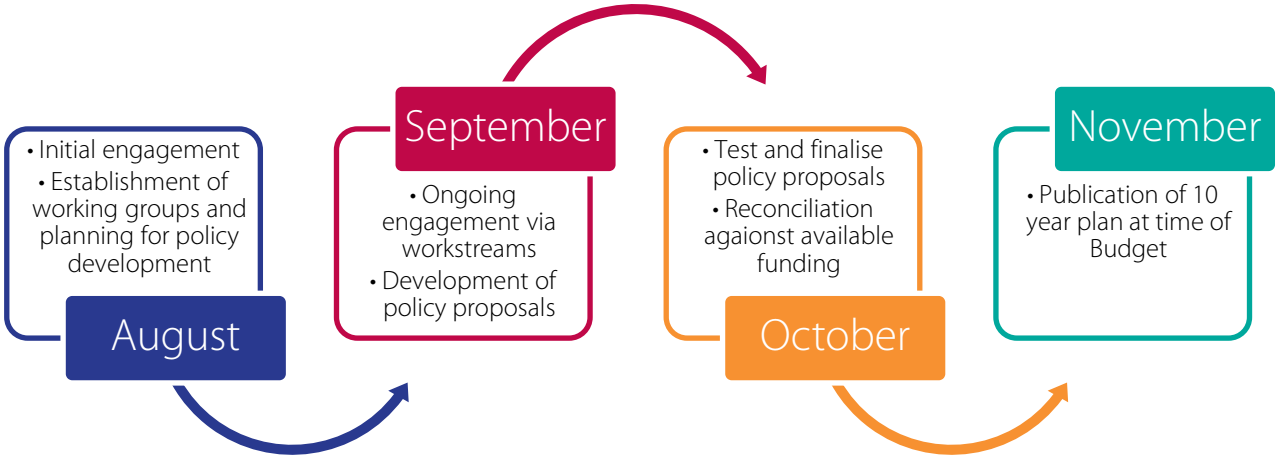
Enablers

- **Workforce, Training and Leadership**
  Dr Ruth May, Professor Ian Cumming, Jim Mackey, Dr Navina Evans
- **Digital and Technology**
  Dr Simon Eccles, Sarah Wilkinson, Steve Dunn, Matthew Swindells
- **Primary Care**
  Dominic Hardy, Dr Amanda Doyle, Dr Nikita Kanani, Professor Helen Stokes-Lampard
- **Research and Innovation**
  Dr Sam Roberts, Professor Tony Young, Roland Sinker, Professor Dame Sue Hill
- **Clinical Review of Standards**
  Professor Stephen Powis, Professor Carrie MacEwan, Imelda Redmond
- **System Architecture**
  Ben Dyson, Ian Dodge, Matthew Swindells
- **Engagement**
  Simon Enright, Sian Jarvis, Imelda Redmond, Rachel Power

Timelines

We expect the timelines to be broadly:

- Structure and themes announced **early August**
- Working groups (aligned to each of the themes – see below for detail) confirmed **over the course of August**, and planning begins
- Engagement takes place **throughout September** – we understand this will include:
    - Bespoke engagement by each of the working groups
    - ALB engagement with the sector, e.g., through regional forums and roundtables
    - Stakeholder engagement, both with the working groups and with the ALB leadership
    - Engagement with staff, patients and the public (likely to take place through STPs)
    - Engagement through NHS Improvement's CEO advisory group
- At the **end of September**, there will be a joint NHS England and NHS Improvement board meeting to discuss the plan
- During **October**, the working groups will refine their outputs and their collective work will be brought together in the plan
- The plan will be published in early **November**
- Following the publication of the plan NHS England and NHS Improvement will establish the NHS Assembly to oversee the delivery of the plan



NHS Providers view

Importance of provider engagement

We welcomed the long term funding settlement when it was announced by the Prime Minister, as a helpful recognition that the NHS needs significantly more money whilst stressing the need to be realistic about what it could buy. This settlement, along with the development of an NHS 10 year plan, offers the potential for a reset moment to get back to a day to day operational and financial task that the vast majority of trusts can actually deliver. It also provides a chance to develop a credible long term plan for improving care for patients and the public that is owned by the sector.

In her announcement the Prime Minister highlighted the importance of the service itself in drawing up the 10 year plan. This suggests an understanding that the plan has more chance of succeeding with meaningful involvement and input from the frontline. Without this, there is a risk that the 10 year plan becomes a lookalike of the *Five Year Forward View* with the provider sector signed up to a delivery task that is unrealistic and which the sector believes is undeliverable, right from the start. We have therefore been arguing that the involvement of the provider sector and NHS Providers, as the membership organisation that formally represents the sector, is crucial. Particularly as representative bodies can reflect the views of groups such as chairs and non-executives who often bring a different perspective.

Provider CEO involvement on working groups

We therefore welcome the involvement of provider sector CEOs on the working groups. It is important, though, that they are seen and act as sector representatives. We will be contacting all the relevant CEOs and offering our help in the following ways:

- Offering to collect member feedback to input into the work of the groups on which they sit
- Offering to test emerging proposals with members
- Offering to act as a formal or informal wider channel of communication with the provider sector.

Wider provider sector engagement

The need for meaningful engagement with the wider sector is also crucial to the successful implementation of the plan. There are plans in place for this wider engagement set out in today's communication. However given that timescales are short, there is a risk that wider engagement beyond the small working groups is tokenistic.

Creating the actual 10 year plan

At present, as outlined above, all the working groups will feed into NHS England and NHS Improvement who will then make the all important trade offs between the work streams and set the detailed priorities. We are currently discussing how to ensure appropriate provider sector involvement in this process as well since this is where the detailed provider sector ask will be finalised. Failure to provide appropriate input and assurance at this point risks a re-run of the flawed *Five Year Forward View* process.

The risks to the provider sector

As outlined above, this process provides a valuable opportunity to reset the frontline delivery task and create an ambitious 10 year plan to improve patient outcomes. But it also carries the following risks for the sector, which we will be seeking to explicitly manage in the process:

- The Government will want to demonstrate that the nation is getting a clear set of extra new benefits for the extra money invested especially if, as we expect, it is partly funded through higher taxes. There is therefore a danger that the plan overcommits the service to new ambitions that can't be afforded or delivered.
- As we pointed out in our recent briefing [link], there is a significant task to recover performance to the existing constitutional standards. There is a risk the plan underestimates the cost and time it will take to deliver this recovery, assuming the current standards or similar are retained.

- Given that the funding settlement effectively only matches current demand and cost increases, there will be pressure to make over optimistic assumptions about demand management and productivity efficiency gains, as happened with the *Five Year Forward View*. For example, we note that in his HSJ interview Ian Dalton argued that the sector should be set a higher productivity and efficiency requirement than the current task.
- The plan will need to carefully balance the need for transformation with day to day operational delivery requirements. There is a risk the plan strikes the wrong balance and underestimates the cost, resource and time taken to deliver the transformation required by the plan.
- The existence of a number of separate work streams seeking to improve outcomes within their area of focus risks creating too large a number of priorities and a set of ambitions that may look deliverable individually but are not deliverable collectively.
- The plan is unable to take proper account of social care, public health and prevention as the budgets for these sit outside the settlement that has been announced.
- The Government refuses to accept the plan and release the extra funding. We think it is unlikely that the government will withhold the funding settlement; however there may be Treasury push back on the plan prior to its publication if it doesn't deliver against the financial tests they have set.

There are also some obvious process risks here including insufficient time and insufficient weight being given to provider views originating from both the provider sector and NHS Improvement.

NHS Providers activity

NHS Providers is engaging in the development of the ten and five year plans at a number of levels:

- We are having private conversations with No10, the DHSC, NHS Improvement and NHS England to ensure that the priorities and process for the plan properly include frontline leaders, including appropriate input into what the provider sector will actually be asked to deliver.
- We will be reaching out to the provider CEOs on each of the working groups to ensure they have the information they need to work effectively on behalf of the provider sector as a whole.
- We will be inputting directly into the policy proposals and development of the plan where appropriate
- We will be inviting NHS England and NHS Improvement to engage with the provider sector at our regular network events.
- We will formally respond to any public consultation on the proposals as well as feed in directly via the working groups and stakeholder meetings.
- We will be regularly communicating with members as the plan is developed and will be seeking your input via email correspondence and roundtables.

We will also be publishing a number of documents, which will include:

- Five key provider sector focussed tests to measure the plan against
- A publication on the productivity and efficiency ask
- Thought leadership on how to address current legislative and regulatory barriers facing the provider sector

Appendix: Priorities of the national NHS leadership

Theresa May, Prime Minister

In the June announcement of increased funding, Mrs May set out her priorities as:

- "Getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care
- Transforming cancer care so that patient outcomes move towards the very best in Europe
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- Better integration of health and social care, so that care does not suffer when patients are moved between systems
- Focusing on the prevention of ill-health, so people live longer, healthier lives"

Matt Hancock, secretary of state for health and social care

In his first speech as secretary of state – delivered in July at West Suffolk Hospital – Matt Hancock said:

- The NHS must reduce and tackle waste, and ensure it "focuses on using this new money to work smarter and more effectively"
- The long-term plan needs to be "nationally agreed, clinically led and locally supported"
- There are three areas where "we must make swift and decisive progress for that plan to be a success": workforce, technology, and prevention

Simon Stevens, NHS England

In an interview with the *HSJ* in July, Simon Stevens set out his priorities as:

- Mental health
- Cancer
- Cardiovascular disease
- Children's services
- Health inequalities

He also highlighted:

- Integration programmes will be as set out in the *Five year forward view*, but accelerated
- Outpatients and community services may be radically repurposed to release funds
- There will be a number of technical changes, such as targets being reviewed and funding mechanisms reformed
- There could be trade offs if those areas not covered by the settlement – education, public health and capital – were not protected
- Social care funding needs to be at a level that people are properly looked after and pressure isn't put on the NHS
- Workforce being integral, with reforms (such as those to cancer care) dependent on changes to the workforce over a 10 year timeframe

Ian Dalton, NHS Improvement

In his August interview with the *HSJ*, Ian Dalton highlighted his views:

- Providers will need to achieve higher levels of productivity than those achieved last year, with further savings opportunities identified as coming from the GIRFT programme, transformation projects, and further cuts to agency, procurement, back office and corporate costs
- National leaders will have to consider writing off some NHS trust debts from the last three years
- The current control total system will be replaced with a new financial architecture from April 2019
- The current fines and sanctions regime, including the marginal rate for emergency care, is likely to be reviewed
- The "significant delta" between the price of the tariff and the actual cost of providing care will need to be addressed
- The Provider Sustainability Fund will be reviewed as the distributional effects of that have again not necessarily been equal across the system
- It is too simplistic to say there'll be an end to the purchase provider split, given the need to continue with strong providers

Jeremy Hunt, former secretary of state for health and social care

In his May interview with the *HSJ*, Jeremy Hunt as secretary of state for health and social care set out his vision for the NHS long-term plan:

- The full integration of the health and social care system
- Better use of IT to make sure the NHS is at the forefront of medicine
- Transforming services in order to ease pressure in the emergency care system during winter
- Recovering performance standards
- "A 10 year perspective on really big efficiency improvements", mentioning the need for modern IT systems and artificial intelligence, and centralising procurement, as well as recognising the impact of predictable funding levels and flows

Trust Board meeting – September 2018

Maidstone and Tunbridge Wells NHS Trust

9-9	**Integrated Performance Report, August 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for August 2018 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- A Quality and Safety Report (including an update on complaints performance)
- Planned and actual ward staffing for July and August 2018
- An Infection Prevention and Control Report
- A financial commentary
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

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

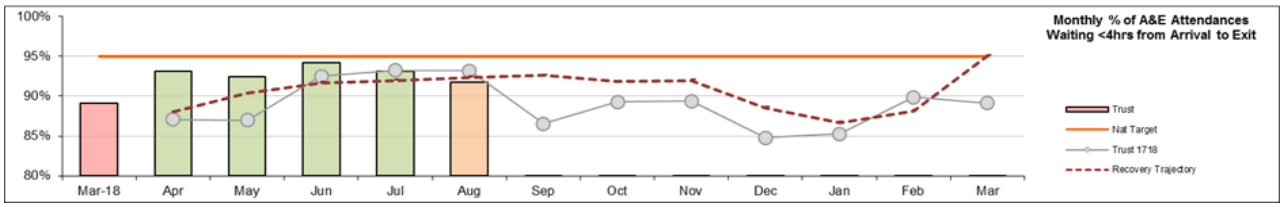
Review and discussion

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

OPERATIONAL PERFORMANCE REPORT FOR JUNE-18

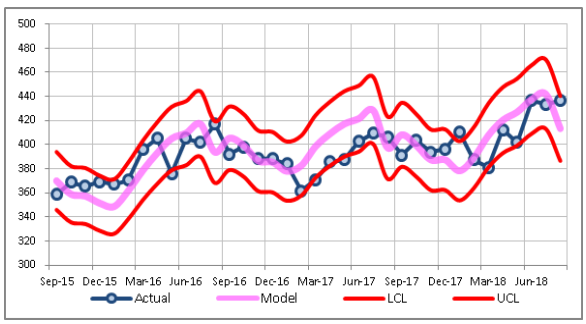
1. 4 Hour Emergency Target

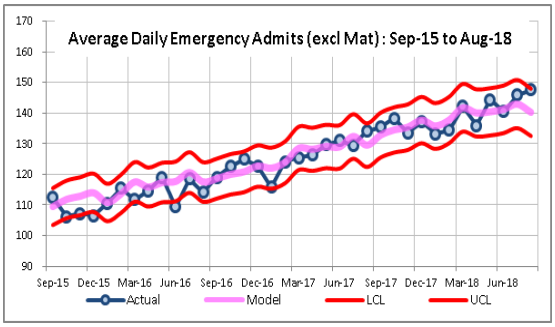
- The Trust has been above the recovery trajectory for each month from April to July 2018. Performance dipped slightly in August (calendar month) to just below the trajectory at 91.8% (including MIU), against the target of 92.3% (-0.5%). However, YTD the Trust is 2% above the Trajectory at 92.9% against 90.9%. September performance is on plan to achieve the target. The target for Q2 is 93.3%, and at 14th Sep performance is at 93.7% therefore the Trust remains on plan to achieve the Q2 target. Q1 score was 93.25% against the target of 90.07%. For the year 1718 we scored 89.1%, compared to 87.12% in 1617.
- Since Jun-17, the Trust has performed significantly better than the national average on the 4 hour standard, averaging 6.7 percentage points higher than the national average over that period



2. ED Attendances & Emergency Admissions

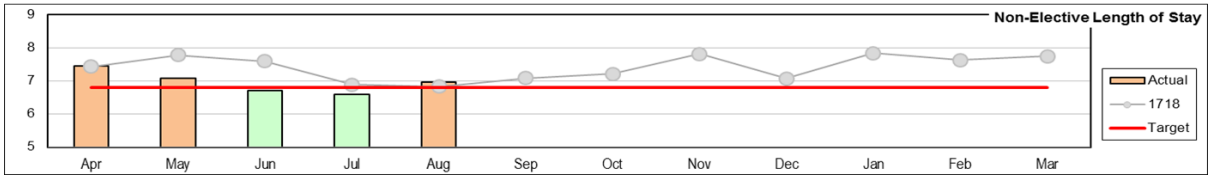
- A&E Attendances continue to increase. The sudden rapid growth seen in late 2015 and early 2016 has eased off, but 1718 like-for-like (ie excluding Crowborough MIU) attendance was still 3.2% up on 1617. Total type 1 for 1718 was 145,527.
- Total August attendances were 0.2% up on model & 2.3% up on trajectory at 15,713. This is 5.5% up on last August (like-for-like). YTD attendances are 0.9% up on model, 2.5% up on trajectory and 5.9% up on this time last year. Average weekly attendances have been at record levels over the summer.
- Non-Elective Activity (excluding Maternity) was 17.0% above plan in August and 15.5% higher than last Aug at 4,978 discharges. This was the highest NE activity ever recorded in one month. 1718 activity was 28.1% above plan and 13.2% higher than 1617 at 50,905 discharges. The plan for 1819 is just 0.2% higher than 1718 at 51,248. YTD, we are running at 9.9% above plan & 13.9% above last year.





3. Length of Stay

- Non-Elective LOS was 6.96 days in August, vs 6.82 in 1718. It tends to vary by 0.5 to 1.0 days between Winter & Summer.



- The average occupied bed days rose from 702 in July to 723 in Aug, compared to an average of 764 for the whole of 1718.

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been:

Key achievements and plans as follows:

LOS: Appointed 8 out of 9 flow coordinators, Flow Coordinators started on all the allocated Specialist Medicine wards at MH, 2 started at TW, awaiting 2 more to start at TW, and 1 further post for TW currently out to advert. KPIs set and agreed and monthly meetings in place led by Matron. Definitions of Red and Green agreed for CUR, to roll out trust wide in September, initial pilot on Mercer Sept. Triumvirate specialities to continue with monitoring and reviewing actions from 'Stranded Patient List' and report in weekly.

New for this month is that each triumvirate has the following key objectives:

- Identify at ward level the 'blockers' to achieving the early discharge agenda in terms of 5 patients before 10am. At each site.
- Identify the 2 local clinical pathways that would optimise the 'Nurse Led Discharge' profile

Frailty: Awaiting Business approval to increase operating hours of frailty units. Training being completed with Ward staff on Allscripts to allow frailty flag to be added. New Rockwood frailty flag in place on Symphony. Frailty dashboards in place. Issues with current data, manual count audit of frailty unit throughput with BI for interpretation. Frailty nurse completing site visits with other local units and forging links with complex care nurses.

AEC: Lead ENP working with Ambulatory consultants and has developed standardised exclusion criteria across both sites, with circulated paperwork to outline these criteria. Business case for Waitless app to go to DOF for consideration as part of winter mitigation by end September. Surgery to adapt medical criteria to ensure pathways in place. Work stream lead undertaking research in discussion with Paediatrics to understand potential pathways. Further discussions required with T&O to bring on board.

Virtual ward: MTW and KCHFT to work together to provide a joint virtual ward service from Dec 18. This will be to discharge sub-acute patients earlier than currently. Specific pathways being addressed; breast care drainage post op, cellulitis and TWOC.

4. Delayed Transfers of Care

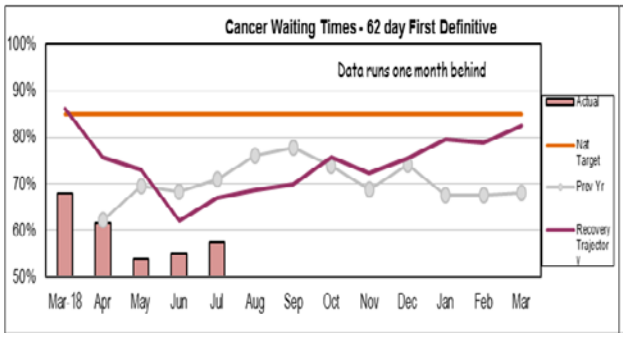
The percentage occupied bed-days due to DToC fell from 4.93% in July to 4.68% in August. Lost bed days fell by 19 to 973. We ended 1718 on 4.95%, and have now been under 5.0% for 10 consecutive months. On average, 30.6 beds per day have been lost to delays in 1819. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1, 2 & 3 of the Home First initiative in full. The Frail Elderly unit at Maidstone is operating effectively and the TWH Frailty Unit opened on 4th June 2018.

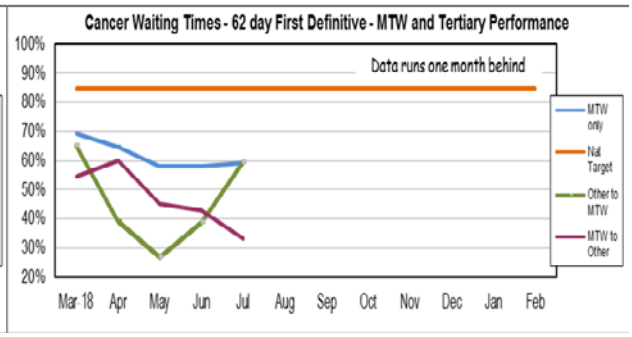
Category	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
A : Awaiting Assessment	2	7	6	2	5	2	1	2	5	3	8	17
B : Awaiting Public Funding		2	1		1	5	1	2	4			4
C : Awaiting Further Non-Acute NHS Care	21	15	10	18	21	9	21	12	20	14	17	22
Di : Awaiting Residential Home	32	21	19	18	24	18	40	15	23	29	22	9
Dii : Awaiting Nursing Home	42	46	54	38	37	47	54	53	43	26	34	54
E : Awaiting Care Package	32	24	36	14	18	20	28	20	31	18	29	24
F : Awaiting Community Adaptations	5	10	12	4	12	10	7	15	7	6	4	8
G : Patient or Family Choice	14	28	38	13	11	5	10	3	14	11	9	14
H : Disputes			1					1				1
I : Housing	2	2	1	2	3	3	2	6	2	7	5	4
Grand Total	**150**	**155**	**178**	**109**	**132**	**119**	**164**	**129**	**149**	**114**	**128**	**157**
Trust Rate of Delayed Transfers of Care	**5.3%**	**5.4%**	**4.8%**	**3.7%**	**4.3%**	**3.9%**	**4.3%**	**4.6%**	**4.3%**	**4.4%**	**4.9%**	**4.7%**

5. Cancer 62 Day First Definitive Treatment

62 day performance for July was 57.5% and 56.9% YTD. 1718 finished on 70.4%.

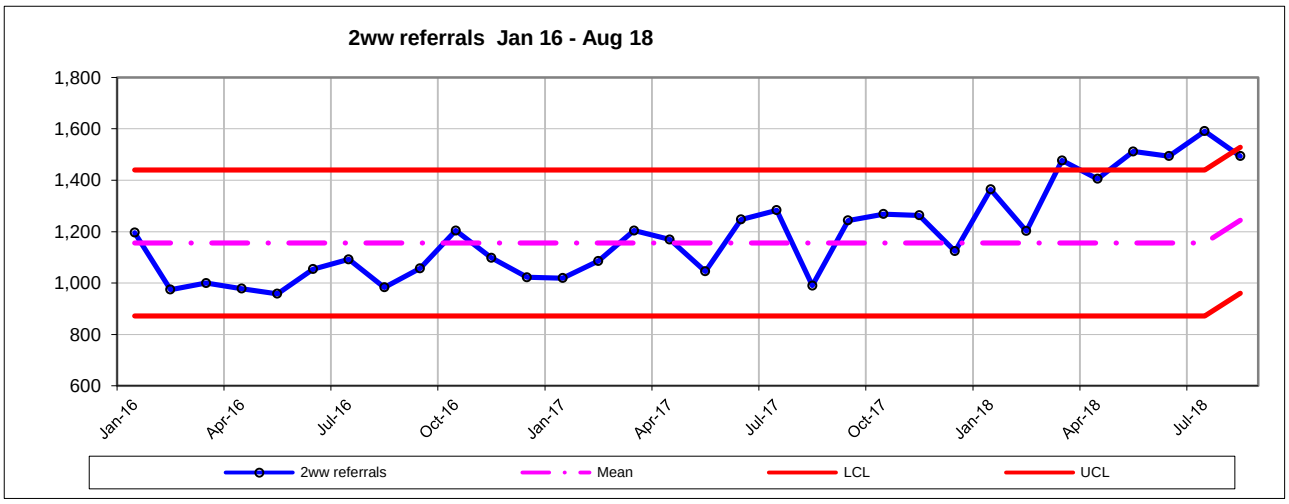
The delivery plan is focussed on increasing capacity at the front end of the pathway (i.e. 2ww capacity, outpatients and diagnostics) as has been demonstrated in the recent analysis. However, treatment capacity will be continually reviewed as more patients are diagnosed faster and cross-over with patients being treated in the backlog. The backlog at the end of July was 80. 51 of these were MTW patients. This is a 2 patient increase compared to June for all patients and a 5 patient increase for MTW only.





62 Day Performance						
July 2018	**All reportable patients**			**MTW only patients**		
	Total	**Breach**	**%**	**Total**	**Breach**	**%**
Breast	**20.5**	**3.0**	**85.4**	**19**	**3**	**84.2**
Gynae	**14.0**	**4.5**	**67.9**	**11**	**3**	**72.7**
Haematology	**3.5**	**2.5**	**28.6**	**3**	**2**	**33.3**
Head & Neck	**7.0**	**2.0**	**71.4**	**2**	**1**	**50.0**
Lower GI	**9.0**	**5.0**	**44.4**	**8**	**4**	**50.0**
Lung	**9.0**	**6.5**	**27.8**	**3**	**2**	**33.3**
Other	**1.5**	**0.5**	**66.7**	**0**	**0**	
Upper GI	**9.5**	**3.5**	**63.2**	**6**	**2**	**66.7**
Urology	**35.5**	**19.0**	**46.5**	**34**	**18**	**47.1**
TOTAL	**109.5**	**46.5**	**57.5**	**86**	**35**	**59.3**

Since January, the volume of 2ww referrals has increased significantly (particularly in Urology and Breast) and now also for Lower GI. The increase in Lower GI referrals is in part due to e-referral being available in MTW but not in Medway. Medway have now gone live for e-referral and so it is expected that some of the increase will now reverse. The average weekly number of referrals has increased by over 20%. However, July saw the highest number of suspected cancer referrals ever received. This decreased slightly for August but remains high. Particularly the increase is noticeable for gynaecology, lower GI and upper GI when compared to the average for last year.



2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper Gi	Urology	Total	Breast Symptoms		Breast total
2016	269	122	11	93	237	38	5	110	139	1024	135		404
2017	319	119	9	109	261	47	8	139	154	1164	165		484
2018 (Jan - Aug)	368	166	15	130	354	49	4	148	208	1441	135		502
% change over last 12 months	15.3%	40.0%	63.6%	19.6%	35.4%	4.3%	-55.1%	6.6%	35.2%	23.8%	-18.4%		3.8%

NB: The total number of referrals for suspected breast cancer and the exhibited (non-cancer) breast symptoms has remained steady, however more patients seem to be referred as suspected breast cancer but this will require further investigation.

62 day patients	2017									2018						
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Chemo	29	40	46	39	36	30	33	31	31	38	46	33	56	46	46	38
Other	15	16	31	15	19	17	22	24	8	19	18	32	23	21	16	24
RT	20	20	23	24	30	11	16	19	19	21	12	21	18	24	23	25
Surgery	32	28	44	29	41	37	33	41	35	40	35	34	45	33	36	36
Grand Total	**96**	**104**	**144**	**107**	**126**	**95**	**104**	**115**	**93**	**118**	**111**	**120**	**142**	**124**	**121**	**123**

The governance structure around PTL management is being revised following advice from the Intensive Support Team. The weekly PTL meetings will continue to focus on patient's day 40 and below, with the daily huddle process being changed slightly to follow up on assigned actions on a Tuesday and Thursday instead of every day. A monthly oversight meeting will be convened, starting in November, to review trends in breaches and to help unlock any bottlenecks in pathways.

The Oncology PTL is taking place weekly to replicate the main PTL meeting in order to progress radiotherapy and chemotherapy treatments and oncology are calling in to the daily huddle as well.

Tumour site action plans are being managed. A Cancer Summit is in place for 9th October.

A Recovery Plan has been submitted to NHSI.

The ADO for Surgery and ADO for Cancer are meeting with the COO on a weekly basis and there is a weekly oversight meeting with NHSI.

Additional support from IST has started and the scope of support is currently to undertake demand and capacity modelling in urology (soon to be completed), lower GI and breast. This will be used for more detailed capacity and demand analysis of the whole pathway to ensure sufficient diagnostics capacity to meet demand.

An Interim Cancer Transformation Manager started on 20th August and a permanent manager is being interviewed for on 26th September. 3 x Pathway Navigators (colorectal, UGI and prostate)

have been appointed and are expected to start in the next few weeks. A straight to test nurse has been appointed for the prostate pathway and start date is awaited.

Immediate actions are aimed at increasing capacity for Radiology, Endoscopy and 2ww appointments (both standard OPAs and STT telephone triage clinics for colorectal and upper GI). Developing straight to test models for prostate are a key priority and also establishing the national optimal lung pathway with packages of tests being ordered at the start of the pathway. The lung cancer team have also agreed a new process with GSTT to remove a 7 day wait from MDM to outpatient appointment with the thoracic surgeon. It is expected that the new process will be fully embedded in the next 8 weeks.

A new dashboard that is updated weekly has been created to track the expected increases in activity and also against 6 key performance indicators (2ww %, 31 day FDT %, 62 day %, median and 90th centile for day of decision to treat, number of patients over 62 days with a cancer diagnosis and total number of patients over 104 days).

Cancer 2 week waits

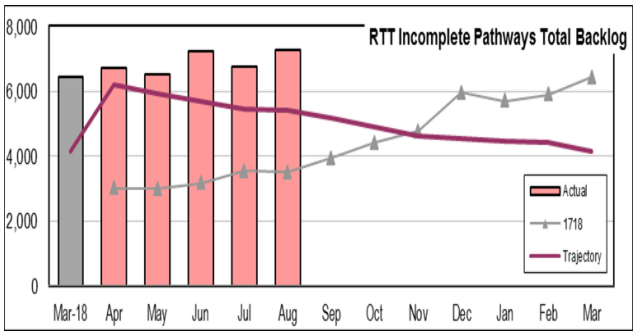
Increased colorectal STT nurse-led triage clinics have been implemented from the end of July. Endoscopy capacity has been significantly increased from the start of September and bookings are now back to two weeks.
A proposal for increasing the capacity internally has been put forward but the ability to use an insourcing company is also being explored. UGI STT nurse-led triage clinics have been in place since the start of July and patient numbers are increasing each week. Gynae are reviewing how to make better use of triage, particularly by utilising the e-referral system. Additional prostate MRI capacity has been secured with KIMS. The straight to test nurse for prostate will support creating a clinical protocol and develop a pathway to reduce the time to diagnosis by directing more patients straight to test rather than outpatient appointments in the first instance.

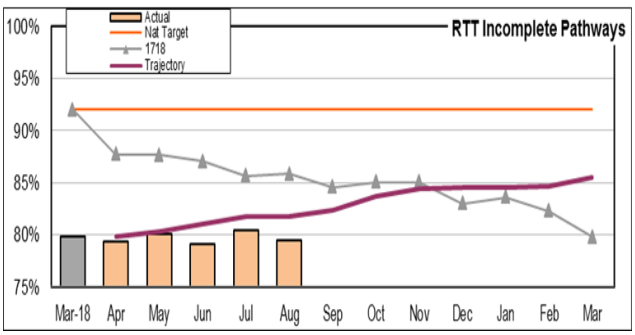
2 breast one stop clinics have been undertaken at KIMS, plus an additional clinic each Friday at Maidstone. Ad hoc capacity is constrained by Radiologist support (following retirement of a senior consultant who has proved difficult to replace). Contacting KIMS and Genesis for additional capacity. GM for Radiology to provide options for increased Radiologist cover.

The IST are providing support one day per week to undertake detailed capacity and demand work and this is being operationalised by the interim Cancer Transformation Manager that started on 20th August. The IST have offered further support for pathway mapping and this will start on 17th September. Scoping paper for this work is awaited.

6. Referral To Treatment – 18 weeks

August performance shows the Trust is non-compliant with the Incomplete RTT standards at an aggregate level –79.4%. The Trust is non-compliant with almost all specialities with the exception of Cardiology and Care of the Elderly





RTT performance has been negatively impacted due to a data quality issue relating to the interim RTT reporting solution. A technical resolution to this issue was identified and implemented.

The impact of the data quality issue means that the IPWL part of the Total Waiting List increased by 1528 and the IP Backlog increased by 921. The monthly position will therefore remain inflated

by this amount. Of the 921 added to the IP Backlog there were originally 22 that appeared to be 52wk breaches which were highlighted. Following investigation this has been validated down to 8 52wk waiters. Further validation of the waiting list continues.

The table below shows the performance against the submitted trajectory:

Original (Submitted) Trajectory:

	Aug-18	Aug -18 Trajectory	Variance from trajectory
RTT Backlog Incomplete	7,194	5,416	1,778
RTT Waiting List	34,947	29,583	5,364
RTT Incomplete performance %	79.4%	81.69%	-2.3%

Duplicate Pathways:

Duplicate pathways are still an issue particularly in Ophthalmology and General Surgery which has caused the waiting list size to grow again. Individual training is being given to members of the CAU teams and the duplicate pathways have been added to the updated Allscripts/RTT training. A validation plan has been implemented.

Total Activity:

Currently the Elective activity YTD is -398 (-12.9%) below plan. Of this the main areas of concern are General Surgery (including Endoscopy) (-309, -20.2% below plan) and Ophthalmology (-241, -10% below plan). Trauma & Orthopaedics is +128, 9.5% above plan.

Currently the OP New Activity (excl Non-RTT Specialties) YTD is -1,989 (3.5%) below plan. Of this the main areas of concern are Ophthalmology (-1375, 11.7% below plan), General Surgery (-1094, -13.2% below plan) and Gastroenterology (-257,-14% below plan).

Activity YTD - April to August	Plan	Actual	Variance	% Variance
Elective Inpatients	3082	2684	-398	-12.9%
Day Cases	18100	18487	387	2.1%
Total Elective (IP & DC Combined)	21182	21171	-11	-0.1%
First OPD Trust Total	84188	89901	5713	6.8%
First OPD Trust Total excluding non-RTT Specialties (ie Maternity, Therapies, GUM, Audiological Medicine, Ward Attenders)	57040	55051	-1989	-3.5%
Non-Elective inc Maternity	24376	26389	2013	8.3%

The key issues contributing to the low performance and increased backlog (aside from the data quality issue) remain:

- The inability to do a sufficient level of elective work caused by the increased non-elective activity.
- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- Key vacancies in consultant and trainee posts in a variety of specialties (GS, Urology, Neurology & Endocrinology)
- Reduced activity in January to support NEL flow and further reduction in February due to snow.

The majority of the backlog continues to be concentrated in T&O, Gynae, ENT, General Surgery, Ophthalmology and Neurology-all of which are being carefully monitored against trajectories and action plans on a weekly basis. Further validation of the waiting list especially the backlog continues.

The ADO for Surgery and ADO for Cancer are meeting with the COO on a weekly basis

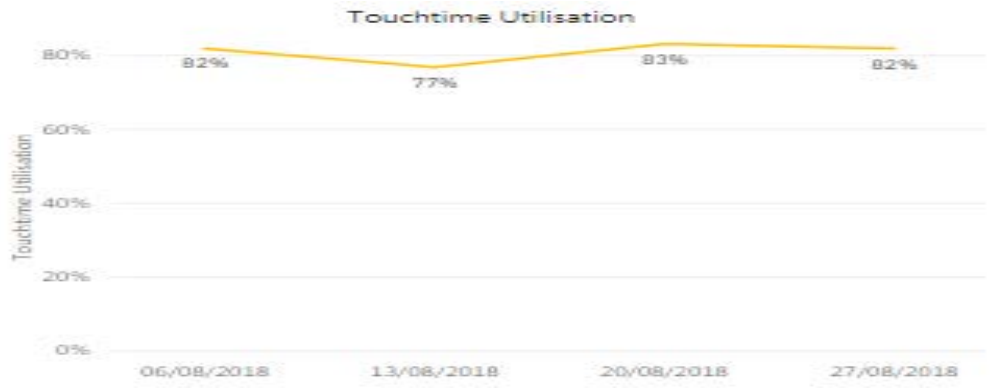
Actions:

- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans
- Monitor weekly all Non-Admitted patients at 11wks or over without an OPA and all Admitted patients at 18wks or over without a TCI
- Ensure backlog patients are booked chronologically to avoid long waits/52 week breaches
- Two Operational Transformation Managers commence at the end of October and will continue the Four Eyes outpatient's project.
- The updated Allscripts/RTT training has been rolled out with good attendance and good feedback. Dates scheduled throughout September, October and November.
- Increase clinic/theatre capacity/activity on weekends to improve income, activity and incomplete performance
- Continue weekly PTL/RTT performance monitoring to maintain overall performance
- Ensure robust management of Diagnostic waiting lists to ensure problems identified early to allow for solutions to be identified in a timely manner.
- Continue with overarching action plan already implemented which includes improving theatre and outpatient productivity.
- RTT recovery plan has been submitted and is monitored weekly.
- A Validation plan has been implemented which includes external assistance to validate the duplicate pathways.

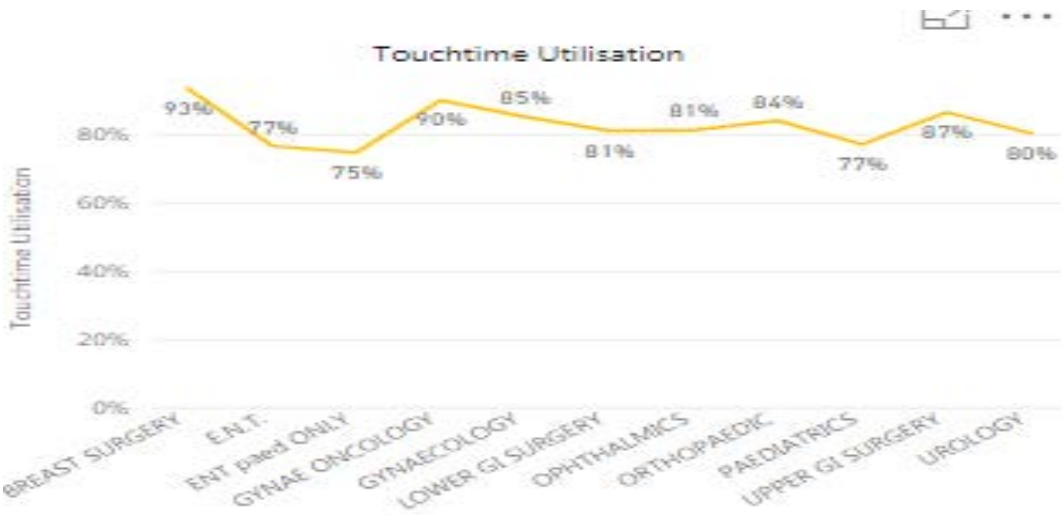
7. Theatre Productivity

The graphs below are taken from the 4Eyes Theatre Dashboard and show the Theatre Utilisation from 06/08/18 – 27/08/18 overall and per speciality. The target for utilisation is 85%.

Overall Touch time Utilisation



Touch time per Speciality



Theatre utilisation is steadily improving although achieving 85% needs to be maintained. Focus is being given to the scheduling of the lists, pre-operative assessment, start and finish times of lists and cancellations.

Quality and Safety (July and August data)

Patient Falls incidents

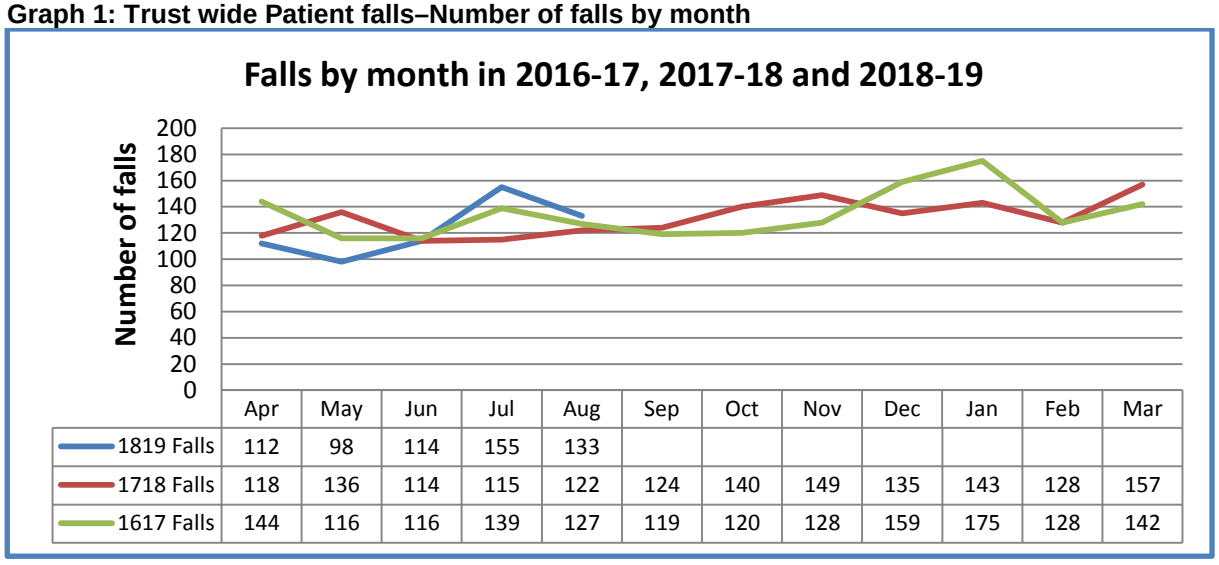
There were 155 falls reported for the month of July and 133 for August, compared to 114 for June 2018. The monthly figures in Graph 1 provide a comparison for each month and for the same period on the previous year. The breakdown of incidents by site equates to 68 falls in July and 41 in August at Maidstone and 87 in July and 92 in August at Tunbridge Wells.

The monthly falls rate per 1000 occupied bed days (OBD) is shown in Graph 2. The year to date falls rate for 2018/19 is 5.95 per 1000 OBD against the threshold of 6.0.

There was 1 (member of the public) Serious Incident declared in July 2018 and 5 Serious Incidents (patients) declared in August 2018.

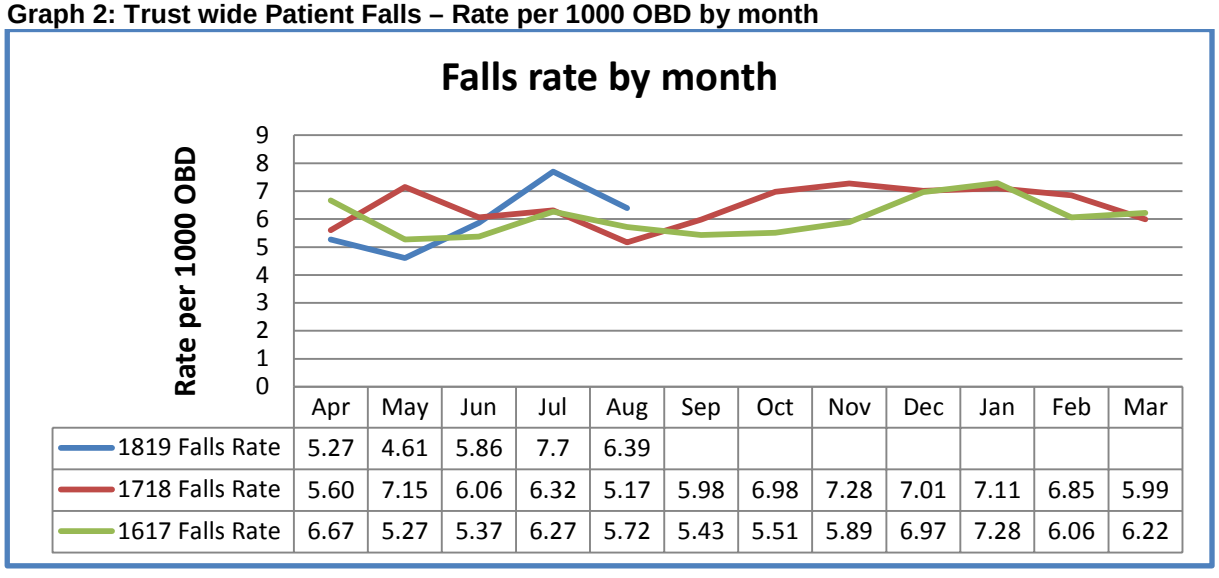
The Trust is due to attend the final 60 day event of the NHSI falls collaborative project later this month and will also be welcoming NHSI to the Trust to visit the two wards who have been involved in this work at the end of the month. The two pilot wards, Ward 32 and Ward 2 have been focussing on the key indicator of assessment and recording of Lying and Standing blood pressure for patients at risk of falls.

Graph 1: Trust wide Patient falls–Number of falls by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls	112	98	114	155	133							
1718 Falls	118	136	114	115	122	124	140	149	135	143	128	157
1617 Falls	144	116	116	139	127	119	120	128	159	175	128	142

Graph 2: Trust wide Patient Falls – Rate per 1000 OBD by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls Rate	5.27	4.61	5.86	7.7	6.39							
1718 Falls Rate	5.60	7.15	6.06	6.32	5.17	5.98	6.98	7.28	7.01	7.11	6.85	5.99
1617 Falls Rate	6.67	5.27	5.37	6.27	5.72	5.43	5.51	5.89	6.97	7.28	6.06	6.22

Pressure Ulcers:

The incidence rate of confirmed Hospital acquired Pressure Ulcers for July 2018 for July was 0.51 (per 1000 admissions) compared to 1.12 for the same month last year. For August the incidence rate of confirmed hospital acquired pressure ulcers is 1.62 against a threshold of 3.0.

The incidence for July is lower than anticipated but with an increase in the incidence for August. There has been an annual pattern, which has been demonstrated over several years, of an increase in incidence during the summer period.

Learning from incident reviews continues to centre around the early implementation of prevention strategies, including good hydration and positional changes. A number of category 2 pressure ulcers are of mixed aetiology having first evidenced as moisture lesion

NHS Improvement published the document 'Pressure Ulcers; revised definition and measurement' in June 2018 following their work undertaken as part of the national 'Stop the Pressure programme'. This work was triggered by an audit report 'Pressure ulcer and wounds reporting in NHS hospitals in England' (Smith, I L et al 2016) which indicated a lack of standardisation in current systems used locally, regionally and nationally to monitor pressure harm to patients. This makes any comparison with other acute trusts unreliable as there is inconsistency in reporting of causation, type, category and incidence.

The national Stop the Pressure seeks to build on the recommendations made by Smith et al to support a consistent approach to defining, measuring and reporting pressure ulcers.

There are 30 recommendations, of which 28 apply nationally and locally to providers. Of these 28 recommendations 9 require action within MTW to achieve compliance. The majority of these the actions relate to reporting rather than clinical practice.

The key changes include the reporting of deep tissue injury (DTI), moisture lesion and device associated pressure ulcer.

Pressure ulcers associated with medical devices are reported in our overall pressure ulcer incidence, but is not immediately identifiable. The change the trust needs to make is a notation change to the current reporting, so will have no impact on overall reporting numbers and rate.

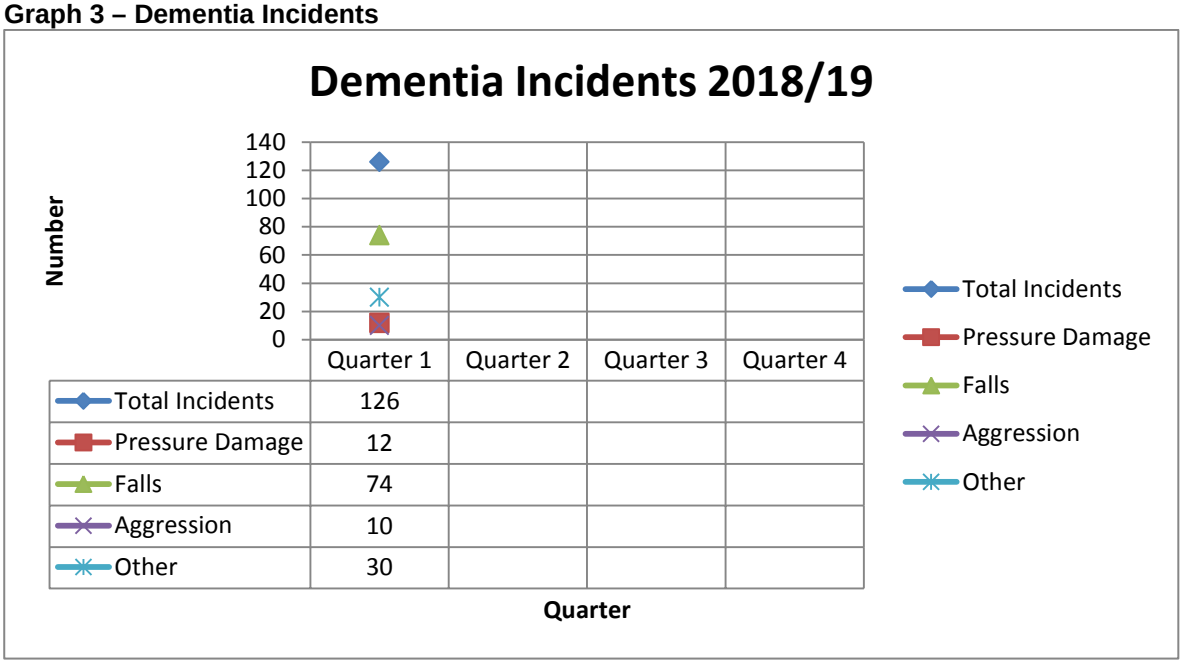
The Trust currently records the incidence of DTI as part of our internal pressure ulcer surveillance; however this is not reported in the overall pressure ulcer incidence or prevalence. Similarly we record moisture lesion via the datix reporting system but do not include in the overall pressure ulcer incidence or prevalence. As this is new reporting it will have an impact on the overall reported numbers and rate. We will see a rise in the incidence of hospital acquired pressure ulcers.

Incidents relating to inpatients with Dementia:

As part of the Trust's Dementia Strategy (2013 – 2016) one of the objectives was to monitor the number of incidents relating to inpatients with dementia in our hospitals. In the Strategy for 2017 – 2020 one of the strategic aims is to modernise our approach to monitoring falls in patients with dementia and identify ways to reduce these. In the process for delivery it states we will: Monitor all incidents associated with dementia patients and report to dementia strategy group e.g. falls.

The incidents have been analysed by the Lead Nurse for Dementia Care, following a search on the Datix system of all incidents relating to patients with dementia. The identification of patients with a known diagnosis of dementia is via the Datix form and this has been validated by the Lead Nurse for Dementia through the flagging system on Allscripts. The incidents have been split into 4 categories: Pressure Damage; Falls; Aggression and Other. Incidents included in the Other category include issues such as drug omissions/errors, patient transfer communication issues between wards and similar low harm incidents.

Graph 3 – Dementia Incidents



The above chart shows the number of incidents per category that occurred during Quarter 1 (2018/19); compared with Quarter 4 (2017/18) there has been a decrease in total incidents from 129 to 126. Pressure damage has decreased from 13 to 12; Falls have decreased from 82 to 74 and other incidents have increased from 19 to 30.

This data is collected and reviewed quarterly by the Dementia Strategy Group and findings are presented to the Trust Clinical Governance Committee as part of the Safeguarding Adults Group.

Friends and Family Test:

Overall response rates through July and August have shown a decrease. Whilst we continue to drill down into the data collection and data input to ensure MTW numbers correlate with those of iWantGreatCare (IWGC) numbers, there are occasions when an overlap of the previous month's data merge into the following month. However, with the decrease seen across two months we continue to investigate the data collection in addition to surveillance of the number of cards collected at Trust level and, ensuring this data correlates to the final upload. This can be attributed to cards used that are not accepted if photocopied or damaged in any way.

Implementing a weekly card collection was established to enable a more timely review of response rates and to allow for a more rapid response and feedback to areas that may have fewer returns than anticipated. This methodology is working in the joined up approach between MTW and IWGC with the use of communication alerts from IWGC if cards have not yet been received however, the data collection at Trust level will be further reviewed to ensure it continues to evolve in line with such service developments.

Consideration of the current collection methodology is not only in line with MTW response rate but also in how we ask our patients to feedback their experiences. Feasibility into an IT based solution to aid user feedback in a more accessible way beyond a paper survey has started. Initial discussions are underway to explore the ability of building a new 'platform' on the Trusts current stock base of IPads which would be dedicated to hosting the IWGC App aligned to the department owner of the equipment. The IWGC app solution would be rolled out across all areas currently using IWGC.

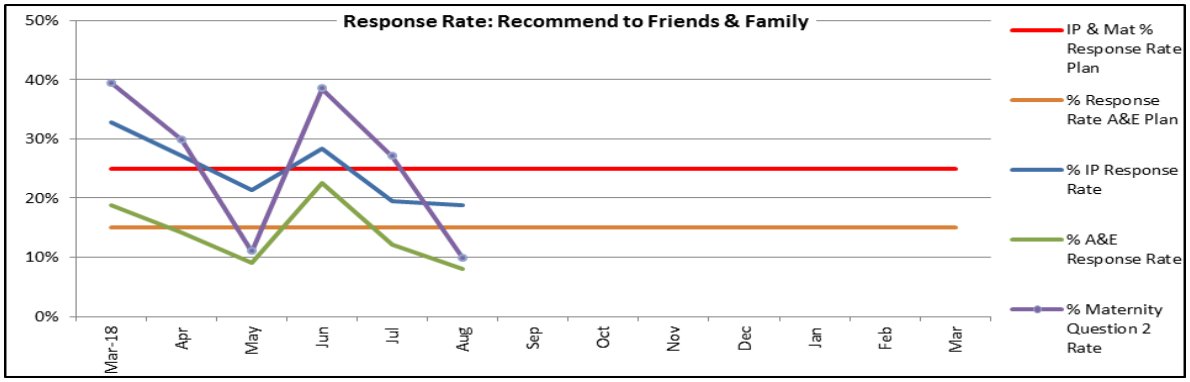
Response rates for July decreased: IP 19.47% compared to 28.4% in June, A&E 12.10% compared to 22.5% in June and Maternity 27.04% compared to 38.43% in June.
The positive responses although demonstrating a slight decrease overall, remained broadly the same: IP 95.3% in June compared to 94.2% in July, A&E decreased from 92.1% in June to 89.4% in July and Maternity (all 4 combined) decreased from 94.8% in June to 93.5% in July.

Response rates for August highlighted a further decrease: IP 18.7% compared to 19.47% in July, A&E 8.1% compared to 12.10% in July and Maternity 9.9% compared to 27.04% in July.

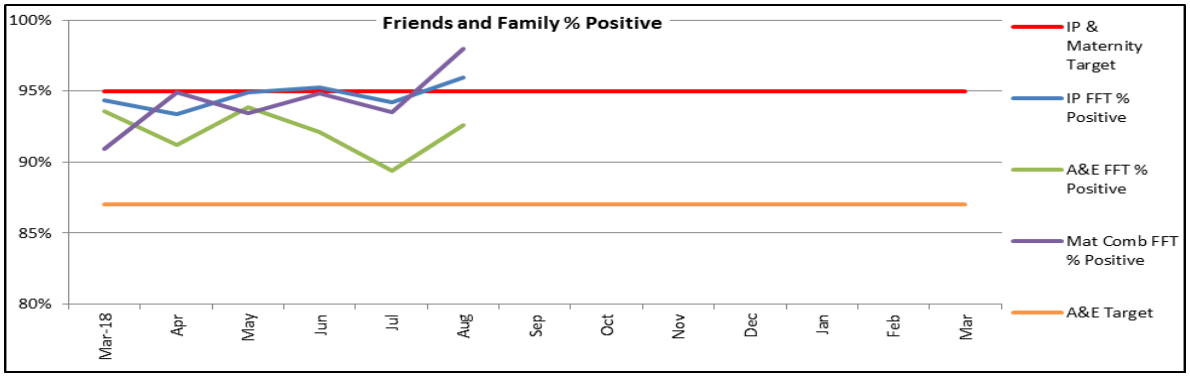
For the % Positive for August, inpatients has increased slightly from 94.2% in July to 95.9% in August, A&E increased from 89.4% in July to 92.6% in August and Maternity (all 4 combined) increased from 93.5% in July to 98.0%.

Out Patient response rate has decreased from 3427 in July to 1807 in August.

Graph 4 FFT Response Rates:



Graph 5: FFT Positive Responses



Single Sex Compliance:

There were five incidences of mixed sex accommodation breaches reported during the month of July 2018, which were reported on the Acute Stroke Unit. The root cause was a medical outlier who was unable to be moved due to issues with capacity and the number of stroke admissions at that time.

In August, 2018 we have subsequently declared 12 mixed sex breaches, 6 of these were reported on the Surgical Assessment Unit, reported overnight and subsequently unmixed the following morning, this occurred for 3 patients on two separate occasions. The further 6 patients occurred on the Stroke Unit, again a medical outlier with the remainder of patients being Stroke. The root cause for these was capacity challenges on site.

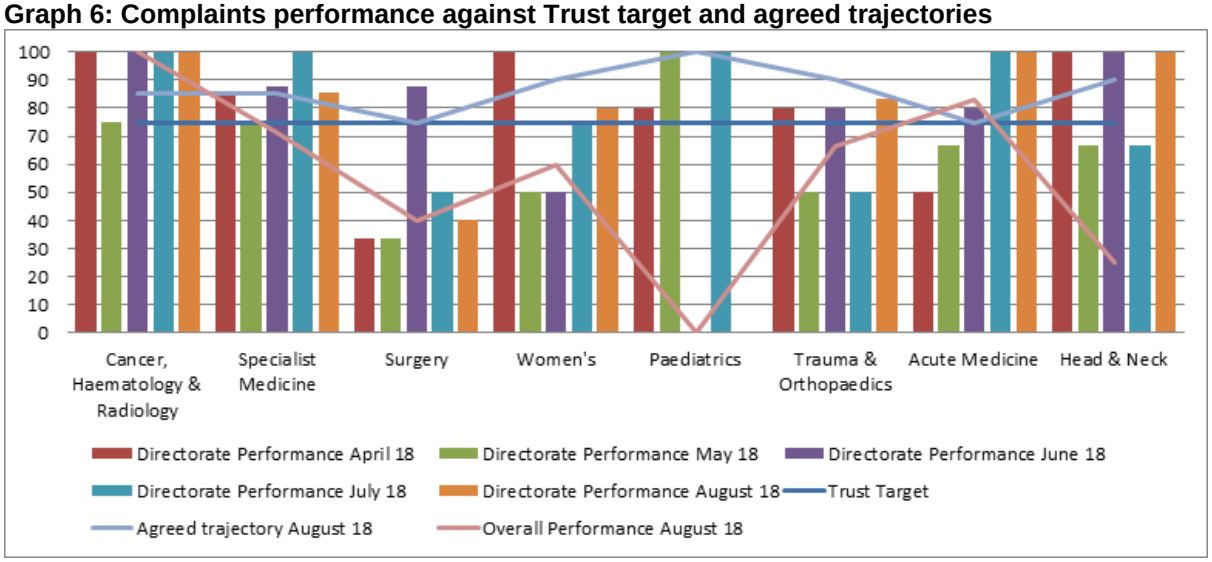
Complaints:

There were 38 new complaints reported for July and 34 for August which equates to rates of 1.89 and 1.63 new complaints per 1,000 occupied bed days. This is an improving picture in comparison to 2.62 reported for June. (In line with National benchmarks) There were 137 open complaints at the end of August compared to 164 in June.

73.3% (July) and 62.8% (August) of complaints were responded to within deadline compared to a target of 75%.

Following on from the series of challenge sessions held to address poor compliance with performance targets, Graph 6 (below) provides information on the performance for year to date against the Trust overall target and the agreed performance trajectories.

Graph 6: Complaints performance against Trust target and agreed trajectories



It is worth noting that 50% of directorates achieved or exceeded their performance trajectory for August. The directorates not meeting their performance trajectory were Surgery (40% against a target of 75%), Women's (80% against a target of 90%), Paediatrics (0% against a target of 100%) and Trauma & Orthopaedics (83.3% against a target of 90%). Overall, the Trust did not reach the 75% performance target for August. In total, 9 complaints breached due to delays within the lead directorate, which account for 20.9% of the lost performance. However, a further 7 complaints breached for other reasons: 3 due to annual leave within the central complaints team, 1 awaiting comments from a GP practice, 1 complaint related to an SI which had not been completed, 1 was delayed awaiting comments from a contributing directorate and 1 was delayed awaiting comments from an Associate Director of Operations. These delays accounts for 16.2% of the lost performance.

In recognition of the challenges the Trust has faced in meeting and sustaining performance in responding to complaints, an action plan has been developed to support this. This comprises actions within the central complaints team (CCT) as well as across the directorates. The CCT undertake a daily huddle to review all cases due out that day and the next day to initiate recovery where possible. Regular directorate meetings are operating in most of the larger directorates, with surgery coming on board. The Complaints Manager has been released from the Best Safety work stream in order to create more capacity within the service and a business case has been approved to provide some short term additional resource to support this programme of work. The Complaints Manager and Complaints Leads are reviewing their work plan to build in regular periods of protected time in order to focus on achieving the Trust target form complaints responses. A set of KPI data has been designed for each directorate to help focus them not only on their performance, but to keep them sighted on the number of complaints open at any one time. This further enhances the regular reports provided to them by the CCT. Complaints performance is being reviewed at all directorate performance meetings. A second set of directorate challenge sessions are planned for early October to review progress against the trajectories agreed in May.

The table below provides the detail of the frequency of each sub-subject raised as issues within complaints received in the Trust. The available data has been analysed by the date of the event being complained about, rather than when the complaint itself was received. It is hoped that this will give a truer picture of the current issues affecting our patients and service users. However, it should be noted that although the majority of complaints are raised within a month or two of the event occurring, there will be a degree of time delay. As a result, there will be less data available for the current and preceding month, than there will be for earlier months. The charts/graphs below will therefore be updated each month and may show variations (if compared retrospectively) for this reason.

Graph 7a - Complaints by Sub-subject – most frequently raised in July 2018

	Apr-18*	May-18*	Jun-18*	Jul-18*
Poor communication with patient/relative	4	5	5	4
Delayed Treatment	3	1	3	3
Incorrect/inappropriate clinical advice	3	0	2	3

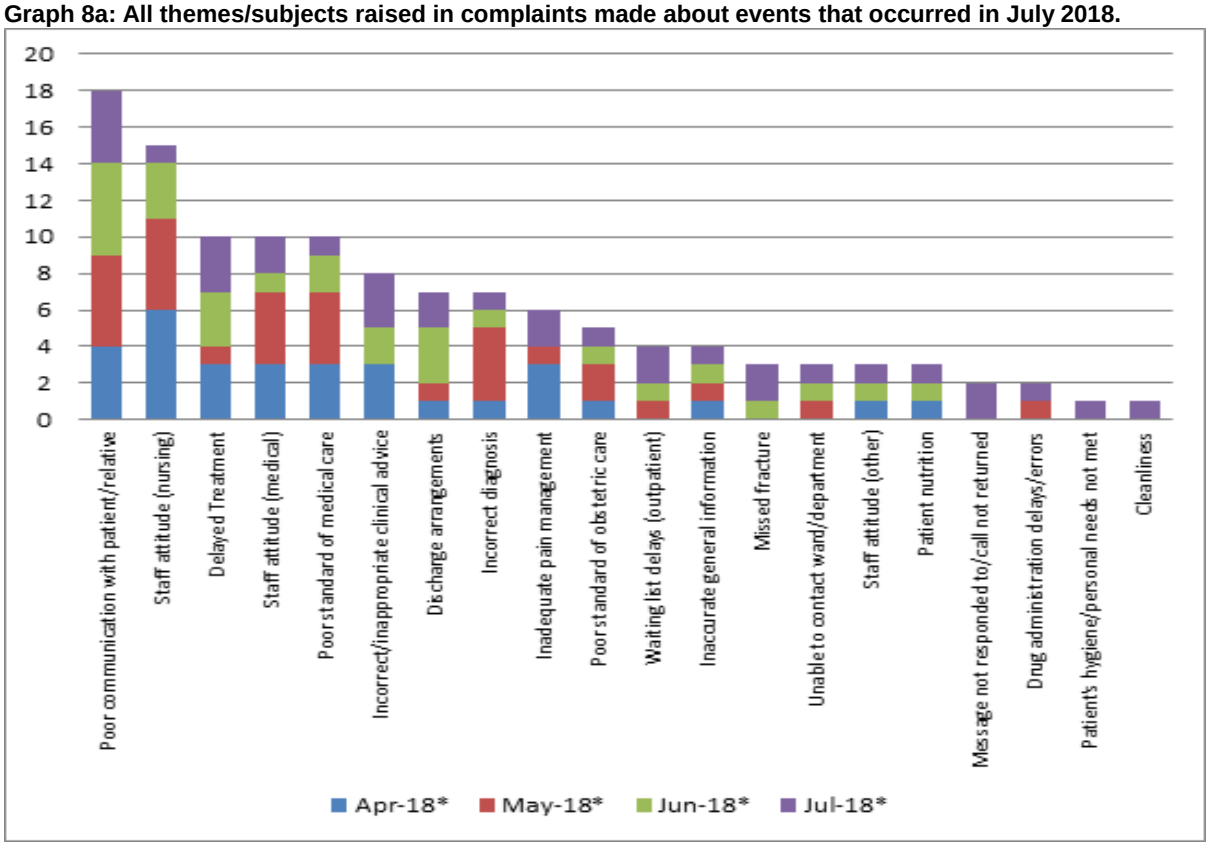
Graph 7b Complaints by Sub-subject – most frequently raised in August 2018

	May-18*	Jun-18*	Jul-18*	Aug-18*
Delayed Treatment	1	3	3	3
Waiting list delays (outpatient)	1	2	2	2

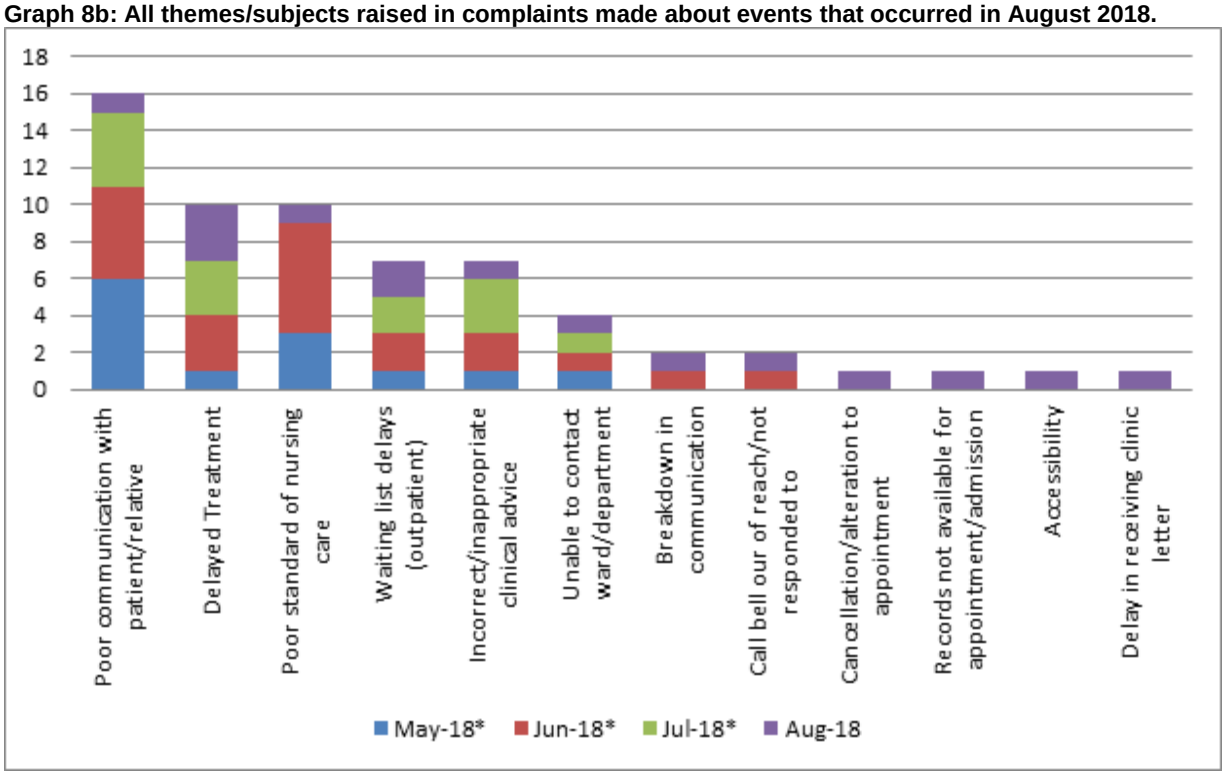
*reflects the date of the event being complained about

The following graphs (Graph 8a & b) show an expanded view of the themes of complaints that occurred in July and August 2018.

Graph 8a: All themes/subjects raised in complaints made about events that occurred in July 2018.



Graph 8b: All themes/subjects raised in complaints made about events that occurred in August 2018.



As with previous reports, communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue in the reporting period (May – August). However, as a trend, this is showing a reducing trend.

Looking at emerging issues, there has been a rising trend of complaints about:

- Delayed treatment

Other areas show stable or slightly reducing trends, with the most significant reduction in complaints about staff attitude (nursing).

Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints and the learning taken from complaint investigations.
On a positive note we have also received feedback from the Parliamentary and Health Service Ombudsman (PHSO) that three of our complaints recently referred to them were upheld with no concerns in regard to our management of these identified.

Serious Incidents (SI's)
There were 11 Serious Incidents reported in July and 18 in August 2018. The total number of SI's open has increased at 79 year to date, compared to 44 during 2017/18.

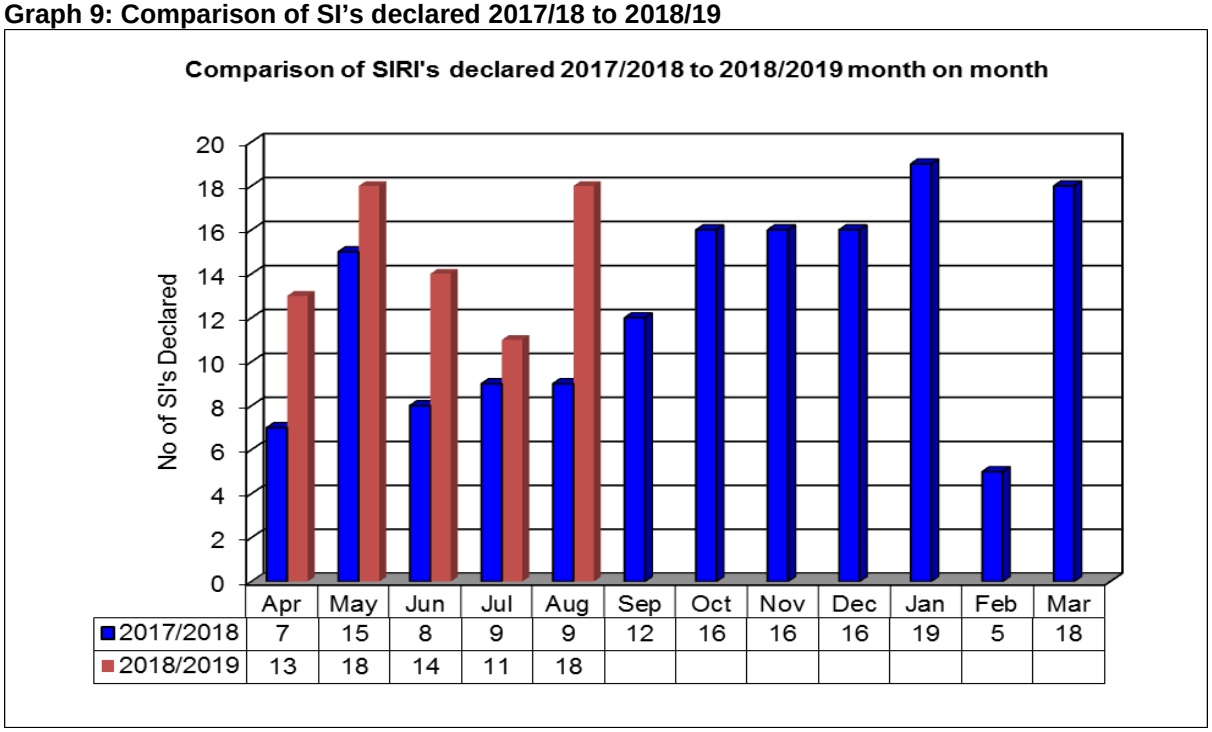
July:-

- 11 Main SI's spanning 5 divisions
  - 3 each in Acute & Emergency / Critical Care / Women's & Sexual Health
  - 1 each in Pathology & Pharmacy and Surgery
- 2 Safeguarding in Specialist Medicine & Therapies – both allegation of abuse
- 1 Pressure damage – category 3 in Specialist Medicine & Therapies

August:-

- 7 Main SI's in two divisions
  - 4 in Acute & Emergency
  - 2 in Womens & Sexual Health
  - 1 in head and neck
- 5 falls – 4 in Specialist Medicine & Therapies and 1 in Acute & Emergency
- 3 Pressure Damage- 2 in Specialist Medicine & Therapies and 1 in Trauma & Orthopaedics
- 2 VTE – both in Specialist Medicine & Therapies
- 1 Safeguarding in Specialist Medicine & Therapies

Graph 9: Comparison of SI's declared 2017/18 to 2018/19



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	7	15	8	9	9	12	16	16	16	19	5	18
2018/2019	13	18	14	11	18							

During the months of July and August, 12 and 17 SI's were closed and 2 SI's were downgraded from May 2018:-

- An unexpected neonatal collapse, no concerns evident upon review.
- A safeguarding concern that was incorrectly raised due to incorrect information from a third party.

The learning from the Falls panel identified the importance of ensuring that the suitability of a patient to undergo orthopaedic surgery is assessed prior to their transfer to the Tunbridge Wells site and that patients need to be reassessed and their care plans updated when transferring with regards to the change of environment from Bays to single rooms and vice versa.

Learning from the VTE panel has identified the importance of reviewing issues of non-compliance of medication and the escalation of omissions of medication to the nurse in charge and medical team responsible for that patient's care. Also the need to document and sign for the wearing of anti-embolic stockings on the drug chart and the need to highlight on nerve centre patients who refuse anticoagulant therapy. The Panel also identified good practice in regard to VTE risk assessments being completed within 24hrs of admission and that the nursing staff had realised that the patient was more compliant with taking her medication when her daughter was present.

Learning from the Safeguarding panel included the need to gain explicit consent for the procedure being performed and to then document this within the health records and the need to follow MCA guidance.

Safe staffing: Planned versus actual for July and August 2018

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for July and August 2018. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Wards of note for Both July and August include:

Acute Stroke Unit (Maidstone): sustained Improvement: Incidence of Falls continues to decrease consistently. Increased fill rate due to enhanced care needs.

Cornwallis / Culpepper / John Day: Increased fill rates across RN's and CSW following redeployment of Whatman staff after planned ward closure

Chaucer: Increased fill rate at night due to escalation 7 times during July and 18 in August. CHPPD increased in August due to the rostering of staff to deliver care through the AFU. Nurse: patient ratio increased on a week day basis to facilitate the AFU pathway which is reflected in the CHPPD.

UMAU (Maidstone): Reduced fill rate of due to lack of available temporary staff across 14 days in July and across 18 days in August. In August, RMNs required on 12 days due to enhanced level of care. Ward escalation at night throughout the month

Ward 10: Skill mix adjustment a consistent and considered action by the ward team in line with a high dependency and moderate acuity.

Ward 20: Increased CSW requirement to support enhanced care needs and cohort care for patients with cognitive impairment and/or risk of falls. Increase in falls in July to 20 which is 13 above the agreed threshold of 7. QuESTT score of 13 rated amber requiring further enquiry. Quality review undertaken 17th August 2018. August: Reduction noted in falls to 13.Reduced fill rate due to lack of available temporary staff. Enhanced care needs daily throughout the month.

Ward 2: 8 Falls above threshold in July and 4 above threshold in August. Reduced fill rate due to inability to fill with temporary staff. Staffing requirements for AFU and episodes of enhanced care needs, increased dependency and escalated on 1 occasion in July and 4 occasions in August.

MAU (TWH): Increased fill rate at night due to escalation throughout the month and increased dependency. QuESTT score under review following recent appointment of new unit manager. August showed improvement in QuESTT score but continue levels of increased fill rate due to escalation

Crowborough Birth Centre: RM fill rate an accepted risk during the day, as community midwives accompany women or can provide support to the unit. This ensures safe staffing levels over night.

Hedgehog: RMN required 24/7 through the month of July for enhanced care need. Unit escalated on 4 occasions and HDU level acuity 21 days / nights. August: CSW not backfilled as a considered action to support paediatric services outside of the inpatient unit depending on clinical need.

Neonatal Unit: Low RN fill rate due to inability to fill with temporary staffing. High level of LTS being managed.

Wards of note for July include:

Mercer: 20 Falls above threshold in July. Cohort nursing due to infection control issues and Enhanced care required throughout the month. Additional CSW 1:1 on Nights. CSW also moved from Whatman following planned ward closure.

CCU (TWH): Low RN fill rate, due to an inability to fill from Bank/Agency

Wards of note for August include:

Edith Cavell: Reduced RN fill rate due to lack of available temporary staff. Increased CSW fill rate due to enhanced care requirements throughout the month

Ward 22 / Stroke: Reduced fill rate due to lack of available temporary staff across throughout the month of August.

Ward 33 / Gynae: Reduced fill rate due to lack of available temporary staff on 8 occasions in month

Ward 32: Reduced fill rate due to lack of available temporary staff across 21 days in month

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.

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 overall 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 successful roll out of Health roster enables for further scrutiny of PvA through the Key Performance Indicators to include:

Roster Score	Unfilled Roster	Duties With Warnings	Partially Approved Rosters	Fully Approved Rosters	Roster Approval (Partial) Lead Time
Roster Approval (Full) Lead Time	Net Hours Balance	Bank / Agency Use	Annual Leave	Total Avoidable Cost Per WTE	

For example Annual leave; the headroom allowance for in patient departments is set at 21%. Annual leave parameters should fall between 11 – 15%. Where there is a reduced fill rate in month the KPI will identify if Annual leave is an influencing factor.

Care Hours per Patient Day

Updated information has been communicated by NHS Improvement in June 2018 (CHPPD) Guidance for Acute and Acute Specialist Trusts.

CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level. The safe staffing paper uses the CHPPD at ward / department level where service leaders and managers can consider the workforce deployment over time, with comparable wards within a trust or at other trusts as part of a review of staff deployment and overall productivity.
To calculate CHPPD, monthly returns for safe staffing along with the daily patient count at midnight, which is the total number of patients on the ward at 23:59 are aggregated for the month.

Calculation:
Day Shift Hours + Night Shift Hours Worked by both Nursing Support Staff and Registered Nurses & Midwives

Approximation of Every 24 Hours of In-Patient Admissions by Taking a Daily Count of Patients in Beds at 23:59

The updated guidance references CHPPD for ward-based AHPs and other clinical staff:
'Ward-based Allied Health Professionals (AHPs) and other clinical staff who provide patient care in multi-disciplinary teams alongside nursing or midwifery staff can be included in the Safe Staffing returns for the purposes of calculating CHPPD. This only relates to staff that are part of the ward roster and are included in the ward establishment. Registered clinical staff can be reported alongside registered nursing and midwifery staff. Non-registered clinical staff can be recorded alongside healthcare support workers.'

MTW have looked proactively at AHPs in traditional nursing roles and as such, has successfully appointed an Occupational Therapist to the role of Ward Manager to MAU (TWH). This role will be included in the CHPPD calculation.

Current guidance does not yet include the patient facing hours that centrally deployed AHPs provide to a ward / department on any given day, into the CHPPD metric, as we would not be counting like with like.

QuESTT:
The QuESTT score seeks to offer a more objective approach to the safety and effectiveness of a ward to reflect aspects of good leadership and multi-professional engagement with care. Nurse sensitive indicators and included alongside the QuESTT score.

The tool has 16 statements that are answered true or false (Table 1). The questions cover a range of domains including leadership, staff support, user feedback and incidence. Each question is weighted with a score between 1 and 3. Any ward or department scoring above 12 would give rise to further enquiry. The aim of the tool is to identify wards that may need additional support or intervention before any adverse impact on the clinical care and outcomes.

The RAG rating for QuESTT is rated as:
Green: 0 - 11
Amber: 12 – 15 Trend analysis and further enquiry
Red : 16 + Immediate enquiry and action to be taken

The Quality, Effectiveness & Safety Trigger Tool (QuESTT) collection tool is now available to all wards. Completion and review rate is now at 100% (not including maternity) for the month of July and 100% in August. QuESTT continues to be further embedded into the monthly reporting systems and promoted through the Chief Nurse's senior team.

A trigger of Amber of Red will initiate a "Quality Review" relating to the quality indicators over a nominated period of time. This will be a minimum of a one quarter annum period to identify any themes or trends arising. The indicators for review include:
Falls
Complaints

FFT
Workforce KPIS including sickness, vacancy, turnover
Performance
Financial performance
E roster KPIs
Other patient safety incidents

Table 1

QuESTT: Quality, Effectiveness and Safety Trigger Tool		
Name of person completing review:	**Date of Review:**	
Section One: The content of this completed tool should be used to form the basis of a *monthly* multi-disciplinary review of the key quality indicators within a clinical area. The assessment should be made by the team leader and then validated by the members of the review group discussing the results. Section One acts as a trigger or early warning tool and must be assessed and completed each month. *Instructions: If the statement is true, insert a X in the cell (the score will be calculated automatically). If it is not true, leave blank.*		
Indicators		**True?**
New or no line manager in post (within last 6 months)		
Vacancy rate higher than 3%		
Unfilled shifts is higher than 6%		
Sickness absence rate higher than 3.5%		
No monthly review of key quality indicators by peers, e.g. peer review or governance team meeting		
Planned annual appraisals not performed		
No involvement in Trust-wide multi-disciplinary meetings		
No formal feedback obtained from patients during the month, e.g. questionnaires or surveys		
2 or more formal complaints in a month (Wards) or 3 or more (A&E or OPD) or 1 or more (CCU & IC		
No evidence of resolution to recurring themes		
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak		
Hand hygiene audits not performed		
Cleanliness audits not performed		
Ward/Department appears untidy		
No evidence of *effective* multi-disciplinary/multi-professional team working		
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)		
	Overall Score:	
Insert comments below (if appropriate):		

Score if True		
1	2	3

July '18		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	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	94.0%	109.0%	98.5%	119.6%	7.9	71.1%	96.3%	5	0	7	Enhanced care required on 11 occasions during the month	151,444	154,240	(2,796)
MAIDSTONE	Cornwallis	97.7%	125.3%	95.9%	90.3%	7.3	38.8%	96.3%	5	0	5	3 Falls above threshold Increased fill rate with redeploymeny of RN's following planned ward closure	96,372	79,394	16,978
MAIDSTONE	Culpepper (Inc CCU)	98.6%	106.8%	100.0%	125.7%	7.9	84.4%	96.3%	2	0	0	1 Fall above threshold	115,883	116,038	(155)
MAIDSTONE	John Day	101.2%	139.6%	100.0%	101.6%	7.2	59.7%	97.7%	8	1	8	3 Falls above threshold and an increase on last month Increased fill rate for CSW as redeployed following planned Whatman ward closure	138,246	162,594	(24,348)
MAIDSTONE	Intensive Treatment Unit (ITU)	90.1%	95.6%	89.1%	N/A	30.0			0	0	0	Reduced occupancy on 11 days throughout the month and 11 days unable to cover with temporary staff. Support CCOT on 1 day	164,439	178,421	(13,982)
MAIDSTONE	Pye Oliver	97.0%	82.7%	97.7%	101.2%	5.9	45.3%	79.4%	11	0	6	6 Falls above threshold Reduced fill rate of care staff due to lack of available temporary staff	125,846	125,368	478
MAIDSTONE	Chaucer	92.7%	85.8%	117.3%	125.8%	11.3	94.2%	93.8%	3	0	2	Escalaterd on 7 occasions in month. Reduced fill rate in day of care staff due to lack of available temporary staff	126,193	105,851	20,342
MAIDSTONE	Lord North	91.2%	109.5%	97.8%	93.9%	7.8	39.0%	87.5%	1	0	4		108,159	104,942	3,217
MAIDSTONE	Mercer	97.4%	110.3%	100.1%	150.3%	6.7	66.7%	100.0%	26	0	5	20 Falls above threshold. Cohort nursing due to infection control issues and Enhanced care required throughout the month. Additionaol CSW 1:1 on Nights. CSW also moved from Whatman following planned ward closure.	113,199	114,905	(1,706)
MAIDSTONE	Edith Cavell	94.9%	109.2%	100.0%	119.4%	5.8	95.8%	100.0%	3	0	0	Enhanced care required for 16 days throughout the month	76,588	87,958	(11,370)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	85.4%	75.8%	104.9%	98.5%	16.6	5.5%	100.0%	3	0	4	Reduced fill rate of due to lack of available temporary staff across 14 days	138,560	133,365	5,195
TWH	Stroke/W22	85.2%	84.2%	98.7%	96.7%	9.5	57.1%	100.0%	5	1	7	Reduced fill rate due to lack of available temporary staff. Staff sickness recorded through the month	160,432	157,566	2,866
TWH	Coronary Care Unit (CCU)	104.8%	79.8%	97.7%	N/A	10.4	102.8%	78.4%	1	0	6	Reduced fill rate due to lack of available temporary staff.	70,579	63,052	7,527
TWH	Gynaecology/ Ward 33	83.0%	89.7%	100.0%	100.0%	7.2	0.0%	-	0	0	1	Reduced fill rate of due to lack of available temporary staff and backfill of band 5 for MMM where appropriate	84,775	79,088	5,687
TWH	Intensive Treatment Unit (ITU)	98.3%	98.7%	99.3%	N/A	33.3	0.0%	-		0	4		196,336	196,753	(417)
TWH	Medical Assessment Unit	97.4%	100.0%	119.8%	180.6%	5.8	2.7%	87.5%	2	0	18	Increased fill rate at night due to escalation throughout the month and increased dependency QuEST score under review	199,948	202,837	(2,889)
TWH	SAU	97.1%	100.0%	98.4%	96.8%	7.1			0	0	0		65,801	67,955	(2,154)
TWH	Ward 32	91.3%	99.7%	98.8%	107.5%	6.8	21.2%	100.0%	11	0	7	5 Falls above threshold	149,681	123,684	25,997
TWH	Ward 10	95.9%	97.5%	75.0%	164.5%	7.7	26.6%	96.0%	4	0	5	2 Falls above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity	129,949	117,333	12,616
TWH	Ward 11	92.4%	99.2%	95.9%	108.1%	6.0	0.0%	-	8	1	3	4 Falls above threshold	135,299	117,029	18,270
TWH	Ward 12	87.9%	107.6%	101.1%	100.0%	6.1	10.1%	77.8%	7	0	6	1 Fall above threshold	129,990	153,894	(23,904)
TWH	Ward 20	92.3%	102.3%	98.8%	94.9%	6.6	68.2%	80.0%	20	0	13	13 Falls above threshold Enhanced care required throughout the month. Not all shifts filled due to inability to cover with temporary staff therefore not measuring an increased fill rate reflective of enhanced care needs.	127,426	135,776	(8,350)
TWH	Ward 21	95.6%	106.4%	103.2%	112.8%	6.5	30.2%	94.7%	6	0	8	Increased fill rate due to enhanced care requirements and aquity levels	143,454	155,214	(11,760)
TWH	Ward 2	83.5%	79.6%	99.6%	79.0%	6.8	91.7%	88.6%	15	0	5	8 Falls above threshold Reduced fill rate due to inability to fill with temporary staff. Staffing requirements for AFU and epsiodes of enhanced care needs, increased dependency and escalated on 1 occasion	148,555	138,828	9,727
TWH	Ward 30	95.2%	96.7%	97.0%	94.2%	5.8	1.9%	100.0%	1	0	7		130,692	124,644	6,048
TWH	Ward 31	89.9%	88.1%	100.1%	90.1%	6.4	0.0%	-	6	0	7		148,454	138,514	9,940
Crowborough	Birth Centre	63.1%	95.1%	91.4%	90.3%				0	0		Considered action to prioritise the night with Community teams support during the day	74,390	81,498	(7,108)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	98.7%	81.6%	98.5%	71.2%	13.8			0	0		Considered action to manage skill mix	726,162	684,489	41,673
TWH	Hedgehog	81.4%	67.3%	115.9%	N/A	15.1	2.8%	87.5%	0	0	6	2 - 3 RMN's required on a 24/7 basis throughout the month	189,836	208,785	(18,949)
MAIDSTONE	Birth Centre	101.4%	91.6%	98.0%	90.3%				0	0			66,761	62,330	4,431
TWH	Neonatal Unit	79.2%	80.0%	96.5%	N/A	11.2			0	0	4	High level of LTS - supporting RTW. Reduced fill rate due to inability to cover shifts	186,262	170,540	15,722
MAIDSTONE	MSSU	106.2%	117.1%	95.6%	N/A	17.6	22.8%	98.8%	0	0	0	3 episodes of additional capcity requirements and an extra list	44,443	45,914	(1,471)
MAIDSTONE	Peale	102.9%	93.8%	100.0%	100.0%	8.7	38.9%	96.4%	1	0	5		80,480	76,623	3,857
TWH	SSSU	106.5%	112.3%	85.5%	164.5%	10.2			1	0	7	Escalated throughout the month	133,594	92,361	41,233
MAIDSTONE	A&E	88.8%	90.0%	100.3%	100.0%		6.6%	89.3%	0	0		2 Falls above threshold TWH	242,942	217,792	25,150
TWH	A&E	94.9%	93.8%	92.5%	97.7%		17.7%	89.4%	4	0			349,549	351,054	(1,505)
												Total Establishment Wards	**5,470,719**	**5,326,626**	**144,093**
												Additional Capacity beds	38,021	37,917	104
												Other associated nursing costs	2,845,451	2,899,654	-54,203
												Total	8,354,191	8,264,196	89,995

RAG Key

Under fill

Over fill

August '18		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	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	91.8%	110.7%	99.1%	104.8%	7.7	68.6%	97.1%	6	1	5	1 Fall above threshold	141,346	140,788	558
MAIDSTONE	Cornwallis	97.7%	110.7%	98.0%	90.2%	6.6	25.5%	91.7%	0	0	5	Increased CSW rate to cover Ward clerk duties and faciliate ward coordination	91,172	92,151	(979)
MAIDSTONE	Culpepper (Inc CCU)	98.0%	101.9%	99.9%	125.4%	11.1	85.4%	100.0%	2	0	0	1 Fall above threshold Increased fill rate due to overnight stay in Cath Lab	109,333	118,865	(9,532)
MAIDSTONE	John Day	92.6%	124.5%	96.8%	109.6%	7.6	49.0%	95.8%	6	1	10	1 Fall above threshold Increased CSW fill rate due to high risk of falls to provide increased ratio of care	130,772	148,148	(17,376)
MAIDSTONE	Intensive Treatment Unit (ITU)	86.2%	90.2%	87.4%	N/A	28.4			1	0	4	1 Fall above threshold Reduced occupancy on 8 occasions and adjusted in line with clinical need. Redcued fill due to temporary staff on 9 episodes	157,740	167,920	(10,180)
MAIDSTONE	Pye Oliver	96.0%	79.9%	98.0%	98.8%	5.5	108.3%	82.7%	7	2	2	2 Falls above threshold Reduced fill rate of care staff due to lack of available temporary staff	118,378	114,822	3,556
MAIDSTONE	Chaucer	95.8%	92.6%	127.4%	119.4%	19.7	125.7%	100.0%	2	0	2	Increased fill rate to support ward escalation at throughout the month. CHPPD increased in line with AFU pathway.	118,269	119,912	(1,643)
MAIDSTONE	Lord North	86.0%	94.3%	99.8%	103.3%	7.0	23.7%	100.0%	3	0	7	1 fall above threshold Reduced fill rate due to lack of available temporary staff.	102,311	102,723	(412)
MAIDSTONE	Mercer	97.3%	106.4%	100.2%	107.5%	6.1	51.4%	89.5%	6	1	5		106,058	114,678	(8,620)
MAIDSTONE	Edith Cavell	89.0%	115.3%	99.9%	123.1%	5.6	53.3%	87.5%	1	0	4	Reduced RN fill rate due to lack of available temporary staff . Increased CSW fill rate due to enhanced care requirements throughout the month	71,880	89,347	(17,467)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	79.8%	68.1%	99.9%	103.1%	11.5	4.4%	57.1%	1	0	4	Reduced fill rate due to a of lack of available temporay staff across 18 days in month. RMNs required on 12 days due to enhanced level of care. Ward escalation at night throughout month	131,484	145,971	(14,487)
TWH	Stroke/W22	75.6%	94.0%	94.2%	97.8%	7.1	60.0%	100.0%	9	0	7	Reduced fill rate due to lack of available temporary staff	150,502	150,320	182
TWH	Coronary Care Unit (CCU)	94.5%	92.9%	97.8%	N/A	10.2	126.1%	96.6%	1	0	3	1 fall above threshold	67,823	66,715	1,108
TWH	Gynaecology/ Ward 33	76.7%	97.0%	100.3%	91.2%	7.2	-	-	1	0	1	1 fall above threshold Reduced fill rate due to lack of available temporary staff on 8 occasions in month	79,637	84,250	(4,613)
TWH	Intensive Treatment Unit (ITU)	97.6%	92.3%	106.6%	N/A	28.8	-	-	0	0	3		187,477	185,649	1,828
TWH	Medical Assessment Unit	104.7%	91.9%	117.7%	120.1%	6.2	7.4%	92.0%	7	1	4	1 fall above threshold Increased fill rate at night due to escalation throughout the month and enhanced care	165,937	200,067	(34,130)
TWH	SAU	94.6%	96.8%	96.8%	100.0%	5.8			0	0	2		61,939	65,063	(3,124)
TWH	Ward 32	86.4%	109.9%	101.2%	101.0%	6.4	23.2%	93.8%	5	0	0	Reduced fill rate due to lack of available temporary staff across 21 days in month which was offset with CSW back fill according to skill mix	139,803	199,473	(59,670)
TWH	Ward 10	93.7%	97.0%	75.0%	171.0%	6.6	1.1%	100.0%	7	1	6	2 falls above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity	120,565	122,518	(1,953)
TWH	Ward 11	95.1%	99.7%	97.6%	124.2%	6.3	-	-	3	0	5		126,638	127,007	(369)
TWH	Ward 12	83.3%	105.1%	98.9%	99.2%	5.9	12.7%	77.8%	12	0	8	6 falls above threshold Reduced fill rate due to lack of available temporary staff to cover current vacancy rate	121,448	150,645	(29,197)
TWH	Ward 20	79.4%	76.9%	94.5%	70.4%	5.9	78.9%	100.0%	13	1	10	6 falls above threshold Reduced fill rate due to lack of available temporary staff . Enhanced care needs daily throughout the month and shifts not covered with temporary staffing.	118,106	127,724	(9,618)
TWH	Ward 21	93.5%	100.8%	101.9%	109.9%	6.2	25.6%	100.0%	6	2	5		134,850	149,012	(14,162)
TWH	Ward 2	82.2%	81.5%	102.2%	88.3%	7.1	67.4%	93.1%	11	0	5	4 falls above threshold Reduced fill rate due to inability to fill with temporary staff. Staffing requirements for AFU and epsiodes of enhanced care needs and escalated on 4 occasions	137,468	109,123	28,345
TWH	Ward 30	95.6%	100.9%	103.2%	96.6%	5.9	14.5%	91.7%	7	1	7	2 falls above threshold	122,711	123,740	(1,029)
TWH	Ward 31	88.1%	98.0%	94.4%	100.0%	6.6	-	-	10	2	7	4 falls above threshold Reduced fill rate due to inability to cover with temporary staff	139,943	126,320	13,623
Crowborough	Birth Centre	62.4%	96.8%	100.0%	96.8%				0	0		Considered action to prioritise the night with Community teams support during the day	71,087	78,485	(7,398)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	86.8%	99.0%	98.6%	98.1%	9.9			0	0		Fill rate influenced with staff moves within directorate to support services according requirements. In addition to unavailable temporary staff. Considered action to manage skill mix	690,917	685,805	5,112
TWH	Hedgehog	85.3%	55.6%	98.1%	N/A	14.9	6.9%	100.0%	0	0	10	Reduced fill rate due to lack of available temporary staff. CSW often not backfilled and can be a considered action to support paediatric services outside of the inpatient unit depending on clinical need.	182,309	203,977	(21,668)
MAIDSTONE	Birth Centre	101.1%	95.2%	97.1%	83.9%				0	0			62,876	62,794	82
TWH	Neonatal Unit	75.2%	41.7%	100.2%	N/A	13.5				0	2	High level of LTS - supporting RTW. Reduced fill rate due to inability to cover shifts	178,691	181,313	(2,622)
MAIDSTONE	MSSU	84.4%	93.3%	95.7%	N/A	10.9	21.1%	97.6%	0	0	0	Reduced fill rate due to lack of available temporary staff and ward closed for BH and one Sunday.	41,887	46,214	(4,327)
MAIDSTONE	Peale	103.5%	107.3%	101.9%	119.4%	9.1	-	-	1	0	5	Increased fill rate to support higher dependency on the ward	76,263	73,510	2,753
TWH	SSSU	106.7%	83.9%	87.1%	169.9%	6.6			0	0	5	Escalated throughout the month	127,152	89,654	37,498
MAIDSTONE	A&E	86.0%	85.6%	99.2%	95.8%		4.1%	88.5%	2	0		Reduced fill rate on occasion but additional fill on other days to support capacity and RMN requirement.	209,318	240,410	(31,092)
TWH	A&E	91.9%	93.8%	94.5%	94.7%		12.0%	94.0%	2	0			335,961	362,744	(26,783)
												Total Establishment Wards	**5,130,051**	**5,367,855**	**(237,804)**
												Additional Capacity beds	36,508	35,624	884
												Other associated nursing costs	-33,528	-35,749	122,051
												Total	5,133,031	5,367,730	-114,869

RAG Key

Under fill

Over fill

Infection Prevention and Control

MRSA

There was one case of Trust-attributable MRSA bacteraemia in August. The case has been reviewed at MDT RCA and the group concluded that the infection was unavoidable due to the patient's multiple co-morbidities and despite MRSA-specific antibiotics being prescribed from admission

C. difficile - There were six cases of post-72 hour *C. difficile* infection in August against a monthly limit of two cases. We are currently 3 cases above trajectory for the year to date with a rate of 10.37 cases per 100 000 bed days. This is compared with a rate of 9.5 for the same period last year.

No link between the cases has been found. There is no evidence of cross infection. Cases have been seen across the trust and incident meetings have been held on three wards where two or more cases occurred. These incident investigations have not identified any common issue to account for the upturn in the number of cases.

All cases have full root cause analysis and are presented at the C. difficile panel with the DIPC and Chief Nurse.

The objective for 2018/19 has been set at **26** cases.

Methicillin sensitive *Staphylococcus aureus* bacteraemia

5 cases of hospital-attributable MSSA blood stream infection were seen in August. Root cause analysis is being carried out on all cases and they will be reviewed at the C. difficile panel

Gram negative bacteraemia

Ten cases of hospital-attributable gram negative blood stream infection were seen in August. Seven cases were due to *E. coli* and three due to *Klebsiella* species

We are working with community colleagues to improve continuity of catheter care across health and social care. An updated version of the catheter passport has now been finalised and will be launched shortly.

Infection Prevention and Control Committee (IPCC)

The IPCC met in August. Key points of interest were:

- A renewed focus on 'bare below the elbows' has been launched to maintain good hand hygiene.
- Re-useable sharps bins have been introduced across the Trust. It is anticipated that compliance with good sharps bin practice will improve and needle stick injuries associated with Sharps bins will decrease. This will be audited once full roll out has been achieved.

Financial commentary

- The Trusts surplus including PSF was £0.1m in August which was on plan, the Trust was £0.3m adverse to the CIP target and had to release £1m of reserves which was in line with the forecast.
- The Trusts normalised run rate in August was £1.7m deficit pre PSF which was £0.9m adverse to plan, the run rate was in line with the quarter 1 average.
- In August the Trust operated with an EBITDA surplus of £2.5m which was on £0.1m adverse to plan.
- The Trust year to date has a deficit including PSF of £2.6m which is on plan, the key variances to plan are: CIP Slippage (£0.8m), overspends within income budgets (£0.3m), pay budgets (£0.7m) and non pay budgets (£1.3m) offset by non-recurrent items (£1.4m), release of contingency reserve (£1m) and £0.2m underspend within depreciation.
- The key current month variances are as follows:
  - Total income net of pass-through related income is £0.9m adverse to plan. Clinical Income excluding HCDs is £0.7m adverse. The key adverse activity related variances were Electives (£0.3m) and Out Patients (£0.4m) which is due to the Prime Provider CIP slippage (£1m). Other Operating Income excluding pass-through costs is £0.1m adverse to plan in the month which mainly relates to Private Patient income.
  - Pay excluding the release of reserves was £0.3m adverse to plan in the month, due to higher than planned agency and bank usage to cover vacant posts. Medical budgets were overspent by £0.1m in August, General Surgery (£0.2m) was the largest overspending directorate due to high number of vacant posts requiring to be covered (17WTE). Nursing budgets overspent by £0.1m in the month which was mainly within Emergency and Acute directorate.
  - Non Pay adjusted for pass through costs was underspent by £0.6m in August although £0.75m underspend is associated with Prime Provider activity slippage and £0.6m of reserves were released therefore the normalised position was an adverse variance of £0.75m. Supplies and Services continues to be the main overspending area within non pay (£0.4m), the main directorates overspending relate to T&O and Critical Care (£0.2m) and Diagnostics (£0.1m), provision for doubtful debt (reported within Other Non Pay) was £0.1m adverse to plan.
- The Trust achieved £1.1m savings in August which was £0.3m adverse to plan and £0.75m adverse year to date. This is mainly due to STP Medical rate slippage (£0.5m), Prime Provider (£0.25m), Private Patient income slippage (£0.1m) partly offset by over performance relating to procurement (£0.1m) and PFI Insurance rebate (£0.2m)
- The Trust held £14.1m of cash at the end of August which is higher than the plan of £5.1m. This is primarily due to the Trust receiving income earlier than forecasted in July, this balance will gradually reduce as pressure points within 2018/19 materialise. In September the Trust has received £1.9m Qtr 1 PSF funding which was forecast to be received in October following guidance from NHSE. The Trust continues to proactively engage with NHS organisations trying to collect all agreed values and organising “like for like” arrangements to reduce both debtor and creditor balances.
- The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; national funding for the next replacement Linac of £1.7m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments. The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects also approved and underway. A major scheme for the Energy Infrastructure has an approved Salix loan of £755k for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application is currently being prepared for TWH LED. The ICT schemes have been prioritised and approved by the ISG in principle, most schemes have business cases approved and are progressing. The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval, Some equipment schemes have been deferred (£237k) to support the ICT EPR project .
- The Capital expenditure FOT is £14.08m which takes account of : 1) Linac 5 funding is £32k less than plan; 2) currently there is a small loss on disposal of assets of (£4k) - this reduces available capital resource and 3) the outturn forecast for depreciation is £351k lower than plan due to slippage

on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment has begun and will be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

- The Trust is forecasting to deliver its financial plan for the year, however it has identified £15m of potential risks that require controlling. The main risks include: £8m risk adjusted CIP shortfall, £5.3m pay pressures and £2.3m non pay pressure (mainly within T&O and Diagnostics). The Trust is working to control these potential risks, such as by continuing to take corrective action on budgetary overspends and working to fully deliver its CIP programme. Should those control actions fail to deliver the required impact, the Trust will have to implement mitigating actions which will include the full release of the remaining Trust contingency reserves and also other non-recurrent measures.

Workforce Commentary

September 2018 Board (August Dashboard)

As at the end of August 2018, the Trust employed 5069.10 whole time equivalent substantive staff, a 19.8 WTE increase from the previous month. Bank and agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (July) increased by 0.09% to 3.29%, 0.01% below target. Directorates demonstrating the highest sickness rates include Private Patient Unit (8.97%), Estates (5.62%) and Facilities (4.66%), with rates having increased in two of the three areas since last month. At a divisional level, Estates and Facilities have the highest sickness levels at 4.74% an increase from the previous month. At a trust level, the breakdown in May is 57.55% short-term, 42.45% long term, reversing the balance from previous months. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting long term sickness in outlying areas.

Statutory and mandatory training compliance has decreased by 3.24% to 85.81%, but remains above the target percentage. The drop is largely attributed to a brief window during August when training course completion could not be recorded due to the migration to a replacement learning management system. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required. Directorates with lower overall compliance include Acute and Emergency Medicine (75.13%), Trauma and Orthopaedics (76.27%) and General Surgery (79.45%).

Turnover has decreased since last month to 9.68%, lower than target, with outliers in Clinical Governance (11.72%), Diagnostics (12.88%) and Estates (12.29%). It should be noted that due to the 12 month rolling calculation, turnover figures typically move more slowly and incorporate historic data as well as the most recent month. HR Business Partners continue to work closely with divisional operational management teams in order to address areas which have a high turnover.

At closure of the appraisal window, appraisal compliance is stands at 82.66% compared with a target of 90%. It is normal for a lag in reporting, even for those appraisals completed during the window, while the documentation is completed and processed. HR Business Partners are working with directorates to highlight areas of non-compliance.

Trust Performance Dashboard

Position as at: 31 August 2018

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 Plan	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)	9.44	28.8	15.9	14.6	11.7	-1.3	2.9	11.5	11.1	
'1-02	Number of cases C.Difficile (Hospital)	2	6	14	15	12	1	3	26	29	
'1-03	Number of cases MRSA (Hospital)	0	1	0	2	0	2	2	0	2	
'1-04	Elective MRSA Screening	98.0%	98.5%	98.0%	98.5%	98.0%	0.5%	0.5%	98.0%	98.5%	
'1-05	% Non-Elective MRSA Screening	Not currently available									
'1-06	**Rate of Hospital Pressure Ulcers	1.84	1.78	1.78	1.62	3.01	-0.17	-1.39	*3.01*	1.67	3.00
'1-07	***Rate of Total Patient Falls	5.76	6.39	5.66	5.95	6.00	0.29	-0.05	*6.00*	5.64	
'1-08	***Rate of Total Patient Falls Maidstone	5.92	5.33	5.19	5.91	-	0.72			4.74	
'1-09	***Rate of Total Patient Falls TWells	6.09	7.01	6.06	5.97	-	-0.09			4.62	
'1-10	Falls - SIs in month	0	5	15	10		-5				
'1-11	Number of Never Events	0	0	0	1	0	1	1	*0*	1	
'1-12	Total No of SIs Open with MTW	44	79				35				
'1-13	Number of New SIs in month	12	18	62	76	50	14	26			
'1-14	***Serious Incidents rate	0.57	0.87	0.58	0.74	0.058	0.16	0.68	*0.0584 - 0.6978*	0.74	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	0.76	1.10	1.18	1.14	1.23	-0.04	-0.09	*0 - 1.23*	1.14	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	1	2			0	1	2	*0*		
'1-17	VTE Risk Assessment - month behind	96.6%	97.2%	96.4%	97.2%	95.0%	0.7%	2.2%	95.0%	97.2%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.8%	98.3%	96.6%	97.8%	95.0%	1.2%	2.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	2.95%	1.68%	3.17%	2.13%		-1.03%	-0.9%	*3.00%*	2.13%	
'1-20	C-Section Rate (non-elective)	14.0%	13.0%	13.7%	13.4%		-0.26%	-1.6%	*15.0%*	13.4%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance Plan	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: July 14 to June 15		1.0878	1.0219		-0.1	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		103.8	105.8		2.0	5.8	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.1%	1.1%	1.1%	1.1%		0.0%				
2-04	****Readmissions <30 days: Emergency	12.3%	14.5%	11.7%	13.9%	13.6%	2.2%	0.3%	*13.6%*	13.9%	14.1%
2-05	****Readmissions <30 days: All	11.8%	13.9%	11.0%	13.4%	14.7%	2.4%	-1.3%	*14.7%*	13.4%	14.7%
2-06	Average LOS Elective	3.70	3.28	2.55	3.01	3.20	0.46	-0.19	*3.20*	3.01	
2-07	Average LOS Non-Elective	6.82	6.96	7.43	6.95	6.80	-0.48	0.15	*6.80*	6.95	
2-22	NE Discharges - Percent zero LoS	38.1%	47.6%	35.9%	44.4%		8.5%			44.4%	
2-08	******FollowUp : New Ratio	1.76	1.57	1.69	1.56		-0.13	0.04	*1.52*	1.56	
2-09	Day Case Rates	88.0%	85.7%	88.0%	87.3%		-0.7%	7.3%	80.0%	87.3%	82.2%
2-10	Primary Referrals	9,295	8,851	45,617	51,062	48,357	11.9%	5.6%	121,638	121,874	
2-11	Cons to Cons Referrals	4,897	5,405	24,658	29,606	23,757	20.1%	24.6%	56,704	70,663	
2-12	First OP Activity (adjusted for uncashed)	15,724	17,064	79,648	89,901	84,188	12.9%	6.8%	204,495	214,576	
2-13	Subsequent OP Activity (adjusted for uncashed	29,352	25,519	147,456	130,772	156,922	-11.3%	-16.7%	379,945	312,126	
2-14	Elective IP Activity	553	602	2,783	2,684	3,082	-3.6%	-12.9%	7,674	6,406	
2-15	Elective DC Activity	3,545	3,622	17,957	18,487	18,100	3.0%	2.1%	44,403	44,125	
2-16	**Non-Elective Activity	4,889	5,570	23,593	26,389	24,376	11.9%	8.3%	58,582	62,954	
2-17	A&E Attendances (Calendar Mth) Excl Crowborc	14,155	14,935	71,806	76,058	75,263	5.9%	1.1%	174,428	174,428	
2-18	Oncology Fractions	5,884	5,315	29,138	27,042	28,444	-7.2%	-4.9%	67,890	64,901	
2-19	No of Births (Mothers Delivered)	506	515	2,497	2,487	2,490	-0.4%	-0.1%	5,977	5,969	
2-20	% Mothers initiating breastfeeding	82.3%	84.0%	82.3%	82.1%	78.0%	-0.2%	4.1%	78.0%	82.1%	
2-21	% Stillbirths Rate	0.2%	0.19%	0.20%	0.16%	0.5%	*0.0%*	*-0.3%*	*0.47%*	0.16%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance Plan	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	12	5	17	0	12	17	0	17	
3-02	*****Rate of New Complaints	1.89	1.63	3.39	2.00	1.32	-1.4	0.68	*1.318-3.92*	1.90	
3-03	% complaints responded to within target	53.2%	62.8%	74.3%	63.4%	75.0%	-10.9%	-11.6%	75.0%	70.1%	
3-04	****Staff Friends & Family (FFT) % rec care	76.0%	77.6%	76.0%	77.6%		1.5%	-1.4%	79.0%	77.6%	
3-05	*****IP Friends & Family (FFT) % Positive	95.6%	95.9%	95.3%	94.7%		-0.6%	-0.3%	95.0%	95.0%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.9%	92.6%	91.4%	91.7%		0.3%	4.7%	87.0%	91.7%	85.5%
3-07	Maternity Combined FFT % Positive	93.9%	98.0%	93.6%	94.7%		1.1%	-0.3%	95.0%	94.7%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.3%	81.7%	83.0%	83.6%		0.6%			83.6%	

* 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 now both consultant and non-consultant led for all specialties -plan still being agreed so currently last year plan

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Qtr to Date Prev Yr	Year/Qtr 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	93.2%	91.78%	90.7%	92.9%	2.3%	2.4%	90.8%	91.9%	76.4%
4-02	Emergency A&E >12hr to Admission	0	0	0	1	1	1	*0*	1	
4-03	Ambulance Handover Delays >30mins	289	399	1419	1,504	85			6,016	
4-04	Ambulance Handover Delays >60mins	30	60	141	179	38			716	
4-05	RTT Incomplete Admitted Backlog	2,298	3,348	2,298	3,348	1,050	856	2,151	2,151	
4-06	RTT Incomplete Non-Admitted Backlog	718	3,911	718	3,911	3,193	987	1,995	1,995	
4-07	RTT Incomplete Pathway	85.9%	79.4%	85.9%	79.4%	-6.4%	-2.3%	85.5%	85.5%	
4-08	RTT 52 Week Waiters (New in Month)	3	4	4	22	18	22	*0*	22	
4-09	RTT Incomplete Total Backlog	3,504	7,259	3,504	7,259	3,755	1,843	4,146	4,146	
4-10	% Diagnostics Tests WTimes <6wks	99.65%	99.6%	99.7%	99.6%	0.0%	0.6%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	4	4	3	1	-2	-8	9	9	
4-12	*Cancer two week wait	93.6%	82.3%	92.1%	85.9%	-6.2%	-7.1%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.4%	67.5%	87.9%	72.2%	-15.7%	-20.8%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	95.3%	97.9%	92.6%	94.8%	2.2%	-1.2%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	70.9%	57.5%	66.2%	56.9%	-9.3%	-25.2%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	59.3%	71.7%	60.3%	-11.5%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	13.5	88.5	59.0	-29.5	59.0	*0*	59.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	80	45	80	45	-35				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	53	34	53	34	-19				
4-20	Delayed Transfers of Care	4.54%	4.68%	5.59%	4.58%	-1.01%	1.08%	3.50%	4.58%	
4-21	% TIA with high risk treated <24hrs	81.0%	No data	67.3%	72.5%	5.1%	12.5%	60%	72.5%	
4-22	*******% spending 90% time on Stroke Ward	94.8%	92.1%	92.4%	90.4%	-2.0%	10.4%	80%	90.4%	
4-23	*******Stroke:% to Stroke Unit <4hrs	65.2%	67.7%	59.2%	54.3%	-4.9%	-5.7%	60.0%	54.3%	
4-24	*******Stroke: % scanned <1hr of arrival	75.8%	66.2%	64.5%	56.0%	-8.5%	8.0%	48.0%	56.0%	
4-25	*******Stroke:% assessed by Cons <24hrs	80.3%	93.8%	85.8%	85.8%	0.0%	5.8%	80.0%	85.8%	
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	11	2	11	14	3	14	*0*	14	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

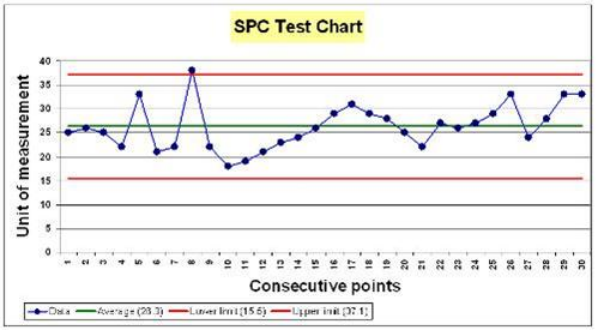
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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	35,658	38,606	182,610	191,645	4.9%	1.2%	466,408	466,408	
5-02	EBITDA	428	2,515	6,891	9,842	42.8%	-2.6%	38,910	38,910	
5-03	Surplus (Deficit) against B/E Duty	(2,126)	82	(5,830)	(2,558)			11,743	11,743	
5-04	CIP Savings	1,927	1,151	7,378	4,988	-32.4%	-13.1%	24,111	24,111	
5-05	Cash Balance	5,594	14,126	5,594	14,126			1,000	1,000	
5-06	Capital Expenditure	287	365	1,579	1,820			*13,762*	13,380	
5-07	Establishment WTE	5,603.2	5,627.4	5,603.2	5,627.4	0.4%	0.0%	5,627.4	5,627.4	
5-08	Contracted WTE	4,995.8	5,069.3	4,995.8	5,069.3	1.5%	0.9%	5,023.4	5,023.4	
5-09	Vacancies WTE	607.4	558.1	607.4	558.1	-8.1%	-7.6%	604.0	604.0	
5-11	Vacancy Rate (%)	10.8%	9.9%	10.8%	9.9%	-0.9%	-0.8%	10.7%	10.7%	
5-12	Substantive Staff Used	4,868.3	4,936.9	4,868.3	4,936.9	1.4%	-1.8%	5,026.5	5,026.5	
5-13	Bank Staff Used	345.5	447.7	345.5	447.7	29.6%	22.6%	365	365.1	
5-14	Agency Staff Used	245.9	301.7	245.9	301.7	22.7%	27.9%	235.8	235.8	
5-15	Overtime Used	46.9	45.8	46.9	45.8	-2.3%				
5-16	Worked WTE	5,506.6	5,732.1	5,506.6	5,732.1		1.9%	5,627.4	5,627.4	
5-17	Nurse Agency Spend	(444)	(847)	(2,692)	(3,716)	38.1%				
5-18	Medical Locum & Agency Spend	(1,428)	(1,585)	(5,895)	(7,741)	31.3%				
5-19	Temp costs & overtime as % of total pay bill	15.0%	18.4%	16.5%	16.9%	0.3%				
5-20	Staff Turnover Rate	12.2%	9.7%		9.7%	-2.5%	-0.8%	*10.5%*	9.7%	11.05%
5-21	Sickness Absence	3.3%	3.3%		3.4%	0.0%	0.1%	*3.3%*	3.4%	4.3%
5-22	Statutory and Mandatory Training	88.3%	85.8%		88.0%	-2.5%	3.0%	85.0%	88.0%	
5-23	Appraisal Completeness	83.9%	82.6%		82.6%	-1.2%	-7.4%	90.0%	82.6%	
5-24	Overall Safe staffing fill rate	97.4%	94.3%	98.4%	96.6%	-1.8%		93.5%	96.6%	
5-25	****Staff FFT % recommended work	50.9%	49%	50.9%	49%	-2.3%	-13.3%	62.0%	49%	
5-26	***Staff Friends & Family -Number Responses	701	263	701	263	-438				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.8%	18.7%	23.7%	23.0%	-0.6%	-2.0%	25.0%	23.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.2%	8.1%	21.4%	13.2%	-8.3%	-1.8%	15.0%	13.2%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	28.9%	9.9%	31.7%	22.8%	-8.9%	-2.2%	25.0%	22.8%	24.0%

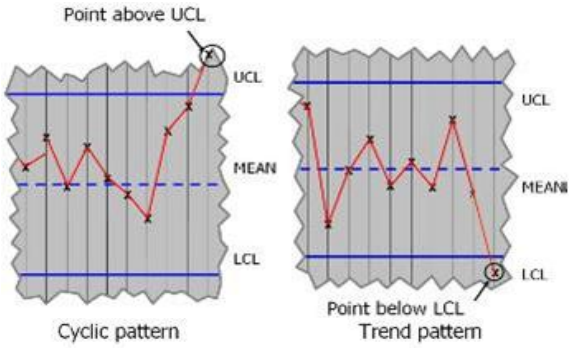
Explanation of Statistical Process Control (SPC) Charts

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:

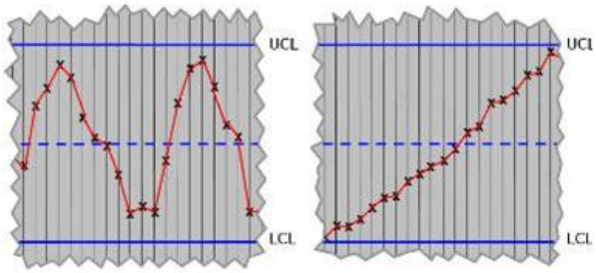


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. 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.

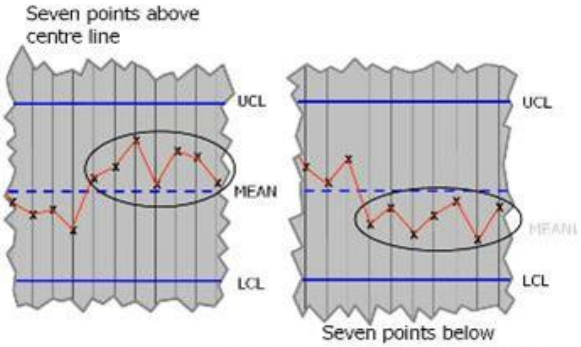


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

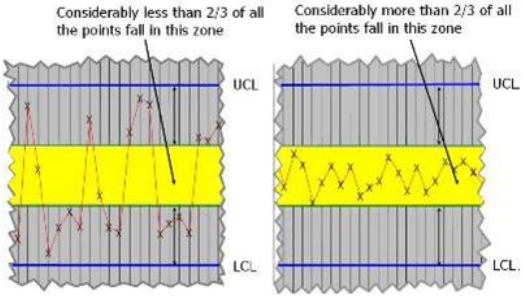


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

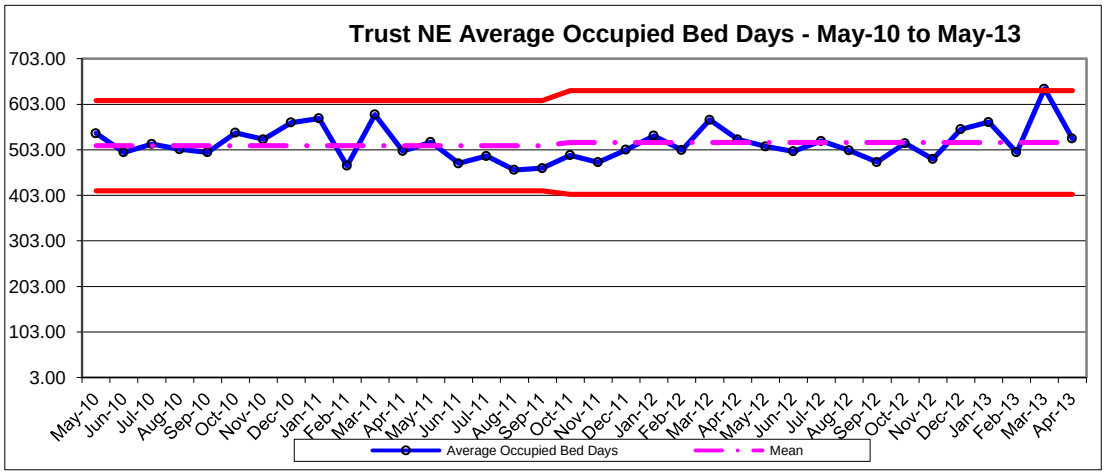


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

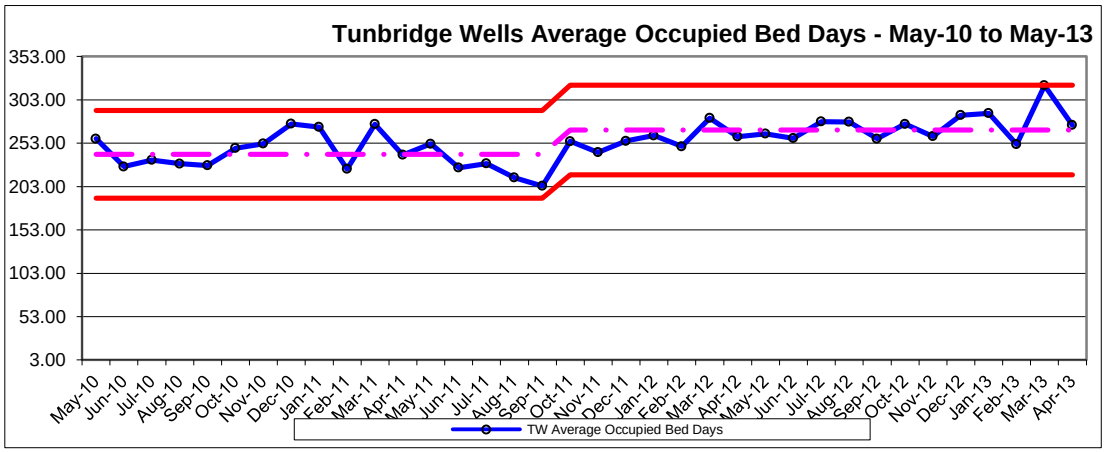


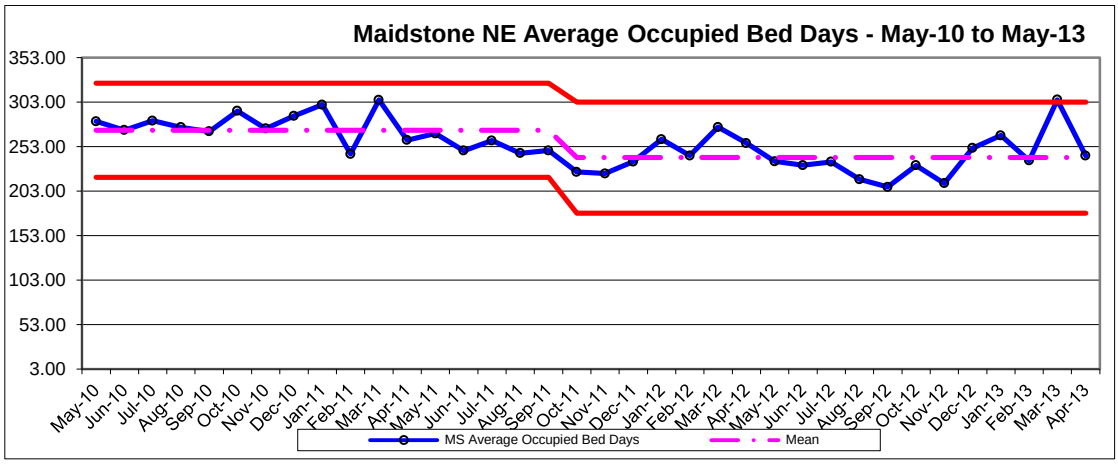
Changes to Control Lines

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:

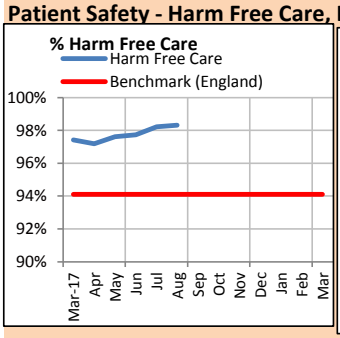


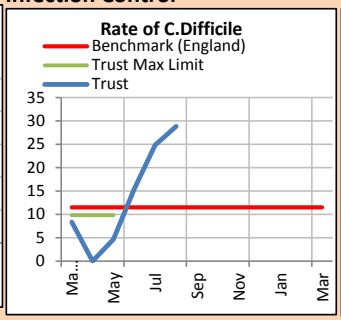


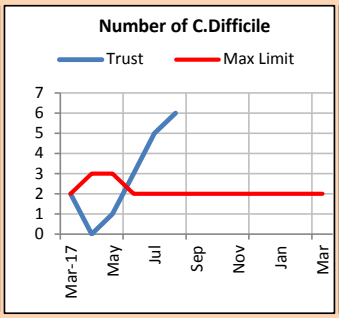
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

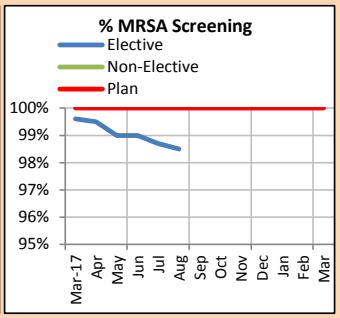
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

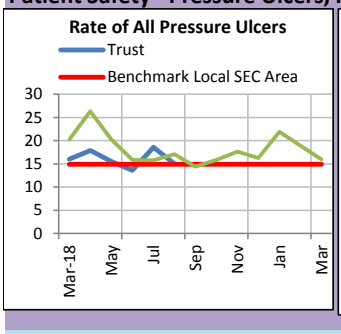


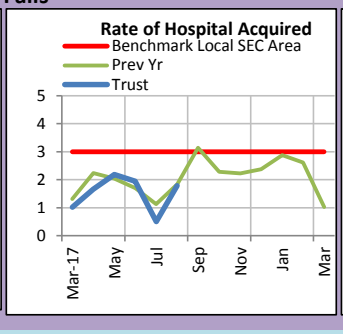


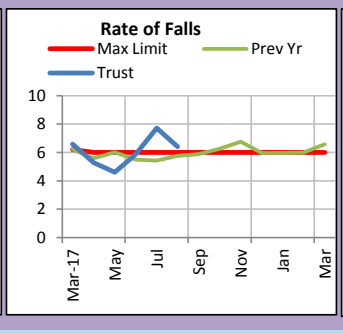


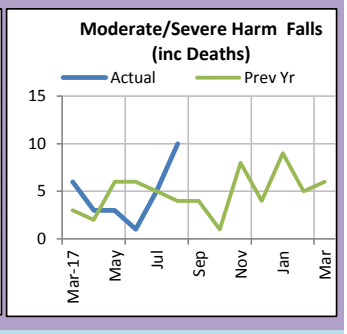


Patient Safety - Pressure Ulcers, Falls

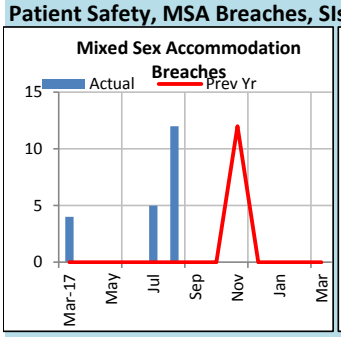


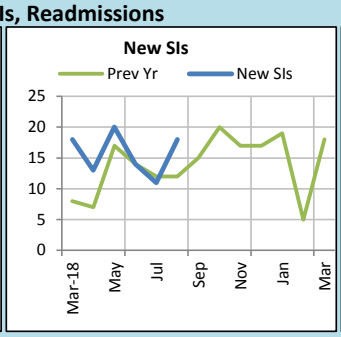


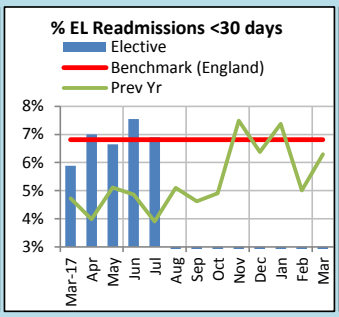


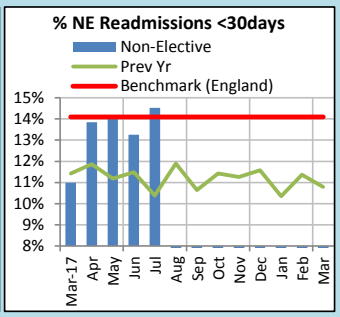


Patient Safety, MSA Breaches, SIs, Readmissions

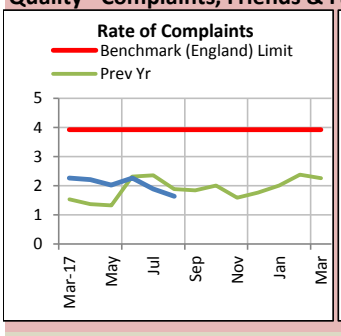


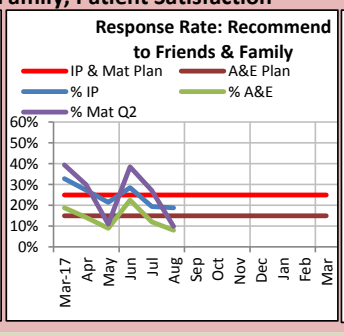


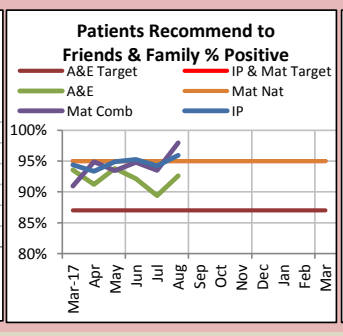


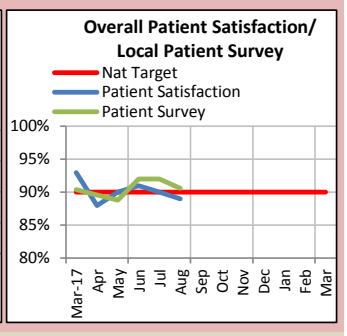


Quality - Complaints, Friends & Family, Patient Satisfaction

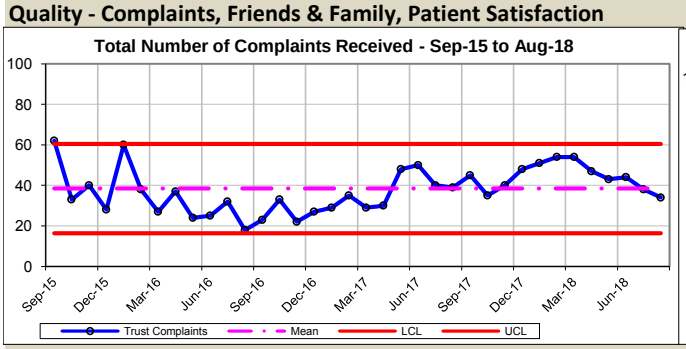


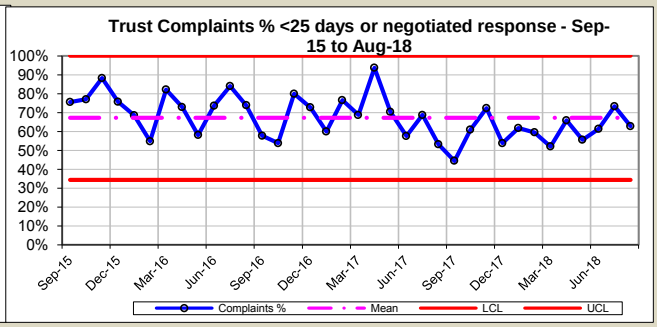




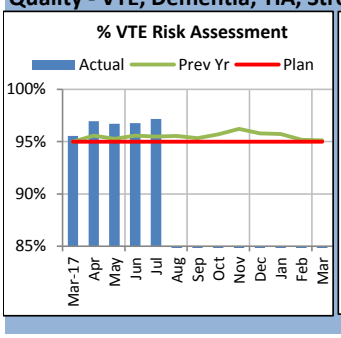


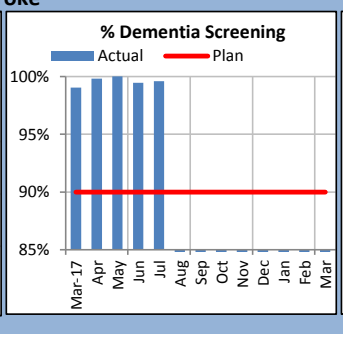
Quality - Complaints, Friends & Family, Patient Satisfaction

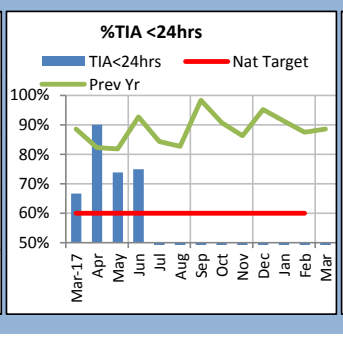


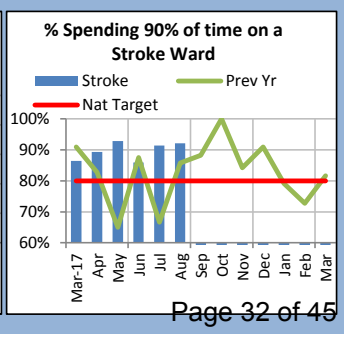


Quality - VTE, Dementia, TIA, Stroke



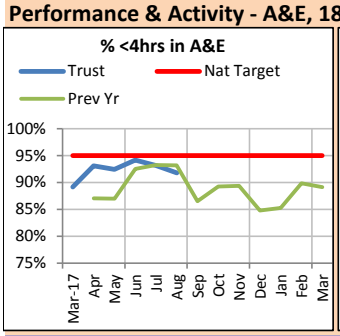


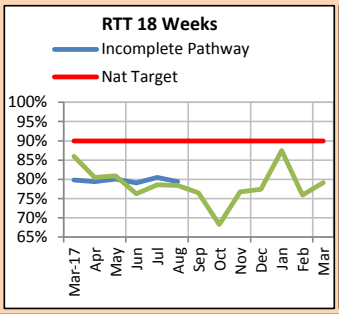


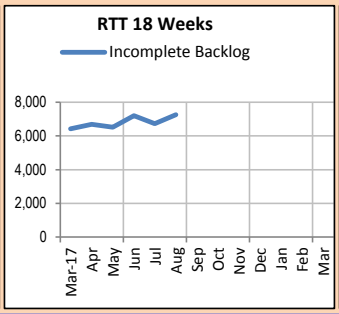


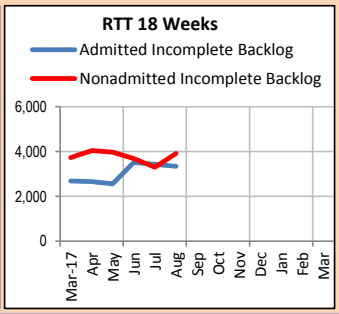
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

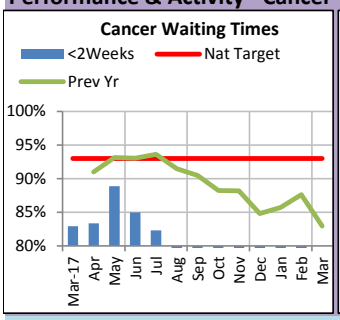


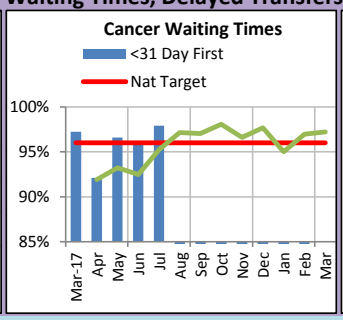


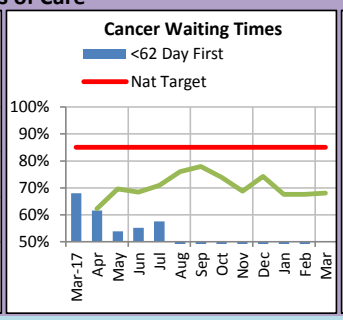


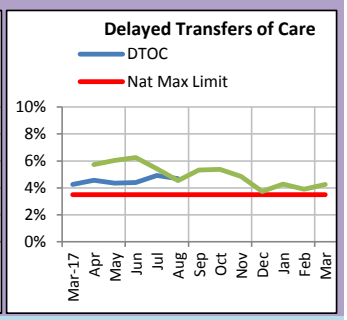


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

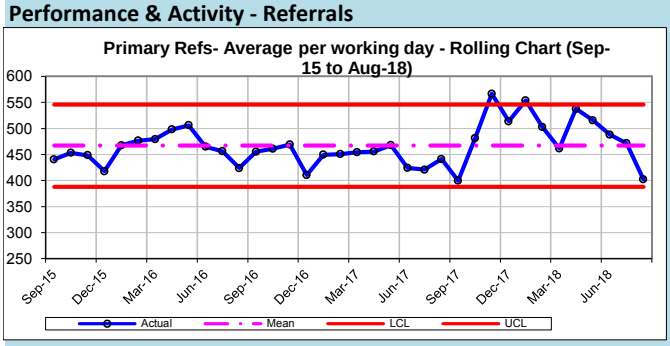


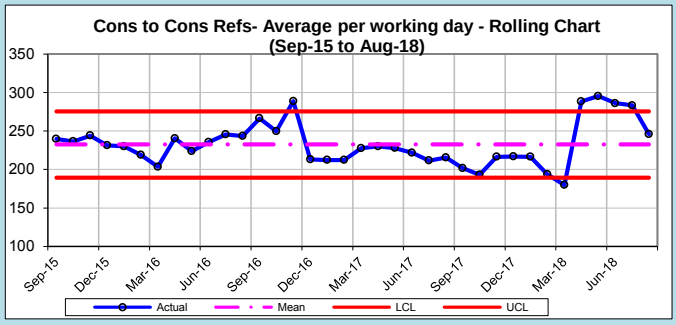




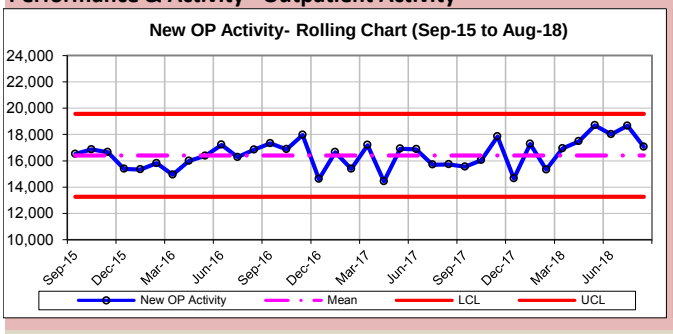


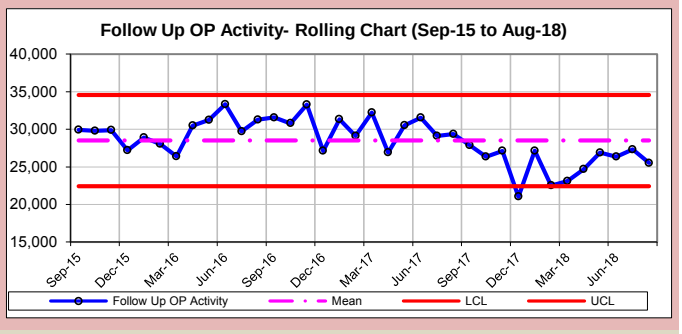
Performance & Activity - Referrals



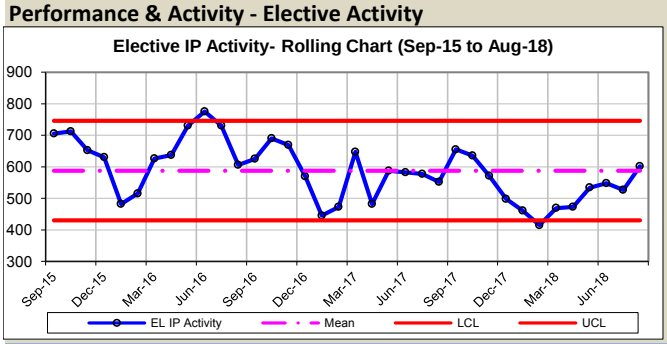


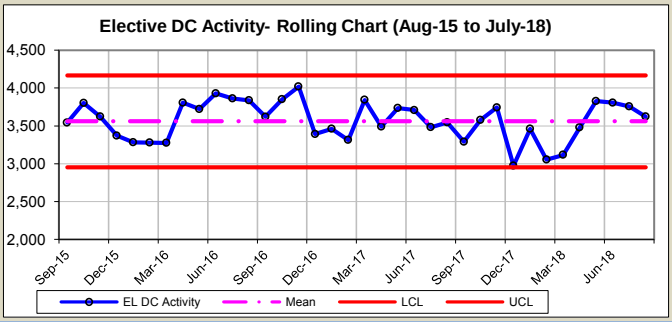
Performance & Activity - Outpatient Activity



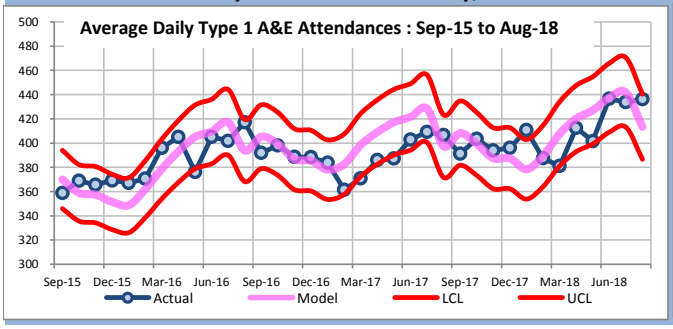


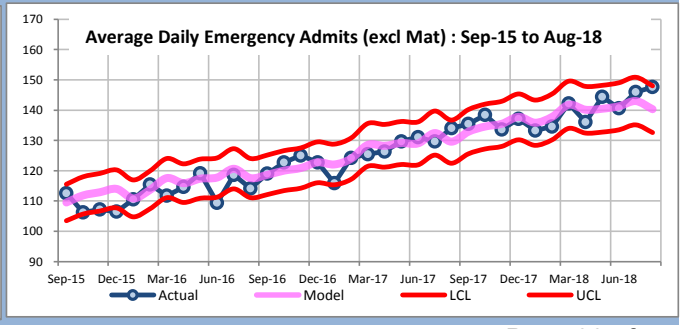
Performance & Activity - Elective Activity





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

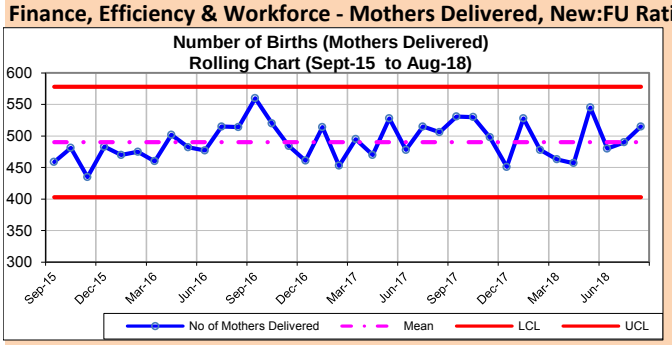


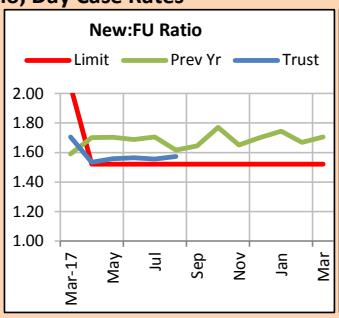


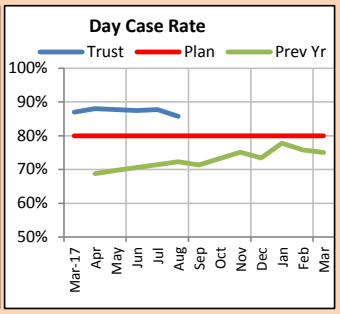
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

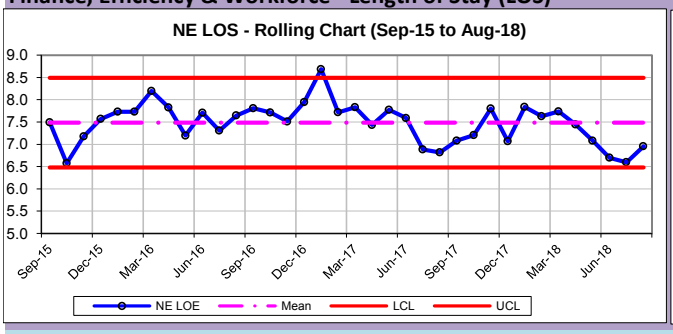
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

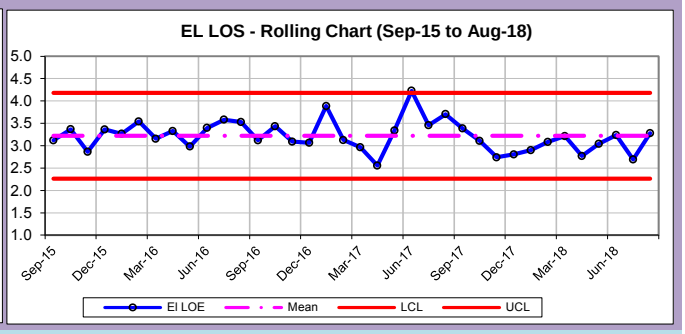




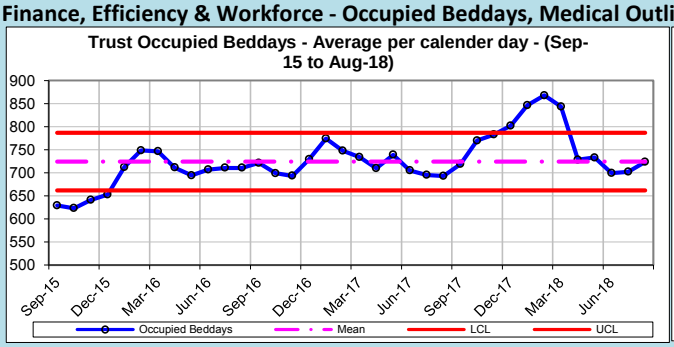


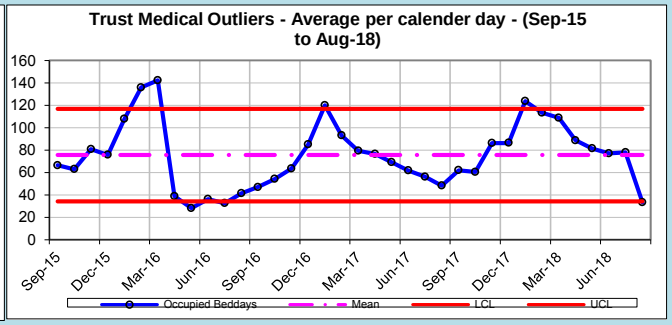
Finance, Efficiency & Workforce - Length of Stay (LOS)



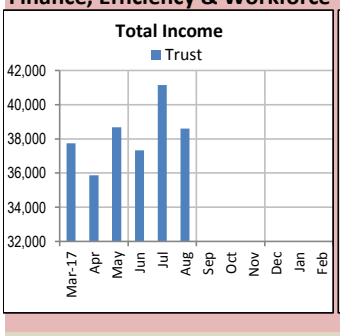


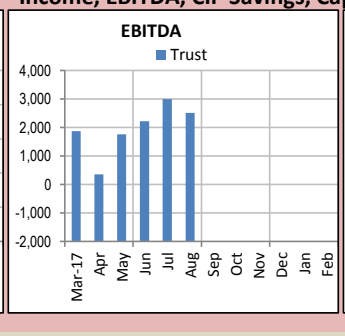
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

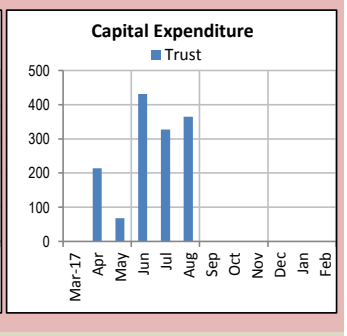




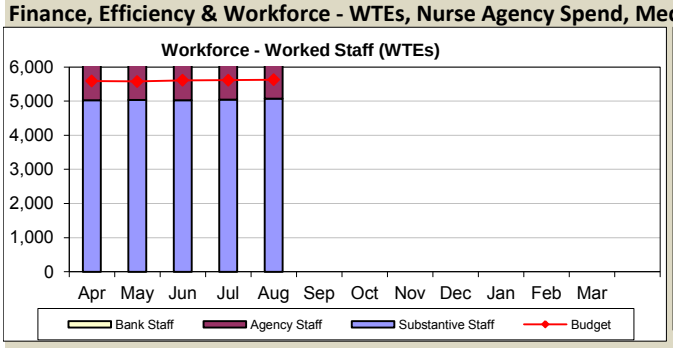
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

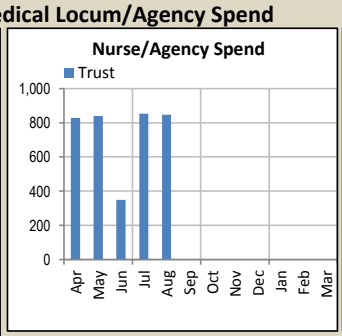


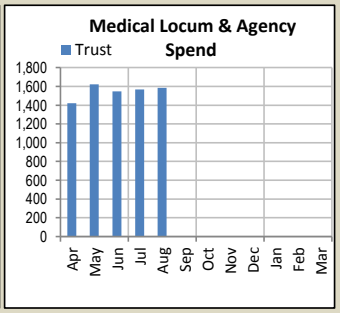




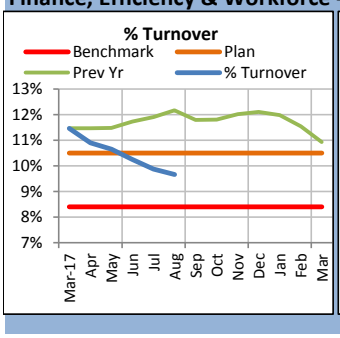
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

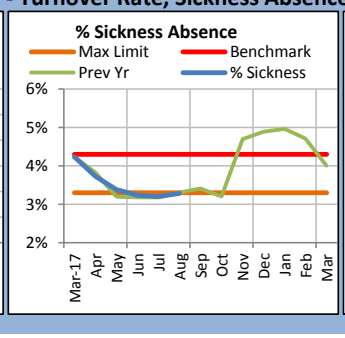


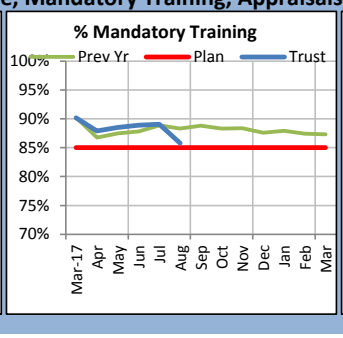


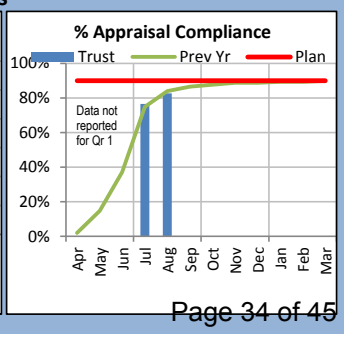


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 5
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for August 2018

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

August 2018/19

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	38.6	39.6	(1.0)	(0.2)	(0.9)		191.6	191.7	(0.1)	(0.4)	0.4		467.7	471.1	(3.4)	
Expenditure	(36.1)	(37.0)	0.9	0.2	0.8		(181.8)	(181.6)	(0.2)	0.4	(0.6)		(432.1)	(432.1)	0.1	
EBITDA (Income less Expenditure)	2.5	2.6	(0.1)	(0.0)	(0.1)		9.8	10.1	(0.3)	0.0	(0.3)		35.6	38.9	(3.3)	
Financing Costs	(2.5)	(2.5)	0.1	0.0	0.1		(12.6)	(12.7)	0.1	0.0	0.1		(25.0)	(28.2)	3.2	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.2	0.0	0.2	0.0	0.2		1.1	1.0	0.0	
Net Surplus / Deficit (Incl PSF)	**0.1**	**0.1**	**0.0**	**(0.0)**	**0.0**		**(2.6)**	**(2.6)**	**0.0**	**0.0**	**0.0**		**11.7**	**11.7**	**0.0**	
CIPs	1.2	1.5	(0.3)		(0.3)		5.0	5.7	(0.8)		(0.8)		24.1	24.1	0.0	
Cash Balance	14.1	5.1	9.0		9.0		14.1	5.1	9.0		9.0		1.0	1.0	0.0	
Capital Expenditure	0.4	0.7	(0.3)		(0.3)		1.8	2.8	(1.0)		(1.0)		13.4	13.8	(0.4)	
Capital service cover rating							4	4					4	4		
Liquidity rating							4	4					4	4		
I&E margin rating							4	4					1	1		
Agency rating							4	4					4	4		
Finance and use of resources rating Excl FSM Override							3	3					3	3		

Summary:

- The Trusts surplus including PSF was £0.1m in August which was on plan. Year to date the Trust has a deficit of £2.6m which is on plan however the key variances within plan are: CIP Slippage (£0.8m), overspends within income budgets (£0.3m), pay budgets (£0.7m) and non pay budgets (£1.3m) offset by non-recurrent items (£1.4m) , release of contingency reserve (£1m) and £0.2m underspend within depreciation.
- The Trust has spent £5.3m more than the YTD agency ceiling set by NHSI (£11.8m per annum)

Key Points:

- The Trusts normalised run rate in August was £1.7m deficit pre PSF which was £0.9m adverse to plan.
- The Trust missed the A&E Trajectory in August, the PSF funding is based on a quarterly performance which the Trust is currently delivering therefore the full PSF income has been incorporated within the positon.
- Year to date Non Pay pressures (£1.3m) net of passthrough and CIP slippage is now greater than the pay pressures. The main non pay pressures relate to T&O and Diagnostics, as part of the EPR executive challenge meetings these directorates have been asked to provide a full analysis and a recovery plan to address the overspend.

Risks:

- The Trust is forecasting to deliver the plan but there are several risks within this forecast which include CIP risk adjusted slippage (£8m), Divisional Pay pressures (£5.3m) and non pay overspends within T&O and Diagnostics (£1.7m). The Trust will have to implement recovery plans and mitigating actions to deliver the financial plan which are covered in section 4 of this report.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure August 2018/19

	Current Month					Year to Date				
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m
Income	37.8	38.8	(1.0)	(0.2)	(0.9)	187.7	188.9	(1.3)	(0.4)	(0.8)
Expenditure	(36.2)	(37.0)	0.8	0.2	0.6	(181.9)	(181.6)	(0.3)	0.4	(0.8)
Trust Financing Costs	(2.5)	(2.5)	0.1	0.0	0.1	(12.6)	(12.7)	0.1	0.0	0.1
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.2	0.0	0.2
Net Revenue Surplus / (Deficit) before Exceptional Items	**(0.9)**	**(0.8)**	**(0.1)**	**(0.0)**	**(0.1)**	**(6.7)**	**(5.3)**	**(1.3)**	**0.0**	**(1.3)**
Exceptional Items	0.1		0.1		0.1	1.4		1.4		1.4
Net Position	**(0.8)**	**(0.8)**	**0.0**	**(0.0)**	**0.0**	**(5.3)**	**(5.3)**	**0.0**	**0.0**	**0.0**
PSF Funding	0.8	0.8	0.0	0.0	0.0	2.8	2.8	0.0	0.0	0.0
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	0.1	0.1	0.0	(0.0)	0.0	(2.6)	(2.6)	0.0	0.0	0.0

Key messages:
The Trust released £1m contingency reserve this month and had a £0.1m benefit relating to non recurrent exceptional items in the month.

Income:
Income YTD net of pass-through related costs is £0.8m adverse to plan, Private Patient income £0.5m and Provider to Provider SLA income £0.1m are the main areas of overspend.

Expenditure:
Overspending against Clinical Supplies and Services (£1.2m) is the main pressure within expenditure budgets, pay budgets have overspent to date by £0.7m (excluding exceptional items and release of reserves) which is within Medical (£0.7m) and Nursing (£0.2m).

Exceptional Non recurrent Items: Exceptional Non recurrent items of £0.1m benefited the position in August, this related to reclaim of overpayment of salary.

Reserves: The Trust is currently holding £1.8m of reserves YTD, a reduction of £0.5m between months.

PSF: The Trust missed the A&E Trajectory in August, the PSF funding is based on a quarterly performance which the Trust is currently delivering therefore the full PSF income has been incorporated within the positon.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure August 2018/19

	Current Month					Year to Date					Annual Forecast		
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Clinical Income	29.4	30.2	(0.8)	(0.1)	(0.7)	146.7	146.4	0.3	(0.3)	0.6	354.4	356.3	(1.9)
High Cost Drugs	3.6	3.7	(0.0)	(0.0)	0.0	18.4	18.4	0.0	0.0	0.0	43.2	43.2	0.0
Total Clinical Income	**33.1**	**33.9**	**(0.8)**	**(0.1)**	**(0.7)**	**165.1**	**164.8**	**0.3**	**(0.3)**	**0.6**	**397.7**	**399.6**	(1.9)
PSF	0.8	0.8	0.0	0.0	0.0	2.8	2.8	0	0	0	12.7	12.7	0
Other Operating Income	4.7	4.9	(0.2)	(0.1)	(0.1)	23.8	24.2	(0.4)	(0.2)	(0.2)	57.3	58.8	(1.5)
Total Revenue	38.6	39.6	(1.0)	(0.2)	(0.9)	191.6	191.7	(0.1)	(0.4)	0.4	467.7	471.1	(3.4)
Substantive	(18.5)	(19.1)	0.6	0.0	0.5	(93.2)	(95.4)	2.1	0.2	1.9	(226.7)	(228.8)	2.2
Bank	(1.2)	(1.0)	(0.2)	0.0	(0.2)	(5.3)	(5.0)	(0.3)	0.0	(0.3)	(12.7)	(12.3)	(0.4)
Locum	(0.7)	(0.4)	(0.3)	0.0	(0.3)	(2.9)	(2.2)	(0.7)	0	(0.7)	(7.8)	(5.5)	(2.4)
Agency	(2.1)	(1.7)	(0.4)	(0.0)	(0.4)	(10.1)	(8.4)	(1.7)	(0.0)	(1.7)	(23.1)	(22.2)	(0.9)
Pay Reserves	0.2	(0.2)	0.4	0.0	0.4	(0.6)	(1.1)	0.4	0	0.4	2.2	(1.8)	4.0
Total Pay	(22.3)	(22.4)	0.1	0.0	0.1	(112.1)	(112.0)	(0.1)	0.2	(0.3)	(268.1)	(270.6)	2.5
Drugs & Medical Gases	(4.3)	(4.5)	0.2	0.0	0.1	(22.2)	(22.7)	0.6	(0.0)	0.6	(53.4)	(52.0)	(1.3)
Blood	(0.2)	(0.1)	(0.1)	0.0	(0.1)	(0.9)	(0.9)	0.0	0	0.0	(2.1)	(2.2)	0.1
Supplies & Services - Clinical	(3.0)	(2.7)	(0.3)	0.1	(0.3)	(14.0)	(13.1)	(1.0)	0.3	(1.2)	(34.2)	(32.1)	(2.0)
Supplies & Services - General	(0.5)	(0.4)	(0.1)	(0.0)	(0.1)	(2.2)	(2.2)	0.1	(0.0)	0.1	(5.2)	(5.0)	(0.1)
Services from Other NHS Bodies	(0.7)	(0.8)	0.2	0.1	0.0	(3.7)	(4.1)	0.4	0.3	0.2	(10.1)	(9.9)	(0.2)
Purchase of Healthcare from Non-NHS	(0.3)	(1.0)	0.7	0.0	0.7	(1.4)	(2.0)	0.6	(0.0)	0.6	(3.9)	(5.2)	1.3
Clinical Negligence	(1.6)	(1.6)	(0.0)	0.0	(0.0)	(7.9)	(7.9)	(0.0)	0	(0.0)	(19.0)	(19.0)	(0.0)
Establishment	(0.4)	(0.3)	(0.1)	(0.0)	(0.1)	(1.6)	(1.5)	(0.1)	(0.0)	(0.1)	(4.0)	(3.5)	(0.5)
Premises	(2.2)	(2.3)	0.1	0.0	0.0	(10.3)	(9.8)	(0.4)	0.1	(0.5)	(23.8)	(21.3)	(2.5)
Transport	(0.1)	(0.1)	0.0	0.0	0.0	(0.8)	(0.7)	(0.1)	0	(0.1)	(1.8)	(1.3)	(0.5)
Other Non-Pay Costs	(1.1)	(0.7)	(0.4)	(0.1)	(0.2)	(4.5)	(3.8)	(0.8)	(0.3)	(0.5)	(8.8)	(8.1)	(0.7)
Non-Pay Reserves	0.5	(0.1)	0.6	0.0	0.6	(0.3)	(0.9)	0.6	0	0.6	2.2	(1.8)	4.0
Total Non Pay	(13.8)	(14.6)	0.8	0.1	0.6	(69.7)	(69.6)	(0.1)	0.2	(0.3)	(164.0)	(161.6)	(2.4)
Total Expenditure	(36.1)	(37.0)	0.9	0.2	0.8	(181.8)	(181.6)	(0.2)	0.4	(0.6)	(432.1)	(432.1)	0.1
EBITDA	2.5	2.6	(0.1)	(0.0)	(0.1)	9.8	10.1	(0.3)	0.0	(0.3)	35.6	38.9	(3.3)
	0.0	*0.0*	*0.0*	*%*		*5.1%*	*5.3%*	*520.4%*	*0.0%*	*-69.6%*	*7.6%*	*8.3%*	*98.2%*
									0	0			
Depreciation	(1.0)	(1.1)	0.1	0	0.1	(5.4)	(5.6)	0.2	0	0.2	(13.2)	(13.5)	0.3
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(0.7)	(0.7)	(0.0)	0	(0.0)	(1.6)	(1.6)	(0.0)
Dividend	(0.1)	(0.1)	(0.0)	0	(0.0)	(0.5)	(0.5)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0	(0.0)	(5.9)	(5.9)	(0.0)	0	(0.0)	(8.9)	(11.9)	3.0
Total Finance Costs	(2.5)	(2.5)	0.1	0.0	0.1	(12.6)	(12.7)	0.1	0	0.1	(25.0)	(28.2)	3.2
Net Surplus / Deficit (-)	0.0	0.1	(0.0)	(0.0)	**(0.0)**	(2.7)	(2.6)	(0.1)	0.0	(0.1)	10.6	10.7	(0.0)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.2	0.0	0.2	1.1	1.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl PSF	0.1	0.1	0.0	(0.0)	**0.0**	(2.6)	(2.6)	0.0	0.0	0.0	11.7	11.7	0.0
Surplus/ Deficit (-) to B/E Duty Excl PSF	(0.8)	(0.8)	0.0	(0.0)	**0.0**	(5.3)	(5.3)	0.0	0.0	0.0	(1.0)	(1.0)	0.0

Commentary

The Trusts surplus including PSF was £0.1m in August which was on plan, year to date the Trust has a deficit of £2.6m which is on plan.

The Trusts normalised run rate in August was £1.7m deficit pre PSF which was £0.9m adverse to plan, the run rate was in line with the quarter 1 average.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, Education and Training costs associated with PSF and CPD funding, Sexual Health outsourced pass-through tests and PAS AllScripts.

Clinical Income excluding HCDs was £0.8m adverse to plan in August. The key adverse variances in month were Electives (£0.3m) and Outpatients (£0.4m). This is mainly in relation to the delay to the Prime Provider tender process

The Trust missed the A&E Trajectory in August, the PSF funding is based on a quarterly performance which the Trust is currently delivering therefore the full PSF income has been incorporated within the positon.

Other Operating Income excluding pass-through costs is £0.1m adverse to plan in the month, the main pressures relate to Private Patient income (£0.1m) and NHS Provider to Provider SLA Income (£0.1m).

Pay excluding the release of contingency reserve was £0.3m adverse to plan in the month, due to higher than planned agency and bank usage to cover vacant posts. Medical budgets were overspent by £0.1m in August, General Surgery (£0.2m) was the largest overspending directorate due to high number of vacant posts requiring to be covered (17WTE). Nursing budgets overspent by £0.1m in the month which was mainly within Emergency and Acute directorate .

Non Pay adjusted for pass through costs was underspent by £0.6m in August although £0.75m underspend is associated with Prime Provider activity slippage and £0.6m of contingency reserves were released therefore the normalised position was an adverse variance of £0.75m. Supplies and Services continues to be the main overspending area within non pay (£0.4m), the main directorates overspending relate to T&O and Critical Care (£0.2m) and Diagnostics (£0.1m), provision for doubtful debt (reported within Other Non Pay) was £0.1m adverse to plan.

The Trust is forecasting to deliver the planned Surplus including PSF of £11.7m.

Maidstone and Tunbridge Wells NHS Trust

2b. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Change between Months
Revenue	Clinical Income	31.2	32.6	31.3	31.2	31.7	32.0	31.2	33.8	30.7	33.5	32.3	35.4	33.1	(2.4)
	STF / PSF	0.0	2.2	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0
	High Cost Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.5	4.1	3.8	3.4	3.8	4.0	5.7	3.9	5.1	5.2	5.0	5.7	5.5	(0.2)
	Total Revenue	**35.7**	**38.9**	**35.0**	**34.5**	**35.5**	**36.0**	**36.9**	**40.8**	**35.9**	**38.7**	**37.3**	**41.2**	**38.6**	**(2.5)**
Expenditure	Substantive	(17.7)	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(18.7)	(18.4)	(19.4)	(18.5)	0.8
	Bank	(0.7)	(1.2)	(1.0)	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	(1.0)	(1.0)	(1.0)	(1.2)	(0.2)
	Locum	(0.5)	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	(0.6)	(0.7)	(0.1)
	Agency	(1.7)	(1.9)	(2.0)	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	(2.1)	(1.7)	(2.1)	(2.1)	0.0
	Pay Reserves	(0.1)	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	0.2	0.4
	Total Pay	(20.8)	(20.0)	(21.6)	(21.6)	(21.6)	(22.2)	(21.3)	(22.7)	(22.0)	(22.7)	(21.9)	(23.2)	(22.3)	1.0
Non-Pay	Drugs & Medical Gases	(4.8)	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	(4.8)	(4.3)	(4.5)	(4.3)	0.2
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.7)	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(2.9)	(2.7)	(2.9)	(3.0)	(0.1)
	Supplies & Services - General	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.1)
	Services from Other NHS Bodies	(0.7)	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.6)	(1.1)	(0.7)	(0.7)	0.0
	Purchase of Healthcare from Non-NHS	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.1)
	Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(0.0)
	Establishment	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.4)	(0.1)
	Premises	(1.9)	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	(1.8)	(1.8)	(2.6)	(2.2)	0.4
	Transport	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(1.6)	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(1.0)	(0.3)	(1.2)	(1.1)	0.1
	Non-Pay Reserves	0.0	0.3	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.2)	(0.2)	0.5	0.6
	Total Non Pay	(14.4)	(11.7)	(14.1)	(13.4)	(14.2)	(13.7)	(15.4)	(13.2)	(13.5)	(14.3)	(13.2)	(14.9)	(13.8)	1.1
	Total Expenditure	(35.2)	(31.6)	(35.7)	(35.0)	(35.8)	(35.8)	(36.7)	(35.9)	(35.5)	(36.9)	(35.1)	(38.2)	(36.1)	2.1
EBITDA	EBITDA	0.4	7.3	(0.6)	(0.5)	(0.3)	0.2	0.2	4.9	0.4	1.8	2.2	3.0	2.5	(0.5)
		1%	*19%*	*-2%*	*-1%*	*-1%*	*1%*	*1%*	*12%*	*1%*	*5%*	*6%*	*7%*	*7%*	
Other Finance Costs	Depreciation	(1.2)	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	(1.1)	(1.1)	(1.0)	(1.0)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	0.2	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
	Total Other Finance Costs	**(2.6)**	**(2.6)**	**(2.2)**	**(2.5)**	**(6.4)**	**(1.9)**	**(2.5)**	**16.3**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(0.0)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(0.8)	(0.3)	0.5	0.0	(0.5)
Technical Adjustments	Technical Adjustments	0.0	0.0	0.0	0.0	4.0	0.0	0.0	(18.9)	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(2.1)	4.8	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	2.3	(2.2)	(0.8)	(0.3)	0.5	0.0	(0.5)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.1)	2.5	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	(0.7)	(2.2)	(0.8)	(0.3)	0.5	0.0	(0.5)

Maidstone and Tunbridge Wells NHS Trust

3a. Cost Improvement Plan

Savings by Division

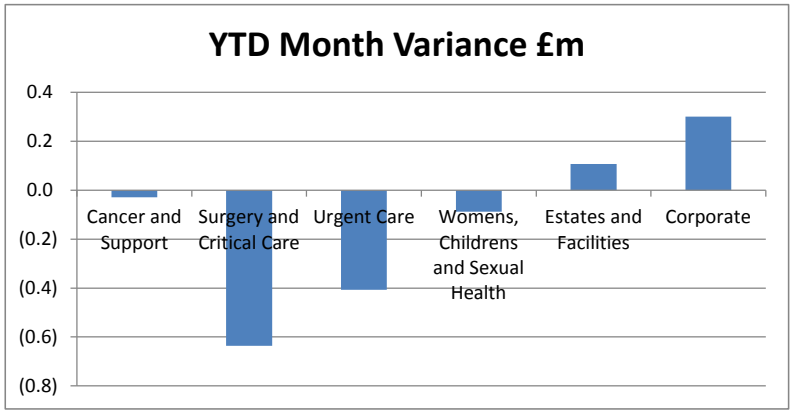
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Support	0.18	0.19	(0.00)	0.68	0.71	(0.03)	1.50	3.01	(1.52)
Surgery and Critical Care	0.47	0.76	(0.29)	2.08	2.71	(0.64)	7.31	11.38	(4.07)
Urgent Care	0.10	0.20	(0.09)	0.53	0.93	(0.41)	1.44	3.46	(2.02)
Womens, Childrens and Sexual Health	0.11	0.15	(0.03)	0.49	0.58	(0.09)	1.46	2.11	(0.65)
Estates and Facilities	0.10	0.09	0.01	0.47	0.36	0.11	1.59	3.15	(1.56)
Corporate	0.18	0.09	0.10	0.74	0.44	0.30	2.76	1.00	1.76
Total	**1.15**	**1.47**	**(0.31)**	**4.99**	**5.74**	**(0.75)**	**16.06**	**24.11**	**(8.05)**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.27	0.40	(0.14)	1.25	1.91	(0.67)	3.18	3.17	0.01
Non Pay	0.82	(0.06)	0.89	3.42	2.41	1.01	6.11	8.40	(2.28)
Income	0.06	1.13	(1.06)	0.32	1.42	(1.10)	6.77	12.55	(5.78)
Total	**1.15**	**1.47**	**(0.31)**	**4.99**	**5.74**	**(0.75)**	**16.06**	**24.11**	**(8.05)**

Savings by Plan RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	0.96	0.98	(0.03)	4.63	4.81	(0.18)	12.63	16.99	(4.36)
Amber	0.10	0.37	(0.28)	0.14	0.58	(0.44)	2.34	2.73	(0.39)
Red	0.10	0.11	(0.01)	0.21	0.35	(0.14)	1.09	4.39	(3.30)
Total	**1.15**	**1.47**	**(0.31)**	**4.99**	**5.74**	**(0.75)**	**16.06**	**24.11**	**(8.05)**



Comment

The Trust was £0.3m adverse to plan in the month and £0.75m adverse YTD. The main schemes adverse to plan YTD are:
- STP Medical Rates £0.55m (£0.1m adverse in month)
- Prime Provider £0.25m (£0.25m adverse in month)
- Private Patient Income (stage 1) £0.1m. The plan includes a further increase from October 18.
- Out Sourcing reduction £0.1m (on plan in month)
- Other Workforce schemes £0.1m

The key schemes over performing against the plan are: Procurement £0.1m and £0.2m PFI Insurance rebate.

The Trusts risk adjusted savings forecast is £8m adverse to plan, the main schemes forecasting slippage are:
- Estates and Facilities Subsidiary £1.75m (although £0.25m now schemes have been added to reduce impact to £1.5m)
- Private Patient Income = £1m
- STP Medical Rates = £1.7m
- Prime Provider = £0.9m (1 month)
- Medicines Management = £1m (£0.7m relates to Avastin)
- Prime Provider (Delay to October) = £0.5m
- Urgent Care Centre = £0.4m
- Directorate Led workforce schemes £0.4m
- Satellite Service Review = £0.3m
- Endoscopy Income = £0.2m
- Procurement = £0.4m

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast

Year End Forecast August 2018/19

		Risks										Recovery Actions					
	Annual Plan £m	*CIP Slippage* £m	*Pay Pressures*	*Non Pay Pressures*	*Net Income benefits*	*2017/18 Benefits*	*RTT and Cancer Recovery Plan*	*Virtual Ward*	*Other (Balance to detail forecast)*	*Risk Adjusted Forecast* £m	***Variance* £m**	*Release Central Reserves* £m	*Reduce CIP Slippage*	*Further Potential Asset Sales*	*Income Support - RTT and Cancer* £m	*Virtual Ward Funding* £m	***Revised Variance* £m**
Income	458.3	(5.8)			0.5	1.2			(0.0)	454.2	**(4.1)**	0	0	0	0.8	0	**(3.3)**
Pay	(270.6)	0.0	(5.3)			0.7	(0.3)		0	(275.5)	**(5.0)**	3.8	3.2	0	0	0.4	**2.5**
Non Pay	(161.6)	(2.3)		(2.3)		(0.6)	(0.4)	(0.6)	0	(167.8)	**(6.2)**	1.9	1.7	0	0	0.2	**(2.4)**
Other Finance Costs	(28.2)								0.2	(28.0)	**0.2**	0	0	3.0	0	0	**3.2**
Technical Adjustments	1.1								(0.0)	1.1	**(0.0)**				0	0	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Pre PSF	**(1.0)**	**(8.0)**	**(5.3)**	**(2.3)**	**0.5**	**1.4**	**(0.8)**	**(0.6)**	**0.2**	**(16.0)**	**(15.0)**	**5.7**	**4.9**	**3.0**	**0.8**	**0.6**	**0.0**

Commentary

The Trust is forecasting to deliver the plan however has a risk adjusted 'business as usual' forecast deficit of £16m pre PSF, £3.9m adverse to last month. The Trust will have to implement recovery actions of £15m to ensure delivery of the 2018/19 plan.

The 'business as usual' forecast has been set assuming pay costs will continue at the same levels as the current month and income and non pay costs will continue at the YTD average all adjusted for non recurrent items.
Additional adjustments have been made to this baseline forecast to reflect, risk adjusted CIP delivery of £16m (shortfall of £8m), Winter costs (£1.9m to include opening of escalation wards and additional medical OOH team) , £0.8m investment associated with Cancer and RTT recovery plans and £7.4m non recurrent benefits to be delivered in full which are still to be finalised.

The Trusts risk adjusted forecast includes the following core pressures
- CIP Delivery of £16m (£8m shortfall, mainly within Income)
- Divisional Pay Pressures (£5.3m)
- Non Pay pressure of £2.3m mainly within T&O and Diagnostics
- The Trusts risk adjusted forecast would mean the PSF funding for quarter 3 and 4 would be at risk (£8.3m)

Recovery Actions - £15.1m recovery actions will be required to be implemented, this would involve the following:
- Full Release of Contingency Reserves (Including Directorate held pay reserve) £5.7m.
- Reduction in CIP slippage (£4.9m), the Trust will have to deliver £19.2m savings in 2018/19.
- Asset Sales (£3m). The Trust will have to review further potential disposals of assets to generate a profit on sales totalling £3m.
- Income Support for RTT and Cancer Recovery plans (£0.8m), the forecast assumes additional funding above the AIC contract baseline will be paid to fund the costs of this recovery plan.
- Virtual Ward (£0.6m), the forecast assumes that any costs incurred to deliver a virtual ward will be offset by additional income.

The Trust is forecasting to deliver a surplus of £11.7m including PSF.

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

August 2018

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

£m's	August Reported	August Plan	Variance	July Reported
Property, Plant and Equipment (Fixed Assets)	290.9	291.3	(0.4)	291.5
Intangibles	2.3	2.3	0.0	2.4
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.2
Total Non-Current Assets	**294.4**	**294.8**	**(0.4)**	**295.1**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.7	7.9	(0.2)	7.7
Receivables (Debtors) - NHS	21.5	26.9	(5.4)	21.3
Receivables (Debtors) - Non-NHS	14.5	12.7	1.8	15.4
Cash	14.1	5.1	9.0	18.2
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**57.8**	**52.6**	**5.2**	**62.6**
Current Liabilities				
Payables (Creditors) - NHS	(4.3)	(4.5)	0.2	(5.4)
Payables (Creditors) - Non-NHS	(38.6)	(33.9)	(4.7)	(39.4)
Deferred Income	(15.8)	(15.2)	(0.6)	(19.1)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Working Capital Loan	(16.9)	(16.9)	0.0	(16.9)
Other loans	(0.1)	(0.1)	0.0	(0.1)
Borrowings - PFI	(5.0)	(5.1)	0.1	(5.0)
Provisions for Liabilities and Charges	(1.8)	(2.0)	0.2	(1.8)
Total Current Liabilities	**(84.7)**	**(79.9)**	**(4.8)**	**(89.9)**
Net Current Assets	(26.9)	(27.3)	0.4	(27.3)
Borrowings - PFI > 1yr	(190.9)	(191.0)	0.1	(191.3)
Capital Loans	(10.1)	(10.1)	0.0	(10.1)
Working Capital Facility & Revenue loans	(26.1)	(26.1)	0.0	(26.1)
Other loans	(1.3)	(1.3)	0.0	(1.2)
Provisions for Liabilities and Charges- Long term	(1.0)	(0.8)	(0.2)	(1.1)
Total Assets Employed	**38.1**	**38.2**	**(0.1)**	**38.0**
Financed By:				
Capital & Reserves				
Public dividend capital	207.3	207.3	0.0	207.3
Revaluation reserve	29.8	29.8	0.0	29.8
Retained Earnings Reserve	(199.0)	(198.9)	(0.1)	(199.1)
Total Capital & Reserves	**38.1**	**38.2**	**(0.1)**	**38.0**

Commentary:
The month 5 balance sheet position is consistent with the plan that was submitted in April. The overall working capital within the month results in a small decrease in debtors but a small increase in creditors compared to the plan. The cash balance held at the end of the month is also higher than the plan, this is primarily due to receiving the cash in July in advance of the planned expectation.

Non-Current Assets -
Capital additions for 2018/19 have been reduced from the plan of £14.5m to £14.1m to reflect the reduction in this years depreciation, £0.7m on donated assets have remained unchanged from the plan. The planned depreciation for the year has also been revised from £13.5 to £13.1m to reflect the slippage in the capital programme. The month 5 capital spend is £0.4m against a plan of £0.7m.

Current Assets -
Inventory of £7.7m is a reduction from the planned value of £7.9m. The main stock balances are pharmacy £3.1m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.5m.
NHS Receivables have increase from the month 4 position by £0.2m to £21.5m. Of the £21.5m reported balance, £11.5m relates to invoiced debt of which £2.7m is aged debt over 90 days. Invoiced debt over 90 days has decreased slightly by £0.9m from the mth 4 reported position. The remaining £10m relates to uninvoiced accrued income including work in progress partially completed spells. Due to the cash pressures of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debt.
Non NHS Receivables have decreased by £0.9m to £14.5m from the month 4 reported position. Included within the £14.5m balance is trade invoiced debt of £2.3m and private patient invoiced debt of £0.7m. Prepayments and accrued income totalling £10.1m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.
The cash balance of £14.1m is higher than plan of £5.1m by £9m, this is due to the Trust receiving income in July which was earlier than plan. As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as these materialise. The Trust has received in September £1.9m qtr 1 PSF funding which was forecast to be received in October.

Current Liabilities -
NHS payables have decreased from the July's reported position by £1.1m to £4.3m. Non-NHS trade payables have also decreased by £0.8m to £38.6m, giving a combined payables balance of £42.9m.
The Balance of £7.6m approved trade invoices at the end of August shows 99% are within 0-30 days outstanding.

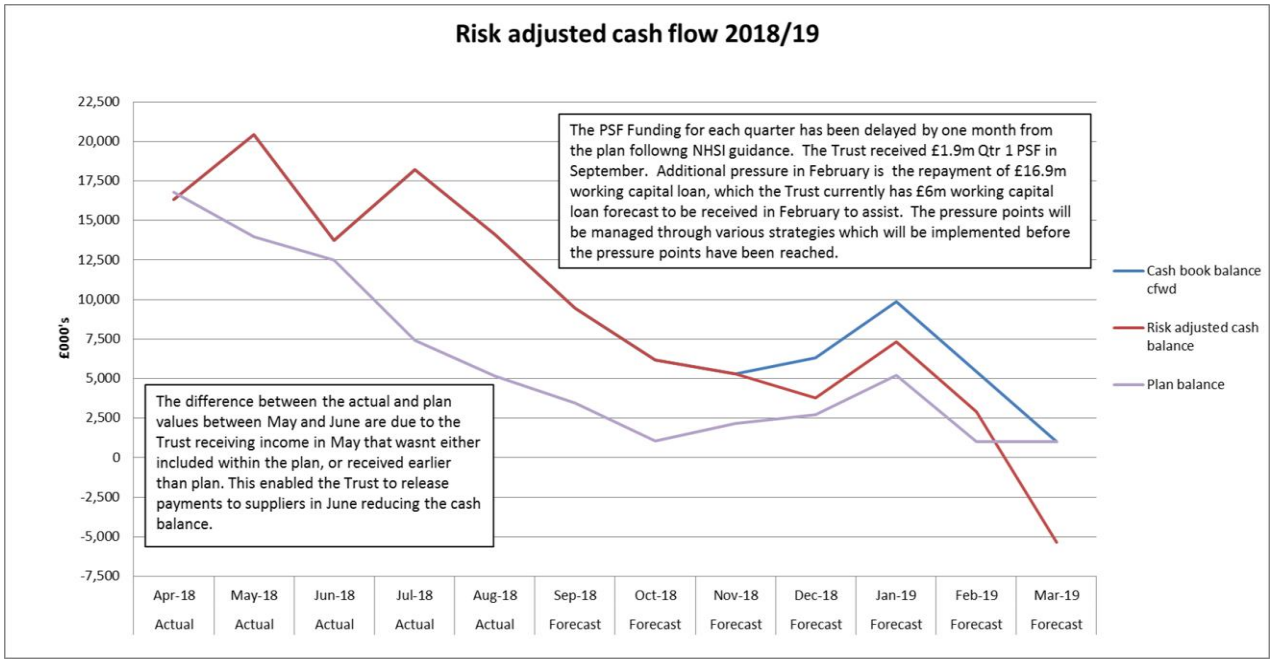
Of the £42.9m combined payables balances, £12.3m relates to actual invoices and £30.6m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments.
Deferred income of £15.8m primarily is in relation to £11.5m advanced contract payment received from WK CCG in April, which reduces by £2.28m over each of the remaining 11 months.
£16.9m working capital loan is repayable in February 2019
Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the energy efficiency of the Trust.

Long term Liabilities-
The PFI liability reduces each month as the Unitary Charge includes financing repayments.
The working capital and revenue loans relate to - £12.132m repayable in October 19, the remaining balance is a combination of 3 working capital loans totalling £13.990m taken out in 2017/18 and are repayable in 2020/21.

Capital and Reserves-
For each area within this element for month 5 are consistent with the plan.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Information on loans:

	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Information on loans:					
Revenue loans:					
Interim Single Currency Loan	3.50%	16.908	0.00	0.25	18/02/2019
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2019
interim working capital loans	3.50%	13.990	0.00	0.49	18/03/2021
Capital loans:					
Capital investment loan	2.02%	12.000	1.20	0.06	15/09/2020
Capital investment loan	3.91%	11.000	0.73	0.19	15/19/2025
Capital investment loan	4.73%	6.000	0.24	0.16	15/19/2035
Other loans:					
Salix loan (interest free) £1.2m to be rec in 18/19	0.00%	1.283	0.15	0.00	2024/2025

Commentary

The blue line shows the Trust's cash position for 2018/19 and the red risk adjusted line shows the position if the relevant risk items are not received and the purple line shows the monthly plan values.

The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance Sheet. If the I&E starts to move away from the plan, this will effect the Trust's cash position.

The cash balance cfwd is higher than the plan values due to the Trust receiving income either that was not included within the plan or received earlier than plan . As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as the pressure points materialise.

The risk adjusted items relate to:
PSF funding (previously STF) which is received if certain targets are met. The cash flow has three quarters included as the income is received in arrears. Quarter 4 will be included within 2019/20 cash flow. The Trust has received Qtr 1 PSF funding of £1.9m at the beginning of September.

The Trust needs to repay the Single currency interim loan of £16.9m in February. In order to repay this the Trust will need to request further working capital financing of £6m. If the PSF funding is not received and if the I&E position move adversely from the plan, the Trust will need to implement strategies to ensure the loan can be repaid before increasing the value of the working capital loan request. in respect to all of the risk items which relate to capital including the planned asset sales of £2.4m. If the income or external financing are not received the associated expenditure will not happen.

Maidstone and Tunbridge Wells NHS Trust

5c. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	1,404	1,134	-270	5,788	5,788	0
ICT	252	450	198	1,002	1,240	-238
Equipment	164	945	781	6,501	5,876	625
PFI Lifecycle (IFRIC 12)	0	0	0	471	471	0
Donated Assets	0	275	275	700	700	0
Total	**1,820**	**2,804**	**984**	**14,462**	**14,075**	**387**
Less donated assets	0	-275	-275	-700	-700	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**1,820**	**2,529**	**709**	**11,360**	**10,973**	**387**

The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; national funding for the next replacement Linac of £1.7m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments.

The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects also approved and underway. A major scheme for the Energy Infrastructure has an approved Salix loan of £755k for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application is currently being prepared for TWH LED. The ICT schemes have been prioritised and approved by the ISG in principle, most schemes have business cases approved and are progressing. The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval, Some equipment schemes have been deferred (£237k) to support the ICT EPR project .

The FOT is £14.08m which takes account of : 1) Linac 5 funding is £32k less than plan; 2) currently there is a small loss on disposal of assets of (£4k) - this reduces available capital resource and 3) the outturn forecast for depreciation is £351k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment has begun and will be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

Trust Board meeting - September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-10	Performance on the 62-day Cancer waiting time target	Chief Operating Officer

Enclosed is a report on performance against the 62-day Cancer waiting time target.

Which Committees have reviewed the information prior to Board submission?
Trust Management Executive, 19/09/18

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

Cancer Performance Update

Mrs Ritchie Chalmers
Trust Cancer Clinical Lead

David Fitzgerald
Associate Director, Cancer and Clinical Support Services

September 2018

Introduction

- Identified chronic development of shortfall in capacity for first seen activity and diagnostic pathway over a five year period
- Acutely affected by large growth in demand (2018 22% higher referral numbers compared to 2017)
- Coupled with substantial reduction of surgical middle grade doctors (simultaneous resignation of trainees and locums) and loss of capacity due to adverse weather in February/March

Immediate Actions - activity increased

- Urology outpatients and flexi cystoscopies increased using 2 x locum doctors
- Endoscopy increased by 5 lists using internal resource w/c 3rd September and increasing to 6 additional lists week after
- Breast one stop clinics increased with an additional weekly clinic (15 patients) plus ad hoc internal and outsourced additional clinics. Planning for an additional weekly clinic internally but requires increased Radiologist support
- Increased Histopathology lab and reporting capacity using overtime
- Increased MRI/CT capacity using agency Radiographer plus outsourcing of scans/reports to Independent Sector

Maidstone and Tunbridge Wells NHS
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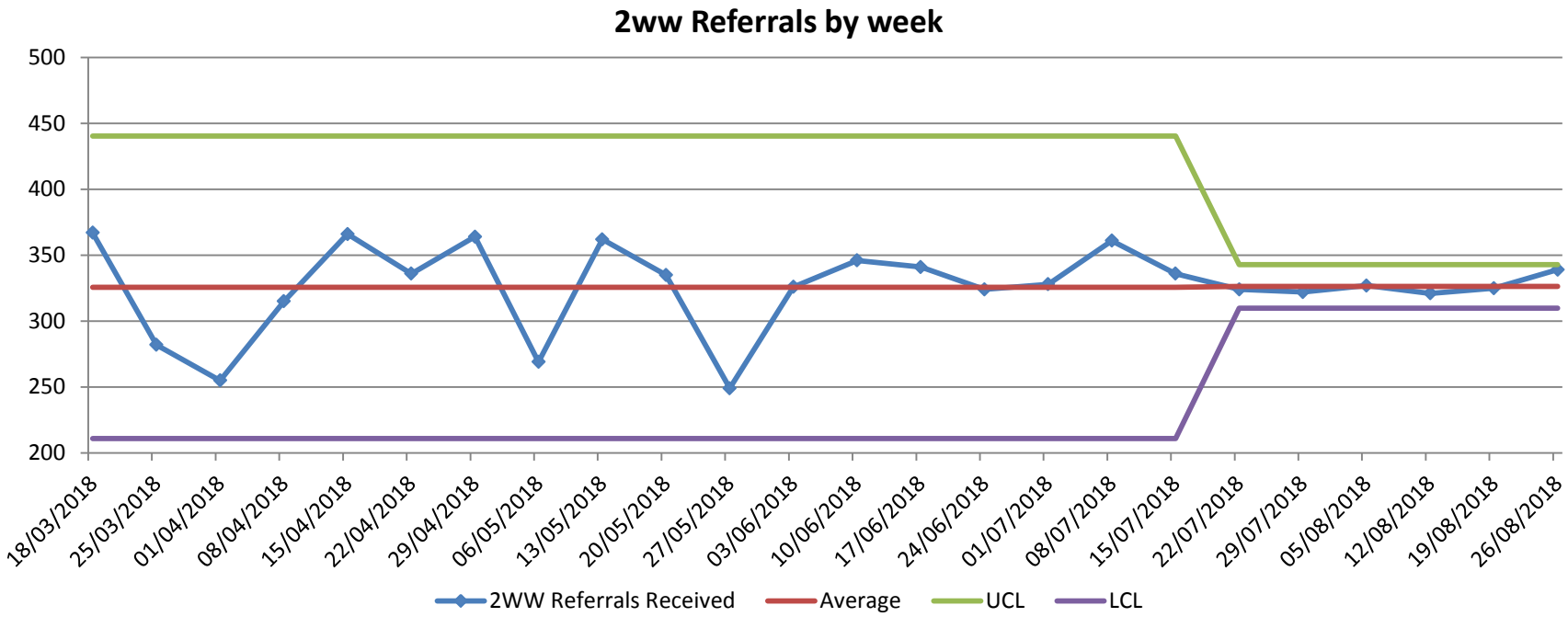

- The SPC chart above shows the number of suspected cancer referrals received per week from March 2018
- Whilst the average has not changed, the upper and lower control limits have reduced markedly
- This means it is much more likely that the number of referrals received each week will be close to the average and therefore that the number of referrals received is more predictable
- This also means that that demand is not reducing

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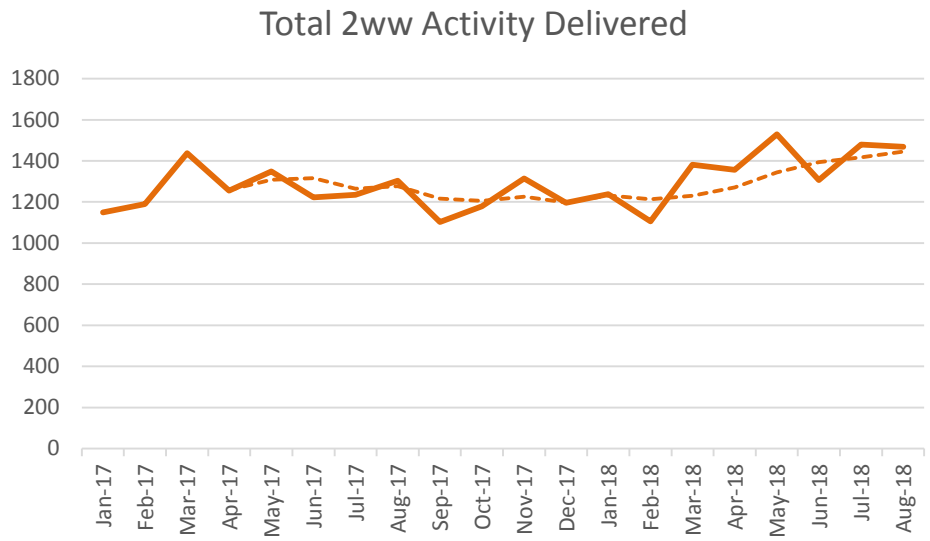
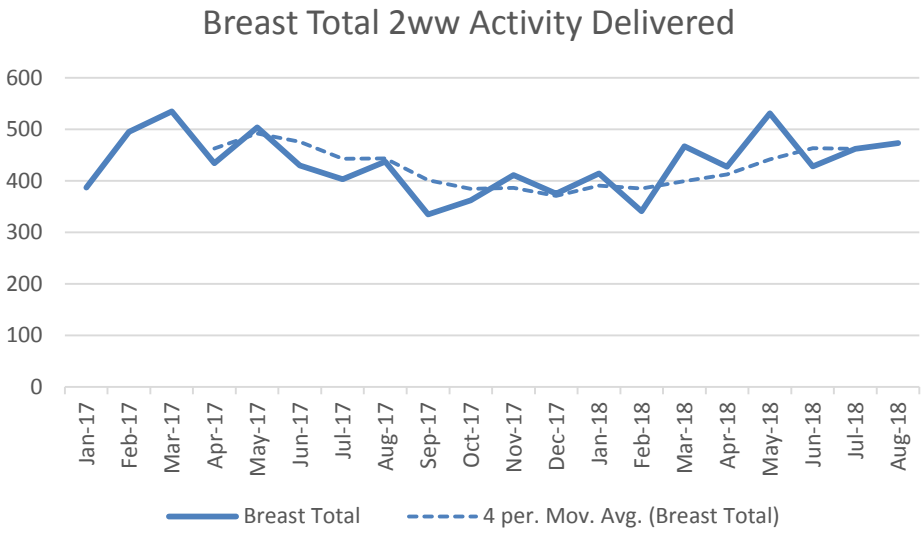
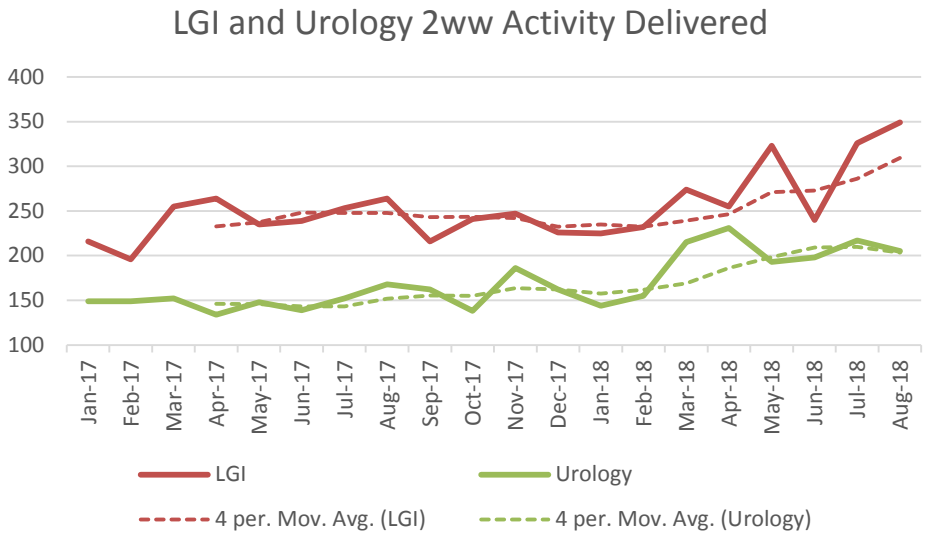


- The activity delivered for first seen appointments (OPAs and straight to test investigations) has increased consistently since March 2018
- The high volume tumour sites have delivered markedly increased levels of activity recently, although the breast activity is yet to reach the levels of delivery that were seen in early 2017
- This is likely due to the retirement of a senior breast Radiologist but may also be linked to the increased screening activity required following the national recall error





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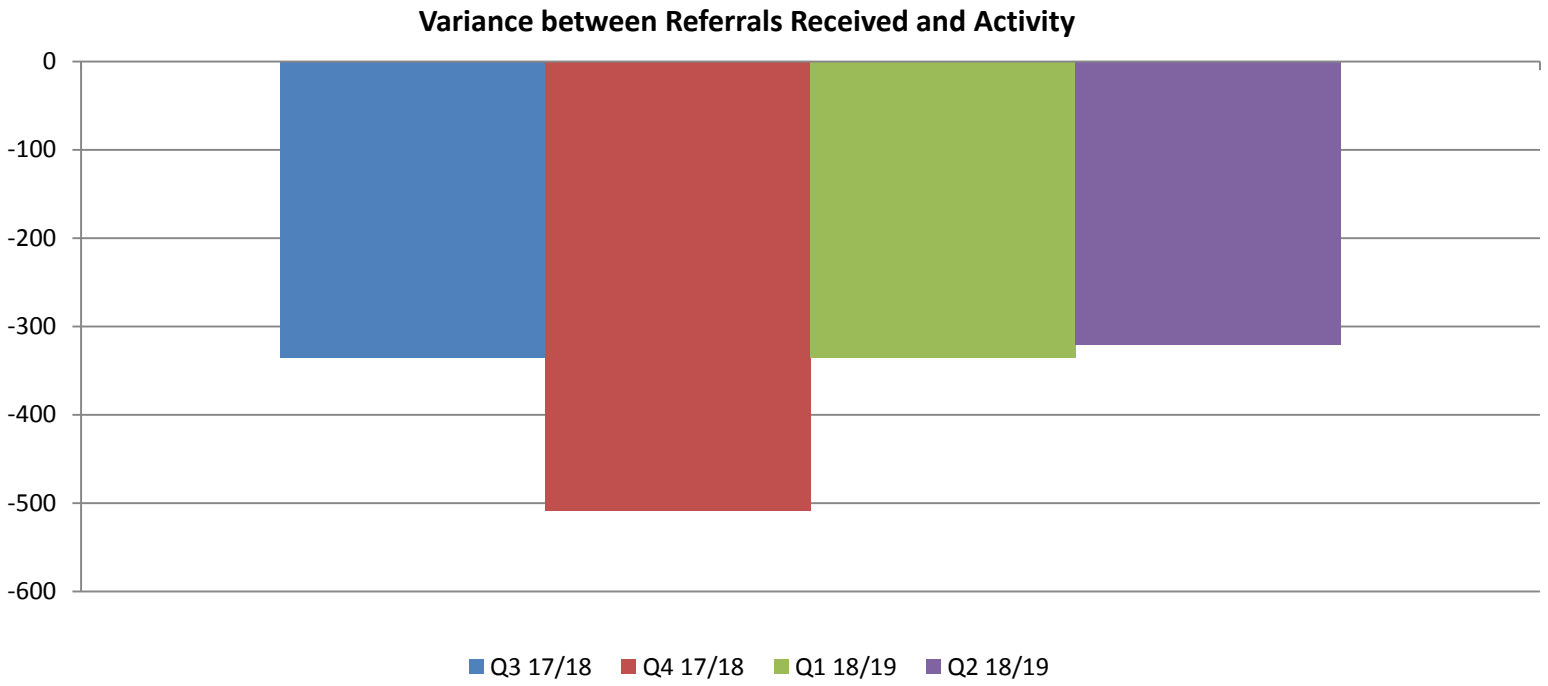
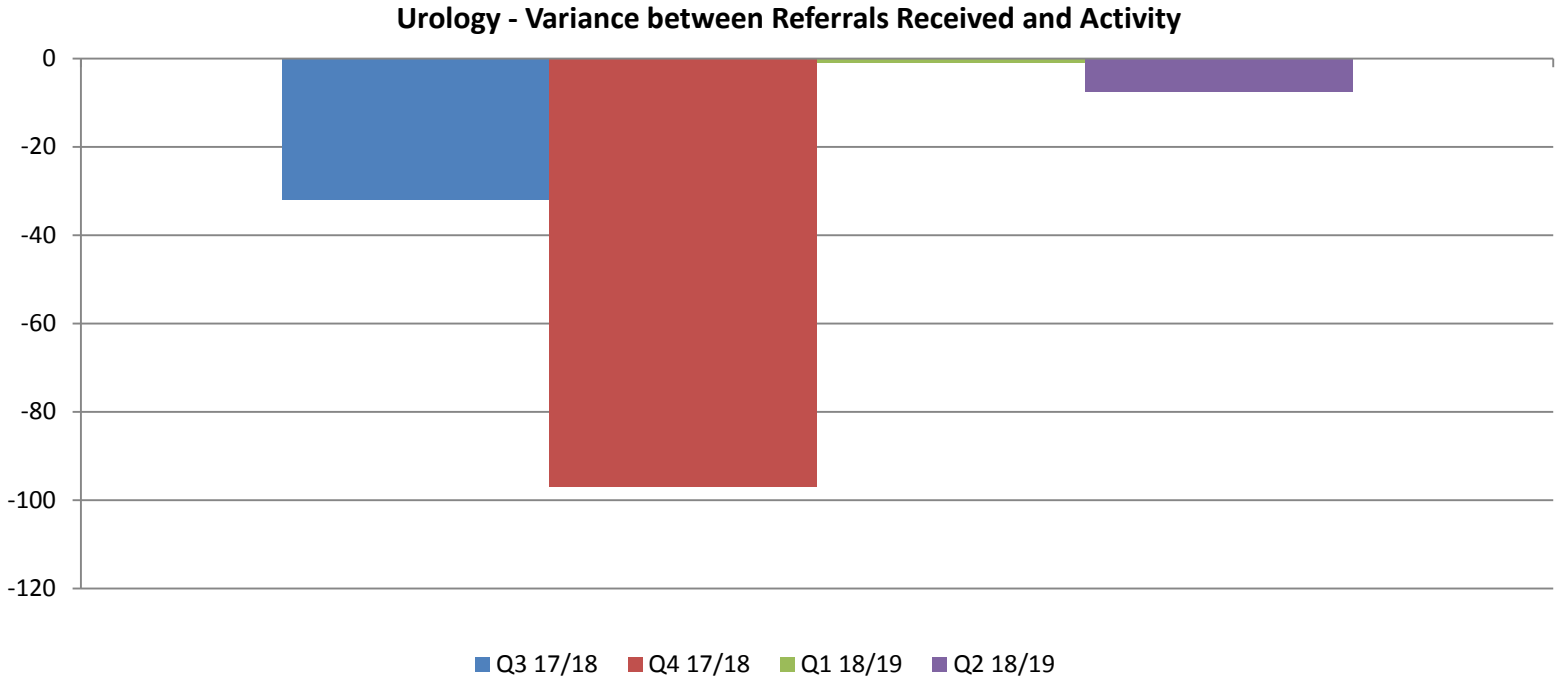
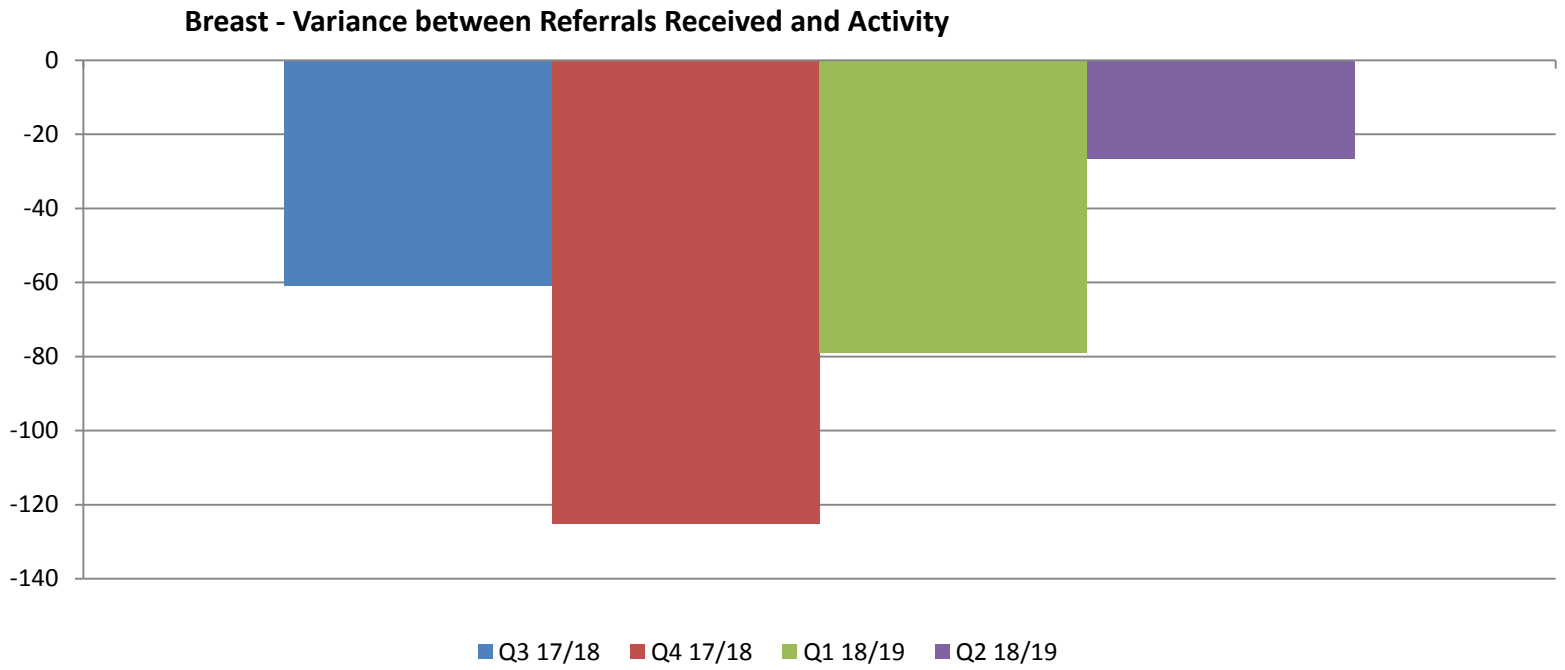


- Additional activity has reduced the difference between demand and delivered activity
- However, less activity has been delivered than the demand coming in
- Some tumour sites have shown significant improvement in reducing the difference between demand and activity delivered, some have further to go



- Urology has significantly closed the gap between demand and activity delivered for first seen activity
- Achieved using 2 x locum doctors and changes to clinic templates
- Need to consider next steps in pathway (bottlenecks) e.g. biopsy capacity for prostate in order to improve 62 day performance



- The difference between breast and breast symptoms activity and demand has been reduced noticeably in Q2 18/19
- This has been achieved with an additional weekly clinic (15 patients) plus ad hoc internal and outsourced activity
- There is a relatively small way to go to deliver more activity than demand in order to reduce the time to first seen appointment, however this is currently constrained by Radiologist time to support any additional activity due to difficulty in obtaining locum or internal cover

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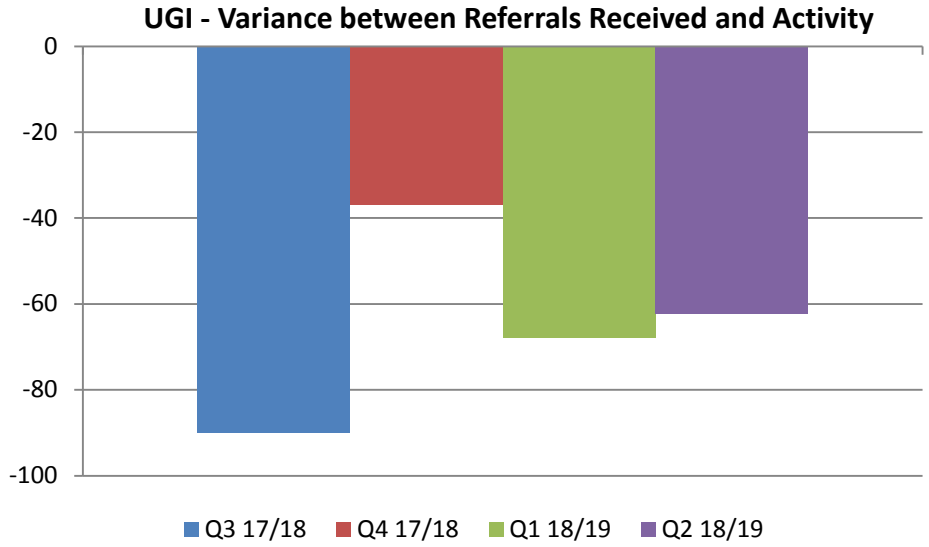

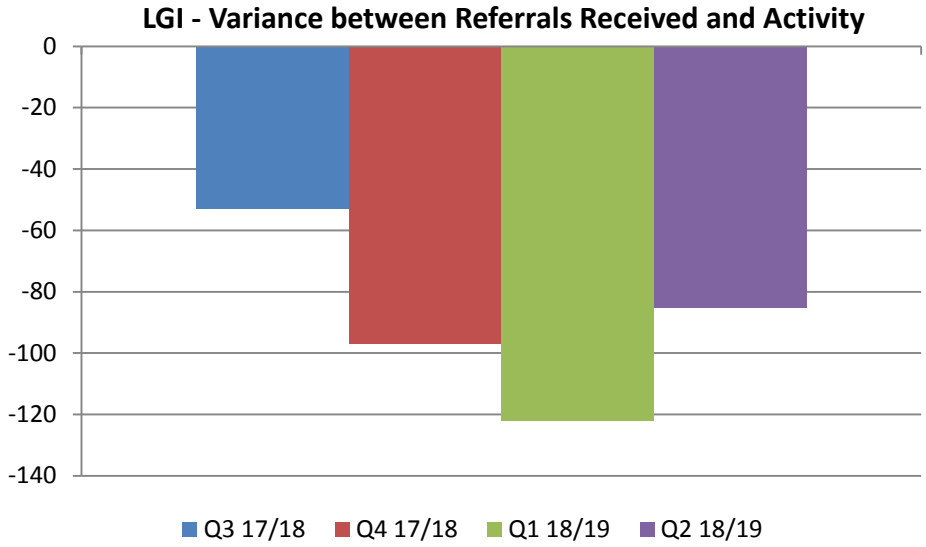

- Continued disparity between demand and activity delivered for upper and lower GI
- However, it is expected that increase in endoscopy capacity in recent weeks will reduce the difference between demand and activity for these tumour sites
- The Upper and Lower GI teams deliver the majority of the emergency surgical service. This competes with elective cancer delivery and needs to be managed parallel to the cancer recovery in order to maintain performance
- The initial analysis of the drivers for declining performance against the cancer waiting times standards, identified a lack of capacity due to a problem with staff retention, particularly in surgical middle grades. Correspondingly, recruitment of candidates of quality into these teams has proved difficult

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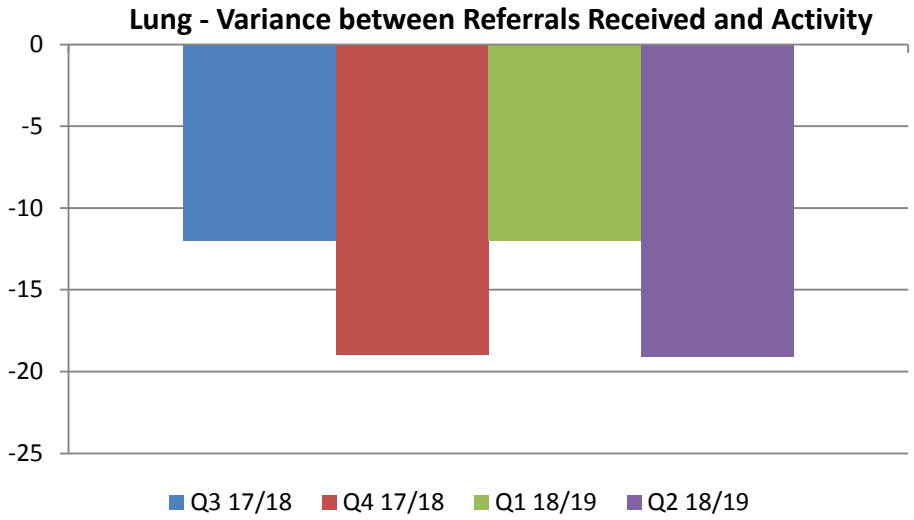
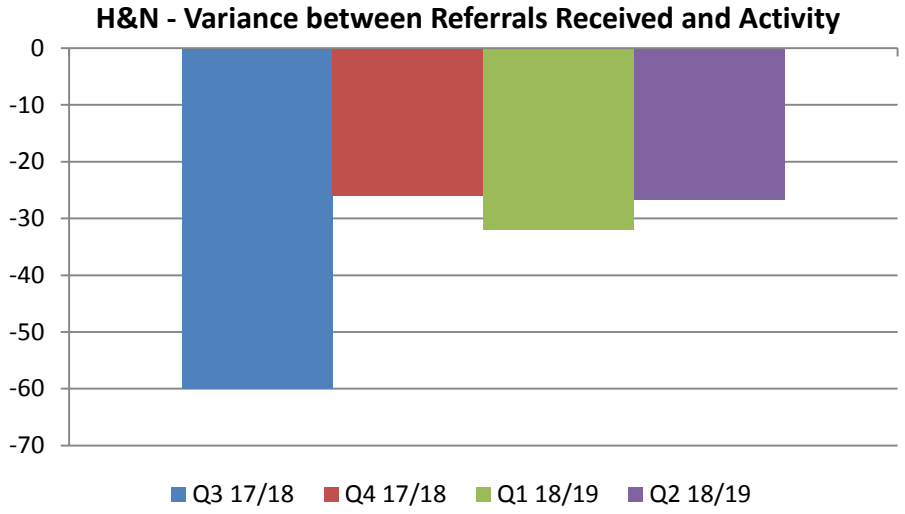
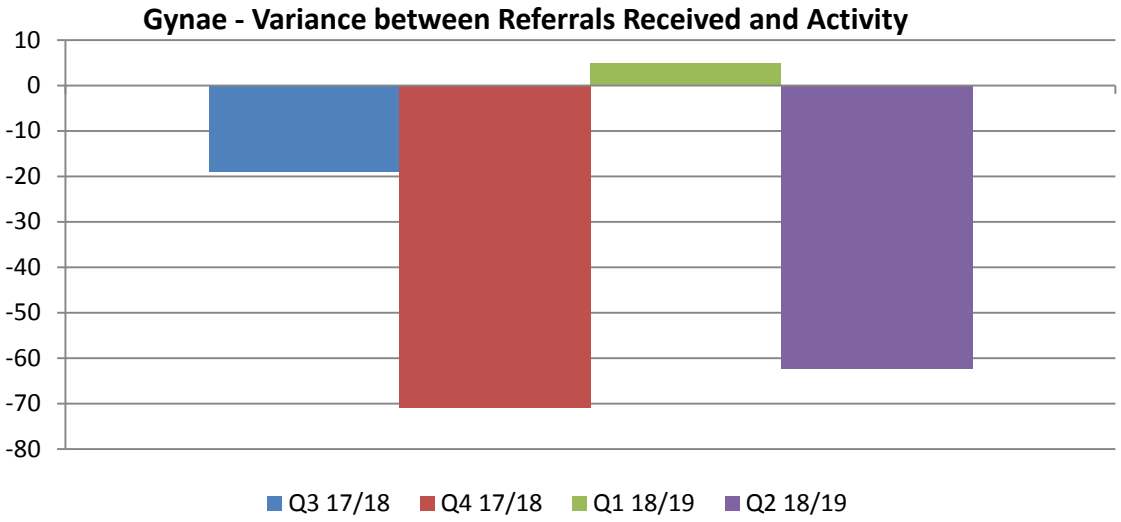




- Continued disparity between demand and activity delivered for lung, head & neck and gynaecology
- Further actions required to increase front end capacity for these tumour sites
- There is a persistent shortage of respiratory physicians to deliver the lung pathway and so consideration needs to be given to how capacity can be increased (e.g. nurse-led triage)
- The gynaecology pathway is delivered by two clinical teams (2WW activity is largely undertaken by the gynaecologists with transfer to the Gynae-Oncology team at the point of diagnosis. Gynae-Onc is a regional service with cross-region referrals having increased by nearly 30% over the last 5 years)



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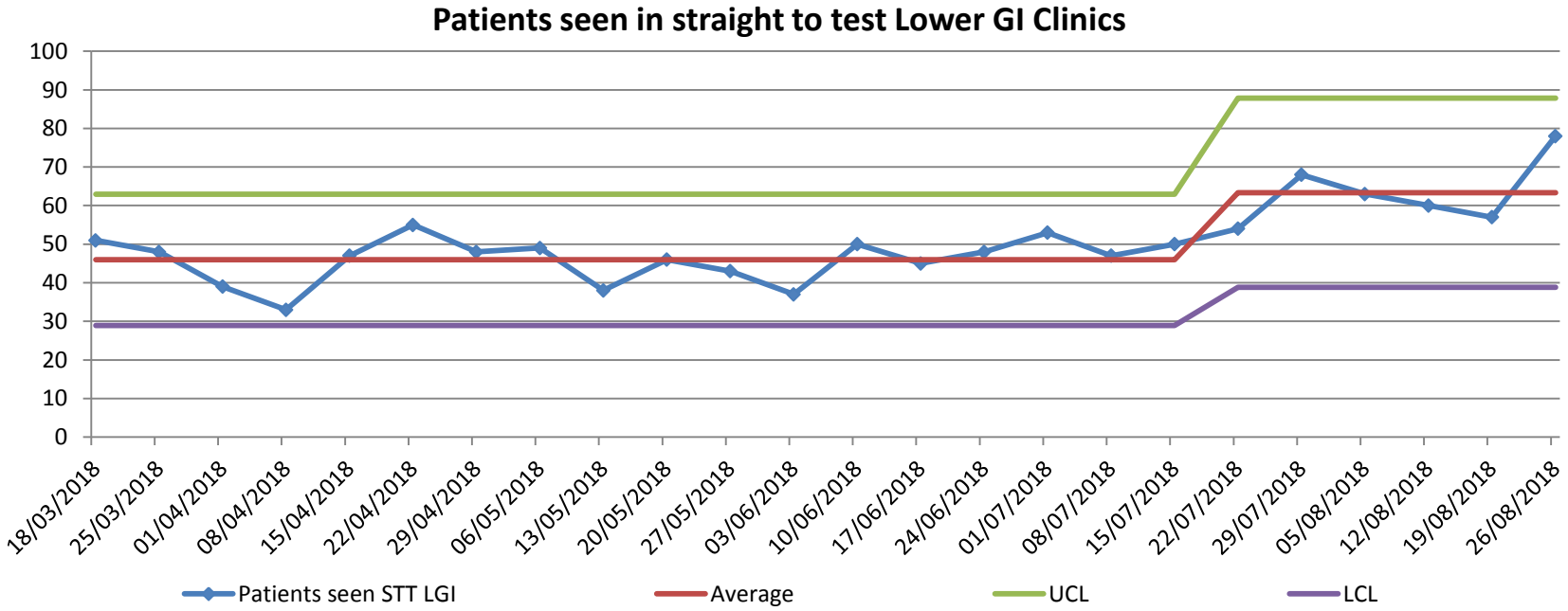

- The SPC chart above shows the number of 2ww patients contacted through the straight to test (STT) assessment clinics for suspected colorectal cancer per week from March 2018
- Additional clinics were planned to come on line from the end of July
- It is clear that the average number of patients following the STT model has increased dramatically since w/c 22nd July
- Previous data shows that patients that follow the STT model are more likely to be treated within 62 days
- This is reliant on sufficient endoscopy capacity and this has been increased from w/c 3rd September

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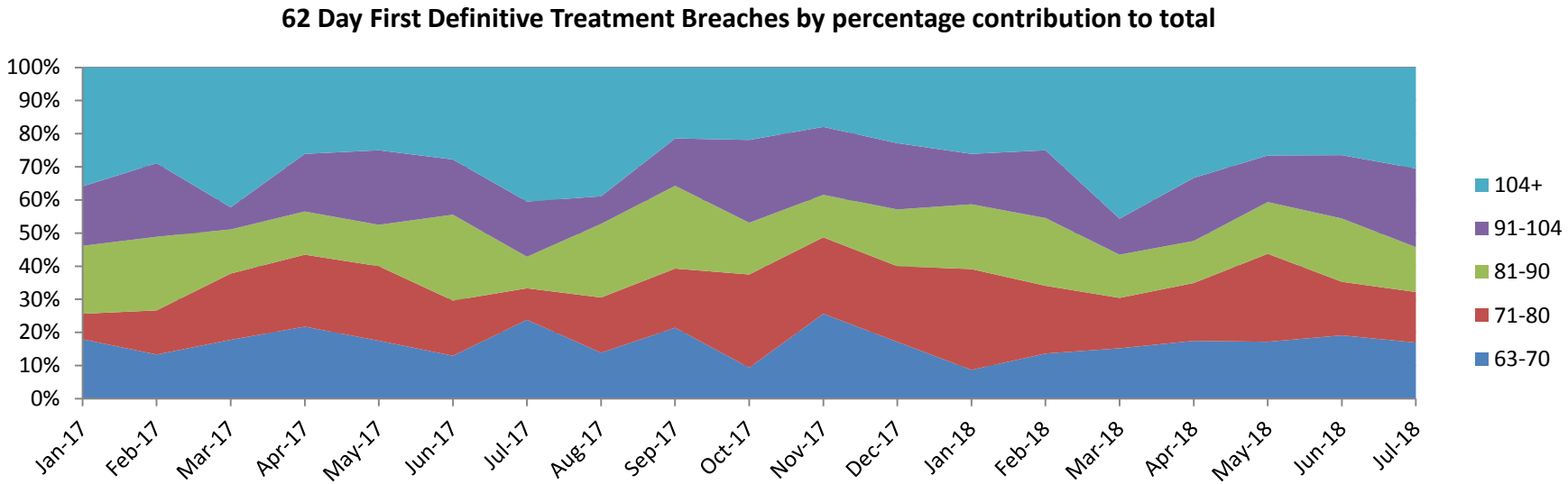
62 Day Breaches



- There has not been a significant change 104+ day pathways over the last 18 months despite varying performance
- Breaches for 104+ days increased in early 2018 to slightly higher levels than those seen in early 2017, and although this may have a minor contribution to the recent acute fall in 62 day performance, it is considered to be unlikely to be a key driver
- About a third of breaches are occurring between 63 and 80 days, another third from 81 to 104 days and the final third over 104 days
- This suggests that short delays in the pathway, representing discrepancy between demand and capacity, is likely to be a greater influence on decreasing performance
- Delays in the diagnostic phase for patients that require multiple investigations to achieve diagnosis will result in a significantly longer pathway due to the cumulative nature of each delay

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Immediate Actions – monitoring/oversight

- Weekly meetings between COO and ADO for Cancer and Clinical Support Services
- Weekly oversight meetings with NHSI
- Reviewed and updated 104+ day breach SOP and harm review process
- Cancer specific outcome harm review pro forma created by Trust Cancer Clinical Lead
- Reviews have been returned for Upper GI and Urology for April and May breaches
- June and July patients have been circulated to clinical leads with a reminder to complete April and May reviews in the next 10 working days
- West Kent Cancer Improvement Group formed and first meeting was on 4th September
- Demand and capacity modelling being undertaken for all services plus pathway mapping and improvement, supported by IST

Immediate Actions – workforce:

- Interim Cancer Transformation Manager started on 20th August (interviews for permanent post 26th September)
- Two new surgical middle grades appointed (one expected to start in October, the second is awaiting visa approval)
- Alternative roles recruited to including 3 x Physician Associates (awaiting start dates) and Surgical Care Practitioner (out to advert)
- 3 x Pathway Navigators appointed for colorectal, upper GI and prostate (joining lung Pathway Navigator already in post)
- 2nd Straight to test nurse appointed for colorectal and will be starting early October
- Straight to test nurse for Upper GI in post and patient numbers increasing through this model
- Straight to test nurse for prostate appointed, awaiting start date
- Options for surgical solution presented to the executive team by Clinical Director for Surgery

Next Steps

- Key performance indicator is to reduce the day to decision to treat
- This will be achieved by increasing capacity at the front end of the pathway – triage, outpatients and diagnostics
- Need to consider further outsourcing or insourcing to maintain or increase levels of activity
- Also must maintain oversight of treatment capacity as more patients will be diagnosed sooner and treated alongside the backlog being cleared
- Administrative actions required to remove as many patients from the PTL as quickly as possible (e.g typing letters, flexi cystoscopy reports on Endobase, etc)

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Capacity and Demand

	Breast	Breast Symptoms	Breast Total	Gynae	Haem	H&N	Lung	LGI	UGI	Urology
Predicted Highest weekly referral rate	90	37	127	40	6	37	15	81	41	55
Predicted Lowest weekly referral rate	62	23	85	22	1	22	7	51	20	37
Monthly Predicted Demand										
Sep-18	300	121	421	122	13	102	50	288	134	210
Oct-18	293	116	409	132	11	122	50	295	139	202
Nov-18	309	139	448	121	15	122	40	274	139	194
Dec-18	294	109	402	130	14	116	47	251	128	188
Jan-19	282	105	387	117	14	117	46	256	138	183
Feb-19	296	134	430	121	13	117	41	278	142	200
Mar-19	326	132	458	140	15	129	43	292	133	199

Trajectory

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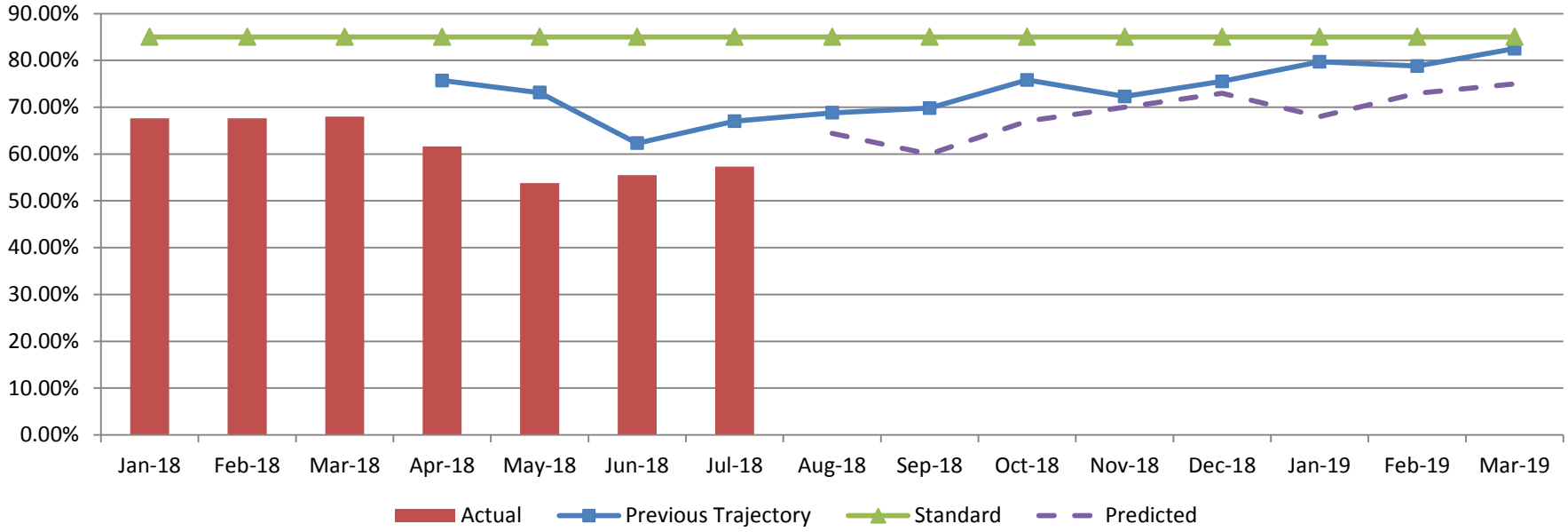


Assumptions on which trajectory is based
2WW demand remains at an average of 1350 each month for the remainder of the financial year
The conversion rate from suspected cancer referral to confirmed cancer would remain as earlier in 2018
Outpatient 2ww clinic capacity is maintained at the increased level seen in Q2 18/19 for breast and urology
Endoscopy capacity continues at the increase level seen from w/c 3rd September until the end of the financial year. Benefit to be seen in Lower and Upper GI performance from October onwards.
Prostate biopsy capacity is increased to more closely meet demand from November
No tumour site performance deteriorates from the July/August position due to a staffing problem or equipment breakdown and that Urology breaches are half the level incurred each month in 2018 from November onwards

Trust Board meeting - September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-11 Update from the Best Care Programme Board — Chief Executive

Enclosed is an update from the Best Care Programme Board

Which Committees have reviewed the information prior to Board submission?

- -

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

Information

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW Best Care
exceptional people, outstanding care

Trust Board

September 2018

Content

1. Executive Summary
    a. Executive Summary

2. Workstream Update
    a. Best Use of Resources
    b. Best Workforce
    c. Best Flow
    d. Best Quality
    e. Best Safety

3. Financial Summary
    a. Financial Summary

1a. Executive Summary

Workstreams Update	Workstreams Update
KEY PROGRESS Best Patient flow Business Manager appointed for Private Patient Unit with mobilisation plan in place. A number of scenarios to support Prime Provider, including Beds, Theatre and Outpatient Utilisation has been modelled. Best Safety – Mortality – number of completed reviews at 80.6% compared to previous months of 30% to 55%. 7 Day Service - the approach and design undertaken at MTW, has been recommended by the Regional leads, that this is rolled out to other trust as an example of best practice. Medical Productivity – 84% of consultants/SAS Doctors have job plans on new system. GIRFT Endocrine scheduled for 26 October and GIRFT Clinical Ambassadors presenting to Trust Board on 25th October.	**KEY PROGRESS** Best Quality – Maternity Safer Births/CNST – received £908k in response to achieving the 10 out of 10 safety actions. Pending the appeal process this could increase. Team are analysing the opportunity of stretching our CQUIN Target. Best Use of Resources - Both E&F team and Medicine Management team continually reviewing alternative options/schemes to plug current gap. Best Workforce – Lessons Learned shared by East Cheshire on their approach to 'Pay bill reduction group' and decision to revert to central staff bank to be quantified as a matter of priority.
KEY RISKS Best Patient flow – Team working on schemes to mitigate the financial gap from Endoscopy Utilisation and Urgent Care Centre and the slippage to Private Patients and Prime Provider and will be present scenarios to Executive team on 2nd October. Best Safety – Resolution required linked to resources to support the use of Datex .	**KEY RISKS** Best Quality – a number of schemes identified to mitigate the financial uplift in October to be quantified, currently gap is £275k Best Use of Resources – savings forecast for both Avastin and E&F Subsidary has been risk adjusted, forecasted shortfall on Medicine management of £1.0m and E&F Subsidary of £1.0m. Medicine management team working with NHSE on a possible gain share schemes. Best Workforce – Revision of recovery plan underway due to slippage to include lessons learned from East Cheshire. Rota compliance reduced this month to 19.3% in terms of sign off 8 weeks in advance of shift against a target of 80%

Maidstone and Tunbridge Wells NHS Trust

2a.Best Use of Resources

Best Use of Resources is focused on reducing waste and improving value on the products and services we buy across the Trust.

The workstream has started with five key areas to achieve best value in by reviewing costs and identifying opportunities for savings, whilst ensuring quality of service and patient experience is not comprised and continues to improve.

The key areas are:

- **Estates and Facilities**
- **Procurement**
- **Medicines Management**
- **Aligned Incentive Contracts**
- **STP pathology review**

WORKSTREAM	Best Use of Resources Summary Report	BEST CARE BOARD DATE	September 2018
WORKSTREAM LEAD	Steve Orpin	PMO SUPPORT	Caroline Tsekaklas & Toyin Falana

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Estate & Facilities	• Unplanned PFI Insurance Savings £270k received. • E&F Change, Trust Board have confirmed that the Trust will not proceed with this opportunity. Scheme removed from plan. • LED installation ongoing at Maidstone • Patient Transport – value of savings have been confirmed, however, legal challenge remains in situ and contract can not be awarded.			• E&F Change, Recovery plan being developed with circ. £700k identified so far. Schemes advised to FM and being built into CIP plan • Complete Audit at TWH for LED lighting scheme. • Submit business case for Salix funding for LED scheme at TWH.
Procurement	• Source of £500k shortfall identified as a change in the target (from £4.2MM to £4.7MM) – needs further discussion around reason for changing the target mid-year without communication. • £275k full year savings delivered in the month (including £72k on excessive use of texts) • Still tracking to meet original £4.2MM target • £250k of value projects removed from plan as categorised 'not cash-releasing' • Looking at outsourcing R&D and management of tail-end spend to find additional savings. • Interim HoCM employed wef 25/09/18 and offer made for full-time replacement who would start in Dec. • Managing legal challenge on PTS tender			• Tracking to deliver £300k full year savings in month • Bring PTS legal challenge to a conclusion • Resolve target issue • Work with NHSSC to identify savings that can be delivered through STP aggregation
Medicine Management	• Contract Wave 11 savings now confirmed to be £198K (including Tazocin) • Transtzuzimab went live in Oncology 1st week in August • Dossette Boxes / MAR Charts - STP approval gained. Project was also showcased as an innovative practice at a Health and Care Innovation Expo on the 14th August 2018.			Outsourcing – set up Steering group and Develop Business Case by end of Sept. Dexamethoso - scoping to be completed by start of Oct 2018 Dossette Boxes / MAR Chart – pilot due in Sept, awaiting confirmation from Community Pharmacy Support, also awaiting payment agreement between Community Pharmacist and WKCCG, risk of project failure if project is not funded. Paeds Feed - (HCD Dispensary unit and Aseptic Unit) finance to confirm value of savings.
AIC Diagnostics	**Pathology** AIC - 17/ 18 Activity data obtained for Direct Access LFT, FLP and Thyroid tests and has been cross referenced with 16/17 data. STP - SOC (Strategic Outline Case) currently being developed, long list of options drawn up and being looked at.			**Pathology** - AIC - Obtain Direct Access data for FBC SOC – completion by end of September, Evaluate and score available options.
	Radiology - Obstetric Scanning – surveys completed In Aug, Business Case proposal: SO, NB, SD, HF, Nba agreed start form proposal and test if taking forward the arrangement with the contractor is achievable.			**Radiology –** Internal demand - meeting with A&E consultants on the 13th Sept to review the overnight CT demand. Obstetric: update Patient communication & obtain execs sign off. Proposal: set out short form application if achievable and can deliver key benefits.
AIC Diabetes	DSN Funding Agreed 4/6/18 which allowed recruitment drive to commence. Agreed IT process for DSN triage of referrals within 24/5/18 DIG, Confirmation of contractual arrangements , roll out first cluster in Tonbridge by 10/2018			Regular DIG to address and monitor set actions via plan Regular DIG to monitor Financial Meeting scheduled in order to ensure actions to plan

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
	Non – Recurrent Savings / Financial Mitigation Schemes	LAST MONTH	THIS MONTH	
Directorate Led Schemes	DNA Screen to reduce anti D injection –Business Case commenced, Patient Pathway completed.			• Quantify Financial Benefit and complete Business Case • Complete and sign off QIA
	Non Recurrent Savings / Financial Mitigation Schemes			
Release Trust Contingency Reserve and Restrict Pay Investment	Trust is holding £0.8m of contingency money and restricting £0.4m of pay investment.			Hold money until the need arises for use.
Asset Sales	Marketing period and RFIs completed Offers are being shortlisted.			• Evaluation of offers – this will take place in September with the Recommendation of Disposal Based on offers received, and submitted to Trust Board for agreement on 27th September. • Commence interviews.
West Kent CCG Income	WKCCG & MTW met with NHSE regional team in June.			Prepare a three way paper (CCG/MTW/KCHFT) that will set out a case for accessing by end of September 2018.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Procurement - Products clinically acceptable but staff preference not to switch delays or prevents product switch	Discussions with General Managers and Clinical Lead to review the evaluation documentation and decide further steps to be taken.	1st March		
Procurement - Slippage on STP work plan - issues with confirming projects start date and leads	Monthly face to face now re-instated to 1st Fridays of every month to move plans forward with.	6th June		
Avastin - Outcome of judicial process may not go in favour of CCGs involved, if this happens will have a great impact on the Trust implementing Avastin and any planned savings.	AIC has agreed to wait for judicial review which starts in July 2018 - till Sept 2018, but develop a plan in prep for go live. Explore further opportunities.	1st April		
Application for drawn down of CCG surplus is not supported by NHSE - £3.6m	Explore other funding sources that could provide a non-recurrent benefit – Education and Training, Research and Development, etc.	1st July		

CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
E&F - Develop Recovery Schemes		On Schedule		
Obstetric Scanning – Update Patient Communication	28/09/2018	On Schedule		
Obstetric Scanning – obtain Execs sign off	28/09/2018	On Schedule		
STP Pathology – complete Strategic Outline Case	28/09/2018	On Schedule		

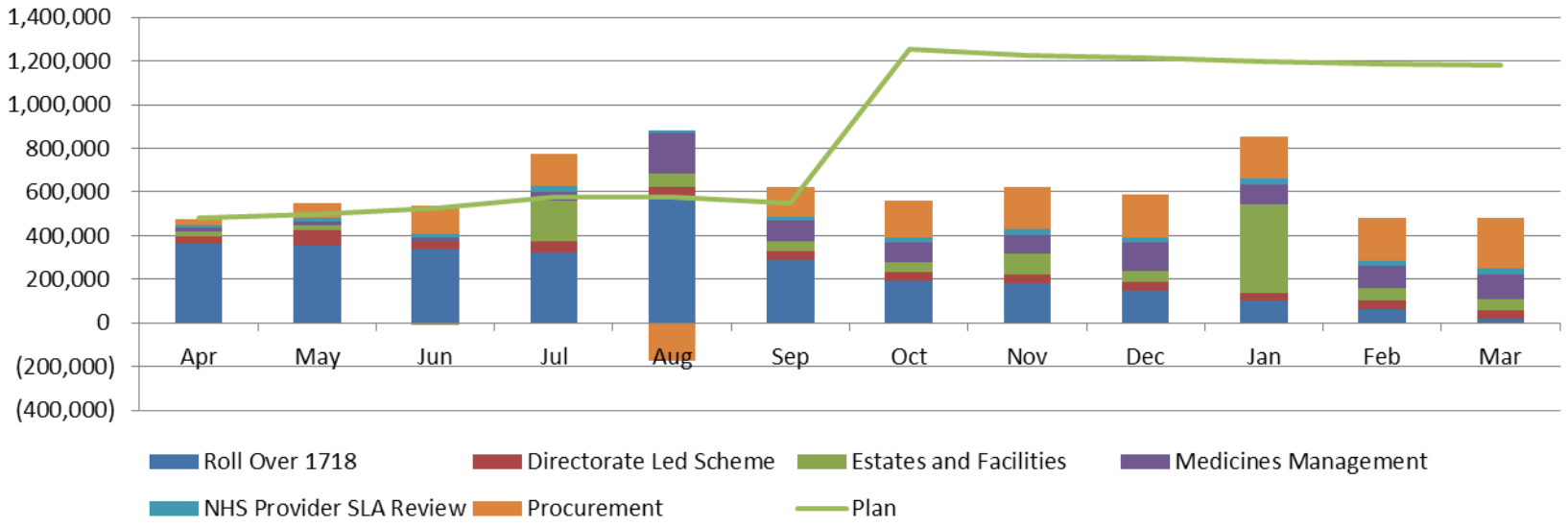
KPIS	Target	LAST MONTH	THIS MONTH
Number of tenders completed each month	13	8	13
National metrics - % of spend under a catalogue	80	98	97
% of spend under a purchase order	80	87	85
Reduction in Vit D Direct Access Tests	20%	Q1 16/17 - 5911	Q1 17/18 - 6050
Reduction in Fast Lipid test requests	20%	Q1 16/17 - 11,172	Q1 17/18 - 8739
Reduction in Liver Function tests requests	20%	Q1 16/17 – 40,200	Q1 17/18 – 39,628
Reduction in Thyroid Stimulating Hormone tests requests	20%	Q1 16/17 – 29,083	Q1 17/18 – 29,285

Finance Narrative

YTD Over performance by £380k

Forecast Risk area

- E&F Change
- Avastin
- Pharmacy Stretch Target
- Procurement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Directorate Led Scheme
Estates and Facilities
Medicines Management
NHS Provider SLA Review
Procurement
Plan

Maidstone and Tunbridge Wells NHS Trust

2b. Best Workforce

Best Worforce is devising innovative strategies to develop new roles and attract and retain staff to the Trust. Implementing more efficient processes to help make people's jobs easier and reviewing temporary staffing are the key areas of focus for Best Workforce.

The workstream's priority areas are:

- **Recruitment**
- **Temporary Staffing**
- **New Roles and Apprenticeships**
- **Workforce Productivity**

WORKSTREAM	Best Workforce	BEST CARE BOARD DATE	September 2018
WORKSTREAM LEAD	Simon Hart/Jamie Phipps	PMO SUPPORT	Kathryn Brown/Steph Pearson

Project	Actions/Milestones completed	DELIVERY RAG		Actions for next reporting period
		LAST MONTH	THIS MONTH	
Temporary Staffing Controls Group	• One Urgent Care Locum appointed to substantive role. Remaining locums have not accepted fixed term offers of employment with the Trust • Discussions held with Locum Radiology Consultant to join Staff Bank. Unable to meet Locum's bank rate expectations. Rate has been reduced. Work in progress to reduce further • Lessons learned phone call held with ex-East Cheshire DMD on 4 Sep • Nurse Agency Rate reduction from 10th August has resulted in a reduction of approximately 300 breaches – CIP being calculated • Revised bank rate proposal submitted to T/S meeting for review on two occasions • Questionnaire issued to all bank staff. 113 responses received • Update required regarding Allocate establishment / roster templates			• Next Top 10 Medical Locums work identified that focus is required on quick wins rather than simply Top 10 • Recommendations from East Cheshire lessons learned to be circulated and clinical lead to be identified by 12 Sep • Urgent Care retrospective bookings to cease by 31st August with process followed to ensure shifts added at time of request • Next stepdown of nursing rates from 10th September in order to comply with STP rates • Bank Locum rates still to be agreed due to non-engagement of Urgent Care • Bank Staff survey response interviews / finding review • Allocate update outstanding and required by end September

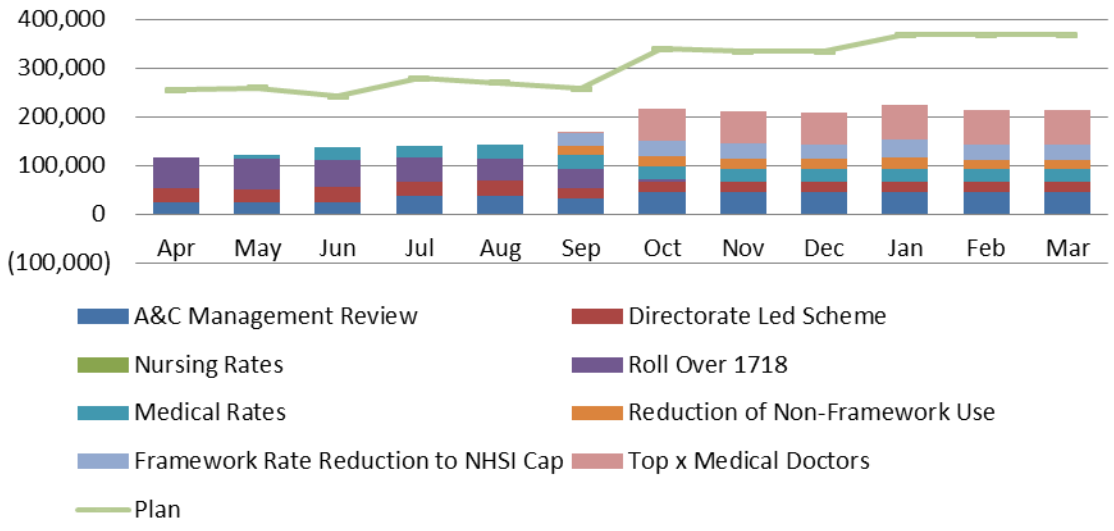
New Roles and Apprentice-ships	• As at 31 August, 73 apprenticeships enrolled on apprenticeship training in 2018
	• Procurement completed for 10 MBA training places
	• The following key roles have been identified to be supported across the Trust:
	  • Physician Associate/Assistant
	  • Medical Training Initiative Fellow
	  • Advanced Clinical Practitioner/Nurse Specialist
	  • Nursing Associate
	  • Apprenticeship Administrator B0-B3 pathway
	• Corporate Back Office engagement session scheduled for 7 September
	• Meeting held with Anand Rajasekaran (Anaesthetist Consultant) who has volunteered to be medical lead on project
	• Project reported as amber as targets are still to be set for the 3 KPIs
				• Working Groups to be established for each role. Leads identified and. Priorities over the next 6 months will be benchmarking, completing case studies, defining career pathways, establishing governance structures, establishing support networks, providing templates for business cases and job descriptions, support recruitment of roles
				• First Physician Associates due to start early October. 2 already in place in T&O along with 2 student PAs currently working in the trust and potentially 5 more subject to interviews and exam results.
				• Set targets for new KPIs
				  KPI1 – spend against apprenticeship levy
				  KPI2 – change from training to apprenticeships
				  KPI3 – spread across MTW of new roles and apprenticeships

Directorate CIP's	• Behind plan QIA's for surgery • Underperformance is still around STP rate reduction			• QIA's to be reviewed October Clinic • Meeting to be set up with SH, PM, SON, KB to identify further CIP opportunities for stretch target
Workforce Productivity	• Senior nurses working with finance team to prepare updated 'in-budget' roster templates - Ongoing • Rostering performance report issued to senior nursing team and matrons on 4 weekly roster cycle –focusing on approval timelines, finalisation and Hours balance • Changes to finalisation processes postponed by Project Board due to potential impact • Wider roster system deployment continues • Initial medical roster system review meeting completed			• 1st Stage of finalisation changes plan to be monitored for improvement prior to implementation • Performance focus: Hours Balances/Roster Approval and Finalisation (Nursing) • Medical roster system procurement approach to be agrees

Recruitment	• Medical Recruitment task and finish group met on 29 Sep. Agreed the following priorities:
	  • Produce a standard advert and letter from medical director/CD with standard items that can then be embellished for specialities
	  • Professional glossy brochure that can also be used online
	  • Professional video
	  • Ask new doctors in MTW for recommendation s in their network
				• Scoping work to be completed with key improvement themes and quick wins identified by end September
				• High level review of end to end process, actions required and gap analysis to be produced by end September
				• Review of KPIs to ascertain key focus areas
				• Project scope to be identified once improvement opportunities identified

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE - £341k saving target for Q1 was not achieved. This will put at risk the £2m of identified STP savings.	Implementation of Recovery Plan delayed. Plans not received for Urgent Care exit strategies for Top 10. Lesson Learned from East Cheshire recommends Medical Leadership and Pay Bill Reduction Group to meet weekly. Such a group is needed in order for decisions to be made on next steps with these locums.	May -18		
Issue - Agencies are not providing quality CVs at a reduced rate. Operations are challenging rates along with Bank but due to significant number of vacancies and high demand for temporary staffing, the service cannot operate without agency staff. Replacing existing agency staff has been explored however Agencies are then offering higher rates rather than reduce	STP step down to continue but with key supporting projects to reduce demand for agency staff. Recruitment has now been brought into scope of Best Workforce as it is an enabler to reduce demand for temporary staffing. Focus also now on growing the bank as only 35% of temporary staff are from Bank. Improving reporting of management information and process control aligning to NHSI requirements. This is to provide better visibility of issues so action can be undertaken for improvement.	Aug - 18		
Potential for apprenticeships levy not to be used. Spend for Mar18-Apr19 is projected to be £153K. Current funds in digital account - £1.358m. If further apprenticeships not added we start losing funds from July 2019 at a loss of approximately £60K per month.	Apprenticeships continue to be promoted through engagement sessions. Corporate Back Office session held on 7 Sep. Five trust-wide roles identified for focus with four involving apprenticeships. A number of training courses are not available until Sep 19, which impacts ability to draw down on the levy. Pressure is being placed on government to extend period for when funds may be lost.	Apr - 18		



KPIS	Target	LAST MONTH	THIS MONTH
Percentage of medical agency shifts over STP break glass rates	0%	98.9%	97.9%
Percentage of shifts requested more than 6 weeks in advance	80%	21.5%	19.3%
Non-Framework Nurses Hours	0	2187	1928
% Nursing Shifts covered by bank staff	TBC	43.73%	43%
% Nursing Shifts covered by Framework agency staff	TBC	42.49%	39%
% Nursing Shifts covered by Non-Framework agency staff	TBC	4.10%	2.96%
Average roster performance score for inpatient nursing areas	85%	70.56%	70.47%

FINANCE NARRATIVE

The Best Workforce achievement to date is £659k against a plan of £1.3m. The shortfall of £662k is largely within the STP Medical rate CIP underachievement (£546k).

Year to Date Directorate Performance

The key achieving CIP in Months 1 - 5 are the 2017/18 Roll Over schemes reporting 42% of the workstream.

Maidstone and Tunbridge Wells NHS Trust

2c. Best Flow

The Best Flow workstream is using a number of approaches to improve the safety, efficiency, effectiveness and productivity of MTW's services, by implementing good practice in patient flow and improving the processes that support this.

Through work currently being carried out, processes will be reviewed and analysed to identify pressure points and better ways of working, to benefit staff and patients.

The projects include:

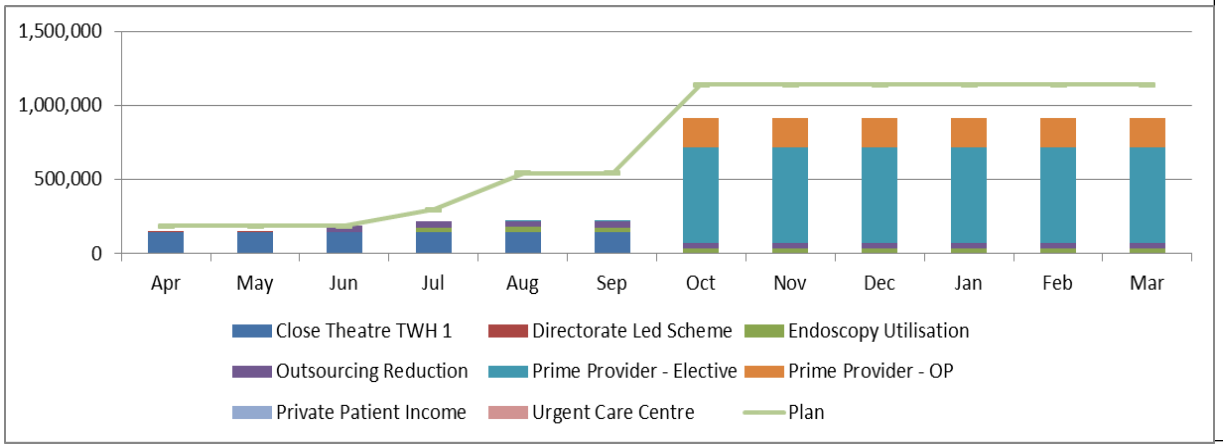
- **Non-elective**
- **Theatre Productivity**
- **Outpatients Productivity and Transformation**
- **CAU Effectiveness**
- **Private Patients**
- **Repatriation of Services**

WORKSTREAM	Best Patient Flow	BEST CARE BOARD DATE	September 2018
WORKSTREAM LEAD	Angela Gallagher	PMO SUPPORT	Tracy Redman / Sarah Smith

DESCRIPTION	ACTIONS / MILETONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH and AIC Frailty	Frailty team, I.T systems lead and head of I.T met and mapped what frailty flag feature would look like and create plan moving forward. Flag now in place-Primrose symbol triggered by Rockwood criteria indicating frail patient. Training completed by Tunbridge Wells team for Maidstone team to ensure correct use of the Rockwood criteria. Audit completed manually counting attendance at CAFU. Information passed to BI to check against system data and problem solve solution. Frailty nurse has met with CCN and SECAMB. Audit of current frailty pathway commenced to ID areas of benefit to patients			Allscripts team to conduct training with frailty ward clerks on how to convert symphony flag to Allscripts and begin roll out trust wide. Develop a detailed plan for reducing LOS for over 75s.Establish pathway for outlying frailty patients and create SOP. Create KPIs for Frailty nurse specialist. Complete business case for HTS to provide 1PA at MH. Route Cause analysis of high readmission rates. Frailty nurse to attend locality MDT and establish router of referral for AFU to improve flow and reduce burden on ED
Out of Hospital Capacity:	Internal standard of 48 hours processing being maintained – LOS for FT has reduced from13.44 to 11.9 @ Maidstone and 15.91 to 11.9 at TWH. Super stranded patient operating procedure in place at Maidstone , and started at TWH with twice weekly review. Hilton project audit complete. Data revealed that many patients unable to recall reasons for turning down services on initial visit due to lime lapse. JCR SOP completed. EDN re-audit completed showing improvements in numbers of EDN related delays. SOP completed. Audit of weekend social care provision delays complete-findings demonstrating many patients referred to social care for DC at the weekend are not able to be DC.6 further schemes decided.			SS lead to ensure Hilton provide notification of service refusal <48hours from event and contact to be made by SS team within 24hours of notification in order to increase accuracy of audit information. Work stream lead to distribute SOPS and raise awareness of JCR and EDN project findings. Weekend social care provision lead to draft comms to ward managers regarding findings, and to give SS internal professional standards to increase awareness at ward level and improve flow. Initial work to begin on new projects to improve flow to include: No discharge plans in place on arrival at W20 and changes to Fast Track pathway when DC home.
Length of Stay Increased number of 0 LOS	Appointed 8 out of 9 flow coordinators, Flow Coordinators started on all the allocated Specialist Medicine wards at MH, 2 started at TW, awaiting 2 more to start at TW, and 1 further post for TW currently out to advert. KPIs in place. Monthly meetings in place led by Matron. CUR MH started in post, KPIs agreed. CUR definitions of Red and Green agreed Increased compliance with CUR and use of CUR at Board rounds. White Card roll out completed at TWH. Endo and Oncology in place at MH. Local dashboard targets set and shared with teams			Roll out of Red and Green CUR trust wide following September Mercer pilot. Red days to be added to KPIs and strategy to eliminate needs to be in place. Standard agenda to be implemented for each triumvirate meeting and minutes to be produced. Over the next 4/12 focus to be on wards with flow co-ordinators to identify 1 patient per ward per day for discharge before 10am. Ensure discharges identified are highlighted on site report to ID early discharges for the next day Ongoing work for White Card roll out at MH with Respiratory, Cardiology, Rheumatology and COE.
AEC	Lead ENP working with Ambulatory consultants and has developed standardised exclusion criteria across both sites, with circulated paperwork to outline these criteria Patients being seen by EDP team in AEC (in AMU Maidstone and TW under medical consultant). Patients would have been seen in A&E. Surgery and Paeds part of project group. Regular attendance of surgical representative to project group-surgical pathways being implemented.			Business case for Waitless app to go to DOF for consideration as part of winter mitigation by end September. Surgery to adapt medical criteria to ensure amb pathways in place. Work stream lead undertaking research in discussion with Paediatrics to understand potential pathways. Further discussions required with T&O to bring on board.SOP to be written to create space for AEC and day to day procedures for planned medical attendances. Community scoping to be undertaken for AEC community-work stream lead to complete exercise to understand numbers MTW can divert.
Therapies	New project plan in place to achieve 90 day "perfect ward" project taking place on Mercer ward. Overarching categories include: Discharge planning process, avoiding deconditioning, Home First and patient and family engagement. Weekly meetings highlight new initiatives for immediate period ahead. Robust KPIs in place demonstrating project and overarching outcomes. Initial project ideas implemented including: twice daily board rounds, "Heading Home placement" to encourage patients to ask questions about their own discharge plans and treatment, therapy plan at individual's bedside, lunch groups with SALT input, introduction of new equipment			Evaluation of project and development of report and recommendations (+ business case) Performance reports for Therapies KPIs – Mercer Ward Project Creation of acceptance criteria and internal professional standards for remaining disciplines Therapy representation at board round audit to be completed
Non-Elective Surgical LO	- CSW now taking on the flow coordinator role. - T&O Enhanced care pathways being piloted – expected to have an impact in September. - T&O Board round improvements including red:green deep dives, ward clerk attendance at board rounds and clinical engagement at board rounds. - Complex colorectal now being undertaken at MH having a positive improvement on LOS due to cons. Decision making.			- Roll out enhanced care pathways in T&O - Further progress on virtual ward actions. - Include ambulatory pathways in clinical inductions.
Increase in private activity	- Business case for PPU staff approved. - PPU location agreed as a trial basis on EGAU. - Estates engaged and are commencing move plus environment refresh.			- Engage with clinicians to utilise new PPU. - Estates modifications to EGAU for PPU and patient transfer. - IT equipment for PPU to be supplied. - Staffing for PPU to be recruited (agency).
Prime Provider	- Operational Productivity – T&O in line with plan - EOI submitted for PP PIN. - Activity and financial modelling was further completed but more work is required. - Supplier day held with interested IS parties in relation to outsourcing/ lot 2. - Steering group with TOR drafted			- Finalise Operational policy (elective activity) - Undertake engagement sessions with GMs and CDs whilst completing the operational policy. - Recruit to Manager if JD approved by execs. - Launch steering group, T&F groups and 'service' implementation.
Operational Productivity	- Procurement of 2-way text messaging service. - Appointment of two outpatient/CAU transformation managers - Approved for TSW to administer drops in theatre to support staffing has commenced			- Complete roll-out of 2-way text messaging service - Finalise MRSA pathway - Finalise patient pathway for POA (include 'fit and under forty' LIA improvement) - Review of the CAU effectiveness programme
Outpatient Transformation	Respiratory FU back log validation pilot gave drop in backlog which provides the potential, in total, of only 15% of patients of the current list needing face to face follow up. Respiratory Telephone Clinic set up week up to commenced 3/8/18. UGI CNS pathway pilot clinic scheduled commenced. Patient Feedback forms issued initial response from telephone reviews is positive feedback. Joint QIA for, Hyperemesis, Virtual OCT clinic, Haematology Ambulatory clinic, Gastro and IBD clinics signed off Urology CNS vacancy under offer.			Review Respiratory clinic obtain patient/Consultant feedback. Continue to roll out Continue with UGI CNS pilot clinic and feedback surveys. Review data from survey forms Stocktake of original schemes/FourEyes completed and outstanding work leading to submission of next steps work plan to OPT Steering Group 21/8/18 OPT, linked with CAU Productivity, progressing recovery plan to : asses data accuracy; review slot appointment slot availability on the system; undertake further capacity work; increase outpatient slot utilisation through transformation schemes

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
There is a risk that the best flow £9.4 Million will not be delivered.. Even with full delivery of the BCBF programme, enabling elective activity to increase, there is still reliance to the external agreement on the Prime Provider.	Expression of Interest shown regarding PIN release from CCG. Capability statement completed, approved by COO and submitted. Executive leads expect to receive feedback from WKCCG to then advise on the timeline for next steps	9/3/18		
The ability to further reduce LOS by on average of 0.5 days, in order to ensure that medical patients are not in surgical beds is a risk, as progress has already been made on reducing LOS over the last year and further reduction to generate capacity will be more challenging.	Best practice schemes identified within the project delivery plans with associated LOS benefit relation , which will be monitored through the work groups and steering group. The LOS group has been split into two – medicine and surgery/T&O enabling greater focus on specialist areas to help ensure delivery.	9/3/18		
There is a risk that the subgroups are unable to speedily access the skilled staffing resource required to support new initiatives either due to funding or recruitment difficulties (shortage of skilled staff) at the pace required. Risk is further exacerbated that without approval for full Frailty and AEC services , LOS unlikely to be maintained or driven lower.	Task and finish groups to identify new ways of working and new roles which are link to Best Workforce programme. The Best Care Programme is enabling additional resource to ensure sustainability. These roles are being recruited into.	9/3/18		

KPIS	Target	LAST MONTH	THIS MONTH
NE LOS Medical	7.7	7.4	7.7
NE LOS Surgery	5.6	5.7	5.4
NE LOS T&O	10.3	8.8	10.9
Achieve or exceed DTOC target (%)	3.5	4.9%	4.7%
Theatre Utilisation for Prime Provider (%)	85	84	80 T&O = 90
Outpatients DNA Target	5%	8.38%	6.3%



Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
ID Frail patients from ED onwards	30/06/2018	20%		
Frailty business case to be approved	30/7/18	20%		
Cross site agreement on increased ambulatory pathways	03/09/18	20%		
Rollout of Red and Green days within CUR	31/08/18	50%		
Approval of paper requesting that EGAU becomes a dedicated PPU	18/06/2018	100%		
Award of CCG tender for prime provider	31/08/2018	50%		
Achieve 75% opportunity within theatres creating capacity for prime provider (near equal to 90% utilisation)	31/08/2018	80% all specialities. T&O utilisation 90% Last week Aug		
Receive income from Prime Provider (primarily from outsourcing) in August 2018	01/08/2018	0		

FINANCE NARRATIVE

The month 5 CIP position was £322k adverse to plan, this was driven the planned £244k Prime Provider expectation that did not deliver in month. There is continued slippage on increasing private patient income and bowel screening income, making up the remaining £78k below plan.

Month 6 is forecast to be identical to month 5 (£322k adverse), with the 3 schemes mentioned already assumed to fall short of their plan.

Month 7 planned CIP delivery sees the 100% foureyes opportunity commence and theatre 8 fully open to deliver the prime provider activity, aswell as private patient income and urgent care GP income to increase. These 3 schemes see an increase in planned delivery of c£600k each month for the remaining 6 months of the year. Currently only the prime provider activity is forecast to achieve.

The year end adverse variance to the best patient flow CIP plan is £2.2m. New schemes need to be identified to mitigate those that are forecast to fall short or not achieve at all

2. Workstream Summary

Maidstone and Tunbridge Wells NHS Trust

2d.Best Quality

The Best Quality workstream has worked with colleagues from across the Trust to help identify four key areas of work that can really transform our patient and staff experience.

While the workstream is focused on a number of important and quite specific clinical improvements, it is also the conduit for developing new strategies for patient, staff and public engagement that support and enable future change.

The projects include:

- **Complex Needs**
- **Quality Improvements**
- **Engagement and Experience**
- **Effectiveness and Excellence**

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	September 18
WORKSTREAM LEAD	JOHN KENNEDY	PMO SUPPORT	JANE ROOSE

PROJECT	MILESTONE ACTUAL	DELIVERY RAG LAST MONTH	DELIVERY RAG THIS MONTH	FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
Complex Needs	**Dementia** • Ongoing audit of patients admitted from Nursing and residential Homes to ascertain frequent admissions. • Initial round table meeting had with Emergency Services colleagues on 16th August 2018 – that proved positive. Further meeting arranged for 29th October 2018. Actions from the meeting included sharing of details of services currently available to refer into to take place. Identification of training needs to take place. • Scoping exercise with carers of people with dementia completed. **Transition** • L3 Safeguarding Children training arranged and good uptake continues – further adverts for staff next week • Named Nurse Safeguarding Children now receives a daily log of all 16/17 year olds admitted to non-Paediatric areas – this has enabled the Safeguarding team to follow up on admissions and ensure that these children are afforded the appropriate safeguards • Links with non-Paediatric areas improving in particular ITU and AMU (both sites)			**Dementia and Delirium:** • Ongoing audit of patients admitted from Nursing and residential Homes to ascertain frequent admissions. • Initial round table meeting had with Emergency Services colleagues on 16th August 2018 – that proved positive. Further meeting arranged for 29th October 2018. Actions from the meeting included sharing of details of services currently available to refer into to take place. Identification of training needs to take place. • Scoping exercise with carers of people with dementia completed. **Transition** • JD completed and to go out to advert imminently
Experience and Engagement	**PPEE** – Venues and dates for Maidstone events in October and November confirmed. Options for venues and dates for Tunbridge Wells events identified. Letters inviting participation in MTW network and Engagement events complete and ready to go. Pilot work with Healthwatch focusing on patients with Parkinsons and medicines management progressed. **Staff Engagement** Staff engagement strategy taken to Workforce Committee. Requests made for Action Leads to specify / refine timescales for delivery .New arrangements for cascading of monthly communications and management messages identified.			**PPEE** – confirm venues and dates for engagement events in Tunbridge Wells Align patient representatives to Best Care programmes Send out letters and manage responses to invitation to join MTW Patient Network Prepare letters of invitation to Engagement Events for sending late August Always events to be integrated into patient experience **Staff Experience and Engagement** Develop detailed implementation plan for strategy identifying milestones and responsibilities by month Agree plan and approach for communicating and engaging staff around development and implementation of staff engagement strategy

Quality Improvement	Quality Improvement Group reviewed progress on 17should do action plans as part of planned transition to BAU			Quality Improvement Committee reviews progress against 17 action plans Quality Improvement for extended discussion at August Best Quality Board.
Effectiveness and Excellence	**Maternity Safer Births / CNST** Total of £908000 confirmed for September **Crowborough** – Building works to start end of September, completion due in December. **CQUINS** • Audit of Sepsis for compliance with Antibiotics completed. • Evidence collection completed and submitted to NHS England for specialist CQUIN's and to WKCCG for National CQUINS. • Meeting with EPR team to format the referral pathway for Smoking and Alcohol cessation advice and guidance • Meeting with Neonatal team to review progress being made- capacity concerns and agreement from the Directorate is required to increase capacity. **#EndPJParalysis** • KPI ideas discussed at BQ meeting. To analyze LOS data during the implementation of End PJ Paralysis. • To commence spot checks on the wards to monitor the engagement of the project. • Rolled out in oncology • Uptake of the project in ward areas is improving • Storage secured on Edith Cavell for clothing • Donations received from Tesco's and Bearsted and Thurnham WI **Criteria Led Discharge :** - **Pressure Sores and Falls** Delivered planned activity.			**Maternity Safer Births / CNST** Appeals being reviewed and further funding to be confirmed **Crowborough** – Increased marketing planned following refurbishment. **CQUINS:** • Safety Calendar for the month of September is Sepsis- poster competition, Sepsis Study day taking place next week and staff are walking the floor to raise awareness of the importance of early diagnosis and prompt treatment within an hour of diagnosis. • Referral pathway for Risky Behaviours to be rolled out once IT issues can be resolved. • PMO Support from 24th September **#EndPJParalysis:** • Present End PJ Paralysis project at the upcoming AGM meetings cross site. • Compare LOS data to identify any correlation in reduction of LOS and End PJ Paralysis launch • To discuss the project at the next NMAHPSG group to take it forward. • Presenting project to Paediatric and T&O PDN's for roll out in their areas. **Criteria led discharge**: **Pressure Sores and Falls:**The Trust has joined the NHSI falls prevention collaborative that provides a framework for us to review practices in falls prevention. Both pilot wards, ward 32 and ward 2 are currently undertaking focus work on the assessment and recording of Lying and Standing blood pressure for patients at risk of falls. Members of the project team will be attending the 60 day event on 12th September 2018.

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	September 2018
WORKSTREAM LEAD	JOHN KENNEDY	PMO SUPPORT	VINCE ROOSE

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
16 / 17 year old's admitted to adult areas are not cared for by staff with necessary Level 3 Safeguarding Training	Daily reporting of admissions of 16 & 17 year olds to adult wards now in place. Planning to work with the Site team to identify 'Transition' wards which this cohort should be admitted to. Proposal in preparation to develop 'Safeguarding Level 3 Champions' training to care for this cohort.	24/05/18		
Lack of capacity in project team and programme management support frustrating ability to deliver project milestones	Targeting of available resources and support to specific projects. Appointment made to PMO Coordinator role and planned 1 day secondment from September. Rescheduling of planned activity where impact on patients is minimal and project outcomes can be secured.	17/04/18		
Changes in midwifery leadership team and management capacity impact on ability to deliver improvements.	Clear project lead responsibility for Crowborough identified from Midwifery Management team. Project team supplemented with Midwifery Mgt Team colleagues. Continuing focus and performance management against NHSR safer births criteria. Appointment of HOM starting in September.	02/03/18		

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
Recruitment to Transition Lead	30/08/18	On target		
Transition – electronic solution to locate 16/17 year olds admitted to adult wards	28/06/18	Complete		
Proposal for paediatrics diabetes care for 16 &17 year olds	30/10/18	On target		
Proposal for PPEE strategy to Best Quality Workstream board for sign off	06/06/18	Completed		
Invitations for engagement event to be sent out	31/08/18	On target		
Engagement events to be set up off site during October & November	31/10/18	On target		
Production of coproduced PPEE strategy	28/2/19	On target		
CNST maternity criteria to be signed off by Trust Board	28/06/18	Complete		
CNST Maternity compliance report to be sent to NHSR	29/06/18	Complete		
NHSR submit decision on % rebate of CNST rebate (up to £908K)	30/08/18	On target		
Crowborough business case sign off	22/06/18	Complete		
Crowborough Out to Tender for works	16/07/18	Complete		
Crowborough Practical Completion	21/12/18	On target		

KPIS	TARGET	LAST MONTH	THIS MONTH
Total Number of Labours commenced at Crowborough Birthing Centre	18	14	23
Number of Births at Crowborough Birthing Centre	14	9	20
Total Number of women receiving Ante Natal Care from Crowborough Team	52	237	226

FINANCE NARRATIVE

Only 2 of the projects have financial values: CNST NHSR rebate and Crowborough Birth Centre Refurbishment.

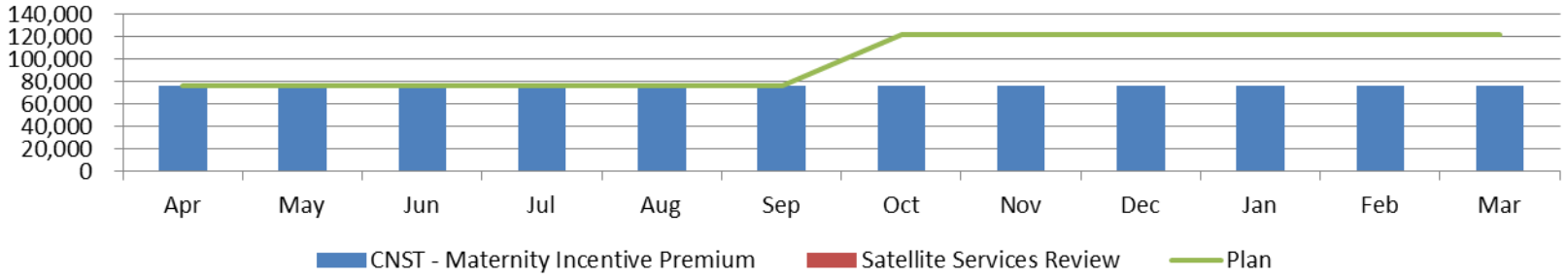
CNST:

CNST – NHS Resolution have confirmed incentive payment of £908k as planned, potential for further payments once the appeal process complete

Crowborough Birthing Centre:

No change to KPI and profile of projected increases in no of births. Projected additional income contribution of £34,000 in 2018/19 (part year effect) £120,000 contribution to income target in 2019/20.

FINANCES



Maidstone and Tunbridge Wells NHS Trust

2e.Best Safety

Providing consistently safe standards of care for all of our patients is at the centre of everything we do at MTW and it's at the heart of the Best Safety workstream.

The worksteam is leading on seven safety improvement programmes in 2018/19, with the aim of collectively transforming the way we identify safety issues, learn lessons and improve our patient experience.

The projects include:

- **Preventing Harm**
- **Learning Lessons**
- **Mortality**
- **Seven Day Services (7DS)**
- **Quality Mark**
- **Medical Productivity**
- **GIRFT**

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	14th September 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm)/Fiona Redman 7DS

PROJECTS	ACTIONS/MILESTONES COMPLETED SINCE PREVIOUS MEETING	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
7 Day Services	7DS Challenge Day - (With Regional Medical Director and NHSE Medical Director) Meetings have begun with CDs and GMs to prepare for the Challenge Day. So far, T&O, Surgery and Urology have had their review meetings and the results are very encouraging. The service models have been updated and the perceived compliance status is very positive as follows: T&O – Being proposed for compliance in principle across all 4 priority standards. Surgery – Being proposed for compliance in principle for 3 priority standards. The exception is standard 2 at weekends, but weekdays are complaint. A supplementary paper will be produced to expand upon the standard 2 issue which is potentially similar to the Women's Health position. This will be discussed with the Regional panel on 18.10.18. Urology: There is potential for compliance across all 4 priority standards. For standard 2, there is currently a weekend issue of non-compliance, but a 2nd daily ward round is being proposed for weekends from October 2018. If this occurs (currently, Consultant Locums are being recruited) then standard 2 will be proposed for compliance in principle. Standard 6 has had an ongoing issue with out of hours Interventional Radiology cover, and an updated position is being sought. Steering Group and Core Team Meetings A focussed session was held with the Urgent Care Division on the 14th August to discuss direction and to further attempt to address constraints. Good progress is being made with the paper and options are emerging for the Tunbridge Wells site which was the least developed element of the plan at the last review of the paper in July . The next 7DS Programme Board is due to take place on the 11th September 2018, (this is the Quarterly Review Meeting that includes NHSE and the CCG). The service models that have been updated for the Challenge Event will be presented to the panel for discussion and compliance views. The Core Team continues to meet. It's next meeting is 30.8.18.			7DS Challenge Day: Meetings with CDs and GMs are taking place to undertake service model updates and to prepare presentations for Panel. Women's Health: Review position with Standard 5 for sonography and eradicate barriers to compliance (chaperones, SOP and kit availability). To report to September Quarterly Review Steering Group. - Action with Divisional Director of Operations. T&O: All actions completed. Awaiting endorsement of Compliance in Principle status. Urology: Awaiting confirmation of appointment of Locum Consultants for establishment of 2nd daily ward round to assure compliance in principle status for standard 2. Also awaiting confirmation of current status of out of hours IR service. Surgery: A supplementary paper is needed for standard 2 at weekends to review casemix and volume. ICU: All actions now complete. Audit finalised and no issues identified. Proposed as compliant in principle. ENT: Confirm whether all ENT admissions will be designated as 'delegated care' following the 14 hour review and that no patients would be remaining as 'medically active'. Meeting arranged with ENT Team for September 2018. Haem/Onc: Present findings of the audit to determine requirement for Clinical Haematologist involvement standards 2 & 8to the September Quarterly Review Steering Group. Action with Divisional Director of Operations. No issues are anticipated and it is expected that this service will become exempt from the process due to classification of patients. Urgent Care: Preferred options paper still being drafted and good progress is being made. Will include proposals for GI Bleed rota. This will be discussed at the Challenge Event on 18.10.18 with the Regional Team. National 7DS Survey : National Board Assurance proposals now released by NHSI. Being reviewed by internal Team.
Mortality	The launch of the new FORMIC forms has been delayed as some revisions are needed following a review of the Mortality Review policy and process flowchart. The minor changes to forms and policy (non-material) have been proposed, discussed and agreed at MSG in August. The revisions will now be made and it is anticipated that the new versions will be launched at the beginning of September 2018. The review of the mortality database and compliance with completion of mortality reviews resulted in a number of inconsistencies which were reported to the Associate Director of Quality Governance (AD) and a number of actions have taken place. Incomplete mortality reviews have been logged and returned to the mortality leads. There are a small number of unreviewed deaths affecting the compliance figures for A&E which have been confirmed as out of hospital deaths/dead on arrival for the period to end of July 2018. The A&E Consultants have agreed to complete a Preliminary Form so that the data can be captured on the mortality database and improve compliance statistics. The development of the Quattro database is in its final stages and a preview was seen in the Learning form Deaths meeting in August. An intranet page for Mortality information is being designed and will include links to mortality review documentation , tips, contacts and role expectations. In addition member of the Learning from Deaths Project Group reviewed the RCP Platform (Datix) as a potential solution for the future recording of Mortality Reviews on the 17.08.18. Unfortunately it was found to not be a helpful solution for MTW and further options are now being pursued.			Learning from deaths review group met on 15/08/2018 to review progress across all areas. Meetings have been scheduled to take place monthly until September whilst there is a focus on development and improvement, following this they will then revert to their quarterly as expected progress has been achieved. Follow-up meeting with Datix being convened to review contract and 'free' Mortality Database and has been rescheduled to take place on the 27th September , 2018. Mortality review audit took place on the 8th August 2018, preliminary findings were positive but final report is awaited.
Learning Lessons	Resource has been lost to this project this month (Project Lead) due to pressure of work. Also, a key staff member is currently unavailable who is leading on Datix. At this stage, work is still on schedule but workstream is under pressure. Revised critical path has been drafted. Meeting arranged with core team plus NEDs to scope out the evidencing and embedding learning aspect of the project – 4.9.18 Learning levels have been tested and set up on Datix Meeting with Datix to discuss issues with software set up for 27.9.18. Draft of new core Directorate Clinical Governance meeting agenda in final development and is awaiting sign off from the Core Team Lead Clinicians (S Flint and P Moran). Once approved, will be shared with PM prior to discussion with the Trust's Clinical Governance Leads on 10.10.18. Datix upgrade pending – key resource required to undertake local work is currently unavailable so delayed. Roll out plan for launching Datix action planning function within incident reporting agreed for completion by 7.09.18. SMART action guidance appended to the SI P&P			Core team meeting being scheduled to review progress and agree agenda for meeting to discuss sharing and embedding learning Wide discussion of above with CG Leads (10.01.18), following approval in principle with PM Meeting arranged with core team plus NEDs to scope out the evidencing and embedding learning aspect of the project – 4.9.18 Datix upgrade (internal work) required first. Meeting with Datix (including Procurement management) to discuss overall contract and functionality.

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	14th September 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Medical Productivity/Preventing Harm)

PROJECTS	ACTIONS/MILESTONES COMPLETED SINCE PREVIOUS MEETING	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Preventing Harm	1. Long Elective Waits (RTT >18 weeks) Audit of 1,100 case notes is still underway . Period of review is October 2017 and involves all Consultants with breached cases (Elective or Outpatient) in study period. Numbers entered 724 (elective I/P, D/C – 476 and OPD 248). Moderate Harm 12 (1.7%) Severe Harm 1 (0.1%) ENT. The overall report is completed, but awaits the outcome of the ENT SI (Severe Harm). Once this is received, the final report can be presented to the Best Safety Board. It is hoped that this will be in time for the September meeting. The Workstream Board will review the results of the audit, including any further instances of severe and moderate harm cases and agree the way forward for this potential project. 2. Documentation and Record Keeping (potential project – in work-up) The review group have met and debated the best way forward for this project, with the aim to combine the proposals made by the Medical Documentation and Record Keeping scope with the needs of the Nursing and AHP professions. It was agreed that the compliance issue was the key one and that this should be addressed in a consistent way across all staff groups. It was felt that the LiA methodology should be used to identify why people do not comply with the standards and that also, a Survey Monkey method could be used. JK is discussing the issue with Steve Williams to identify whether he agrees to take this on as an LiA project. Gemma Craig will take the lead for Nursing & Quality, working with LS from September. 3. Acute Kidney Injury (potential project – work up completed) The BS Board had reviewed the briefing paper prepared by LR, focussing on the gaps in the services section. It was agreed that PM would discuss the matter with Claire O'Brien (COB) to determine how best to take these issues forward. COB had agreed to take this forward as part of the work relating to NEWS2 and The Deteriorating Patient. This project has now been removed from the Best Safety Project list and transferred to COB. 4. Consent – Potential project – work up completed). The subgroup established to inform the drafting of the revised document has been established and the meeting was held on 28th August 2018. There is wide representation on the subgroup , covering all areas in the Trust where consent is applicable, including the following medical staff (Dr Sara Mumford, Dr Bijay Baburajan, Dr Alistair Challiner, Dr Sarah Flint and Dr Charles Bailey. . All members of the subgroup had been sent the comments made by Capsticks and a full list of consent forms and appendices in current use/circulation. The group agreed to set up a Consent Advisory Group to support Wendy Bates in the redraft of the consent policy, and to establish a work programme to include the development of the process going forward, including compliance with the Montgomery findings, e-consent, training & competency, consent forms and appendices, MCA and links to consent, post-consent withdrawal, informed consent and cooling off period, communication with patients and GPs, roles of clinicians and levels of risk explanation/stages. Membership for the Advisory Group was agreed at the meeting from members of the group and some additional clinicians (Consultants, Nurses and AHPs) plus 2 other staff were proposed. Dr Alistair Challiner kindly offered to take on the role of the Lead Clinician for Consent. It was agreed that LS would support WG in setting up the Advisor Group and that the group would be in place before the updated Policy could be issued for consultation. It was also agreed that as this work sat within the Governance Team, the lead would move to Best Quality for onward management. The aim is to produce a revised Consent Policy for consultation by the end of October 2018.			Long Elective Waits: Completion of audits by Directorate Consultants then full analysis of final audit returns Action: Directorate Consultants and Pat Singleton. Documentation & Record Keeping: Identification of project links to the documentation audit already being discussed for Nurses and AHPS (re-focussed discussions with Gemma Craig to take place on 31.07.18) Acute Kidney Injury: Discussion between PM and COB to agree future of potential project and whether a Best Safety/Best Quality or other leadership. Consent: Multidisciplinary Sub-group meeting taking place on 28.08.18 to inform redrafting of policy.
Quality Mark	LS has met with Gemma Craig and Suzanne O'Neil to discuss the read-across to existing improvement and award mechanisms (including LiA and QSIR). The BS Board discussed the existing options put forward and the inherent issues with choosing the wrong approach. The BS Board debated an option to link the 'Quality Mark' to Best Care and Sarah Emberson agreed with draft a paper with further propoals. The timing of the launch of a Quality Mark for the Trust was discussed in some detail and the importance of linkage into the launch of the new Clinically Led Structure was considered a key factor. This will be further discussed at the Best Safety Board on the 5th September and from this, LS will develop a proposal to discuss with PM and Miles Scott (MS).			Further work-up and progression of agreed brief for project by Core Team, then discussion with PM and Miles Scott to confirm direction.
Medical Productivity	Job planning Progress has slowed down over the last 2 months with competing priorities for the directorate management teams. This has been escalated through the Medical Productivity Working Group. The directorates have all been given a final deadline to sign off all job plans on the system by the 3rd September, failure to meet this deadline will be escalated via the Best Care Programme Board. This extended deadline has used the contingency time set out in the project plan and is the critical milestone, failure to meet this will impact on delivery of the rest of the project to time. As of 28th August 263 job plans are on the system and 66 job plans signed off. Issues remain with SAS job plans which are proving difficult to add to the system –as the SAS Dr's that are not independent practitioners are on the middle grade rota in effect. These is being worked through on a directorate by directorate basis. Demand and Capacity The BI Intelligence analyst has been appointed and has completed their induction programme. The project team are attending NHSI demand and capacity methodology training on the 31st August. A meeting has been set with all corporate stakeholders on 6th September to agree objective in the approach this year prior to a wider discussion with operational stakeholders. Best Value WAU metrics were agreed at the Medical Productivity Working group and will now be produced monthly. Once job plans have been fully signed off at a directorate level , DCCs will be added into this . The definition of DCCs is continuing. National Project The data collection work for Wave 2 was submitted to time. An initial project meeting is being set up with the NHSI team for the wave 2 work –it is likely that this will be early October. A further data request has been received for Model Hospital with a deadline of October and the team are starting to work on the approach to this.			Job planning Continue to support directorates in loading and signing off all job plans into the e-job planning system Work with the directorates to sign off local PAAT Demand and Capacity Design approach to demand and capacity planning for 2018/19., taking into account Trust and project objectives. Best Value Produce first draft of Best Value DCC definition by Directorate National Project Awaiting the next instalment of work package. This programme is considered Amber due to the delay in loading and signing off all job plans. The programme has allowed for some slippage in this and the critical milestone is September for all job plans to be signed doff and complete

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	14th September 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Preventing Harm)

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Risk of best safety projects being sidelined due to greater operational or corporate pressures	High level of Executive support/ robust governance structure	03/03/18		
7DS: Consultant numbers and recruitment constraints in Urgent Care	Work ongoing with Division and Director of Workforce in respect of recruitment aids	05/05/18		
7DS: Temporary Casenotes – causing issues as amalgamation with permanent set takes a long time and the ability to review the episode (for a number of processes, not just 7DS – includes mortality, SIs and other) is becoming a risk.	Wendy Glazier has raised this as a corporate risk, so on the corporate risk register for monitoring and action.	01/05/18		
Datix system does not satisfy requirements for Learning Lessons and Mortality Projects	Datix review meeting to be convened (re-scheduled for 27.9.18)	14/05/18		
Long Elective Waits Project – risks to completion due to non-compliance by consultants not having time to undertake reviews.	Audit now finished – awaiting results of SI review before paper can be released.	08/03/18		
All job plans to be added to the system and signed off by Directorate Management Teams.	Delays have been escalated via the Medical Productivity working group and final deadlines have been issued from LS.	17/03/18		
Learning Lessons: Resource constraints – Project Lead and Datix Lead.	Programme Lead is covering as Project Lead with support from the Associate Director of Governance and Team were possible. Datix resource is being reviewed within the line management structure in the Governance Team.			

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
7DS meeting with NHSE and CCG to ratify compliance in principle for 4 priority standards	12/06/18	Completed		
7DS submission of paper outlining Urgent Care options for achieving standards (complex and reasons for delay understood by 7DS Project Board).	30/07/18	In progress		
7DS – Challenge Event with Regional Team (NHSI/E) 18.10.18 to confirm compliance status	18.10.18	On target		
Mortality - Audit has been put in place to review a sample of 1st Stage Reviews that reported no concerns (based upon a 10% selection	08/08/18	On target		
Preventing Harm – LEW – completion of audit in order to progress with diagnostic of project (just awaiting results of SI report – otherwise report completed).	11/07/18	In progress		
AKI – Meeting arranged with senior nursing team to discuss output from task and finish group. Diagnostic work completed – now in Best Quality.	12/06/18	Completed		
Quality Mark – Further options being discussed. A paper will be drafted for Miles Scott and Peter Maskell to discuss timing and proposals (noting the Clinically Led Organisation work).	05/06/18	Delayed		
Learning Lessons – human factors training for approval at TME	16/05/18	Completed		
Learning Lessons – Outline draft of new Directorate Clinical Governance agendas to be presented to Best Safety Board for approval	11/07/18	On target		
Learning Lessons – Meeting with Datix Area manager to discuss issues with action planning notification (second meeting).	27/09/18	On target		
Learning Lessons – internal upgrade of MTW Datix system Resource issue – key staff member availability problem	30/06/18	Delayed		
KPI's being finalised following paper to best safety workstream board. Not all KPIs can be drafted at this point as some projects are still in their diagnostic phase.	11/07/18	Delayed		
All job plans on the system and signed off by directorate management teams.	3/09/18	In progress		

	KPIS	TARGET	ACTUAL	THIS MONTH
** KPI'S PAPER WENT TO BEST SAFETY BOARD 06/06/2018 – MORE KPI'S TO BE FINALISED AS PROJECTS PROGRESS				
7DS	Generic KPIs have been in existence since project was first initiated , but will be reviewed if they can be localised by Division once each Division has completed their actions against the Challenge Day action plan.	NA	NA	
MORTALITY	HMSR (Monthly)	100.0	106.7	
	SHMI (Quarterly)	1.0	1.0219	
	% compliance with all mortality forms following a patient death (death cert, preliminary screening form, first stage mortality form and where appropriate, SJR)	95.0	80.6	
PREVENTING HARM	Long Elective Waits: Delivery of NHS England report 'External Clinical Review Handbook' Remaining Projects' KPS to be developed once scoping complete and indicators identified for each project.	NA	NA	
QUALITY MARK	KPIs to be agreed when the indicators have been confirmed for the project.	NA	NA	
LEARNING LESSONS	% Reduction in Top 10 recurrent incidents (To be confirmed)	NA	NA	
	% Reduction of duplication of incident occurrence	NA	NA	
	Evidence of learning from successes (Metric TBC)	NA	NA	
Medical Workforce Productivity	Number of Job plans on the e-job planning system	330	274	
	Number of Job plans signed off on the e-job planning software	300	120	

3a.Best Care Programme - Financial Summary

Comment

Original Plan Savings - £24.1m / Risk Adjusted - £16.1m

The Trust was £0.3m adverse to plan in the month and £0.75m adverse YTD, this is mainly due to slippage on STP Medical rate (£0.55m),Private Patients (£0.25m), Outsourcing reduction (£0.1m), other Workforce Schemes (£0.1m) with over performance of procurements schemes by £0.1m and PFI Insurance rebate of £0.2m.

Risk adjusted forecast is £8.0m adverse to plan, the main schemes forecasting slippage are:

- Estates & Facilities Subsidary
- Private Patients Income
- STP Medical Rates
- Medicine Management
- Prime Provider (Delay to November2018)
- Urgent Care Centre
- Endoscopy Income

9-12 Review of the Board Assurance Framework 2018/19 — Trust Secretary

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

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

Key objectives for 2018/19, and summary of year-to-date position

The key objectives in the BAF were approved at the Board on 24/05/18 (objectives 1 to 8) & 28/06/18 (objectives 9 & 10). The latest summary rating of the 10 objectives in terms of the Responsible Director's confidence of achievement by year-end is as follows:

Key objective	Confidence[2]
1. To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target	Green
2. To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target	Red
3. To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway	Red
4. To deliver the financial plan for 2018/19	Green
5. To ensure a falls rate of no more than 6.0 per 1000 occupied bed days	Green
6. To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions	Green
7. To deliver the agreed 'lessons learned' plan for 2018/19	Amber
8. To deliver the agreed medical productivity plan for 2018/19	Amber
9. To deliver a vacancy rate of no more than 9%	Amber
10. To deliver a staff turnover rate of less than 10%	Green

When the Finance and Performance Committee review the BAF in July 2018, it requested that the "What could prevent this objective being achieved? (including external factors)" section included all relevant external factors. This has tried to be reflected in the

Review by the Trust Board

This is the second time during 2018/19 that the Trust Board has seen the populated BAF. Board members are asked to review and critique the content, by considering the following prompts:

- Are the key objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Is the Board assured that actions reported as being undertaken are satisfactorily evidenced?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

Review by other forums

The full BAF is already submitted to the Trust Management Executive before it is submitted to the Trust Board, but the full BAF was also reviewed at the Executive Team Meeting (and the rating for objective 3 was amended as a result). The objectives relevant to the role of the Finance and Performance Committee are reviewed at that forum before the full BAF is submitted to the Trust Board, whilst the Audit and Governance Committee considers the latest full BAF after the Trust Board has undertaken its review (the Audit and Governance Committee only meets quarterly). In July 2018, the Board considered whether the other Trust Board sub-committees should review the relevant key objectives of the BAF and it was agreed that this was not necessary, as the Workforce and Quality Committees already reviewed the key objectives as part of their routine business.

[1] HM Treasury: Assurance frameworks

[2] This is the confidence of the Responsible Director that the objective will be achieved by the end of 2018/19

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

- Accepting the information or requesting amendments, to objectives, risks, ratings &/or content
- Requesting further information on any of the BAF items
- Requesting that a Trust Board sub-committee review the risks to an objective in more detail

Additional aspects relating to the Risk Register

A summary of the status of the Risk Register is enclosed in Appendix 1. Having reviewed the current list of red-rated risks, it is considered that the substance of each are either accounted for within the BAF (to some aspect) or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Trust Board is obviously free to challenge this.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 18/09/18
- Trust Management Executive, 19/09/18
- Finance and Performance Committee (for objectives 1 to 4), 25/09/18

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

Review and discussion (taking into account the prompts listed on page 1)

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

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[4] *Key objective*

1 To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target[5]

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

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

1. The capacity required to deliver the 'new norm' for non-elective activity being insufficient
2. A&E attendances continuing to remain higher than plan
3. Bed occupancy remaining above 92%
4. The level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard
5. If there is failure to follow best practice in response
6. If there is lack of ownership by Clinical Directorates

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Demand and capacity planning for 2018/19 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning (1)
b. The Directorate management team and the Information Department have agreed a set of monthly targets to facilitate how the required performed is monitored (the Trust must achieve 90% or above for Q1, Q2 & Q3, and then 95% in March 2018). Monthly targets are also in place (2)
c. GP streaming is now fully operational (5)
d. The Chaucer Acute Frailty Unit (CAFU) is fully operational at Maidstone Hospital whilst the Frailty Unit at Tunbridge Wells Hospital opened as planned in June 2018 (5)
e. There continues to be intensive focus by the Urgent Care team on resolving capacity and flow issues, supported by Emergency Care Improvement Programme (ECIP) (4, 5)
f. The 'Home First' Pathway 3 programme has been fully implemented (5)
g. The objective is reflected in the Best Flow priorities for Urgent Care i.e. reduction of LOS and of super-stranded patients (those with a LOS over 21 days) (6)

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

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

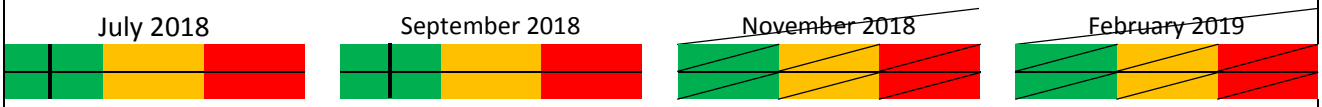
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Review of A&E Data Capture and Recording" published in December 2017 gave an overall conclusion of "Reasonable assurance", although 2 "Important" [6] and 2 "Routine" [7] priority recommendations were made, which have been monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner/s:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	TME / Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[8]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest monthly performance (for month 5, August 2018) was 91.78%
- The latest year to date performance (at month 5, August 2018) was 92.9%

[4] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[5] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total	Q1	Q2	Q3	Q4
87.99	90.38	91.7	91.97	92.35	92.62	91.8	91.96	88.54	86.68	88.14	95.03	90.82	90.07	92.3	90.77	90.05

[6] The 2 recommendations were "All relevant members of staff be reminded of the requirement for ensuring that up to date data is consistently captured within the live A&E patient tracker on Symphony with regards to patient status notes" and "Review current user access to establish whether individuals with access to edit discharge times can be minimised. Alternatively, regular monitoring of changes to discharge times to be undertaken with any significant changes being investigated"

[7] The 2 recommendations were "Clinicians be reminded of the requirement for timely and accurate recording of patient discharge times within Symphony" and "Review operational processes with regards to the administrative responsibilities of the clinical members of staff responsible for the day to day live monitoring of the A&E patient tracker and whether these can be undertaken by administrative members of staff on a permanent basis"

[8] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[9] *Key objective*

2 To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target[10]

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

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

1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. Pathways not being optimal in relation to achieving the required performance
3. Insufficient capacity to meet the increased demand for 2-week wait clinics and diagnostics (Endoscopy and Radiology)
4. Inability to recruit sufficient staff

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Cancer Summits, and Tumour Site-specific mini-Summits have been held (1, 2, 3)
b. The issues have been discussed in Governance meetings & the Cancer Clinical Board (1, 2, 3)
c. Action/Recovery Plans are in place for each of the tumour sites (1, 2, 3)
d. The weekly Cancer Patient tracking Lists (PTLs) meeting is being further revised to include administrative staff responsible for booking inpatient and outpatient appointments. This will enable real time changing of appointments and for dates to be pre-booked for patients when a next key event is known (e.g. likely for surgery).
e. Changes have been made to pathways, including Straight to test triage clinics for colorectal referrals (which is reducing the interval between referral and initial diagnostic and OP appointments for these patients and will eventually enable the number of breaches to be reduced) (2)
f. Individual Cancer pathway workshops are taking place, to focus on key issues in those specific areas (i.e. Breast, Lung, Colorectal) (2)
g. There has been improved engagement with all Tumour Site MDT leads and Directorate management teams, which has increased focus & accountability (1, 3)
h. A daily 'huddle' has been implemented for patients between day 40 & day 61, to expedite actions on their pathways (2)
i. Improvements in administrative processes will enable better performance especially for Urology, such as the implementation of the Endoview reporting system in Tun. Wells (to reduce the number of letters dictated & appropriate patients to be removed earlier from the pathway) & the clinic outcome proforma (to reduce the number of letters dictated & to remove the patient earlier) (2)
j. The 'To come in' (TCI) form for surgery is being updated to provide a reminder to clinicians to record the data needed to apply waiting time adjustments where appropriate (2)
k. Oncology has implemented a new process to identify patients referred after day 38 where breaches can be avoided if the patient is treated within 24 days. Oncologists will reserve 1 new patient appointment per week & the process is being piloted to book the 24-day patients to these
l. A review of the Cancer-related operational governance has been undertaken by the NHS Intensive Support Team (IST)
m. The Trust's recovery plan is focused on demand management and capacity provision
n. Some key appointments have been made that are crucial to sustaining pathway improvements i.e. Cancer Transformation Manager and Pathway Navigators
o. The Trust is monitoring the clinical outcomes of patients who have experienced long waiting times

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

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2015/16 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in June 2016 reviewed the KPIs relating to the Cancer 62-day waiting time parget. This gave an overall conclusion of "Reasonable assurance" and stated that "The figures reported to the Board for the Cancer 62 day wait…were found to be accurately reported"

[9] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

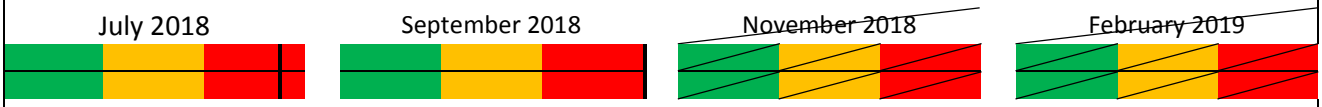
[10] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total	Q1	Q2	Q3	Q4
75.73	73.11	71.7	75.65	79.46	82.08	85.48	83.17	83.96	83.74	85.58	86.96	80.5	73.48	78.98	84.29	85.04

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[11]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 4, 2018/19, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 56.9%. For MTW-only patients, performance was 60.3%

[11] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[12] *Key objective*

3 To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway[13, 14]

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

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

1. An insufficient level of elective and outpatient activity being undertaken
2. Non-elective activity increasing beyond current levels (incl. A&E attendances)
3. Additional data quality issues and/or technical 'glitches' following the implementation of the Allscripts Patient Administration System (PAS)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Close monitoring continues for the highest-risk non-compliant specialties (T&O, Gynaecology, and Cardiology) against action plans put in place to reduce their longest waiters (1)
b. These specialities are trying to continue to reduce their backlogs by maximising available capacity across both hospital sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays (1)
c. Operational teams are focused on their recovery plans to increase elective activity (including outsourcing & Waiting List Initiative activity) (1)
d. The Trust engaged a productivity company, Four Eyes Insight Ltd, to optimise theatre and outpatient productivity and efficiency (to maximise the potential for increased activity to be undertaken within the Trust's baseline capacity) (1)
e. The Waiting List Office has been reorganised with the addition of a validation team to manage ongoing issues relating the PAS, and ensure that data is reported correctly (2)
f. A specific waiting list validation, to address data quality issues, will take place in Sept/Oct 2018 (2)

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

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

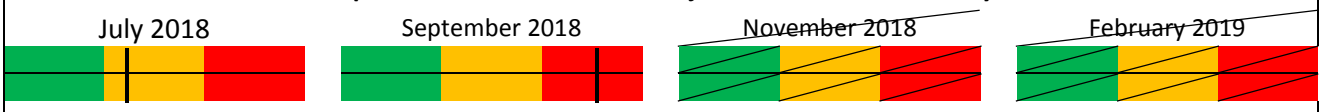
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to the RTT incomplete pathway and gave an overall conclusion of "Reasonable assurance", although 2 "Important" priority recommendations were made[15], which will be monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Finance and Performance Committee Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[16]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest available monthly performance (for month 4, July 2018) was 80.4%
- The latest available year to date (which equates to the quarter to date) performance (at month 4, July 2018) was also 80.4%

[12] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[13] An 'incomplete' pathway is where a referral has been received and the patient is still waiting for something, be that an Outpatient appointment, diagnostic test, elective admission etc. 92% of patients on an incomplete pathway should be waiting less than 18 weeks from receipt of referral.

[14] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
79.77	80.35	81.02	81.69	81.69	82.37	83.63	84.4	84.5	84.59	84.69	85.46

[15] The 2 recommendations were to "Resolve the technical issue in regards to the outpatient clock stop dates not transferring to Quattro from AllScripts within an agreed reasonable timeframe"; and "Documented evidence to support the referral date captured on the system to be retained within the patient file in all cases with the date of receipt recorded"

[16] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[17] *Key objective*

4 To deliver the financial plan for 2018/19

Relevant CQC domain/s: Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-led ☒

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

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the CIP schemes were not delivered (regardless of their RAG rating or identified value)
5. If the Trust's plans for 2018/19 had been developed without consideration of best practice elsewhere
6. If there was insufficient engagement with external stakeholders
7. If there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Executive has continued to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. The Trust has signed up to its control total, and submitted a plan to achieve this (1)
c. Agreed budgets have been set for each Directorate (2)
d. A number of 'Grip and Control' measures have been implemented to ensure delivery (1, 2, 5)
e. The Performance Management Framework is now embedded (2, 3)
f. Action has been taken to engage with external stakeholders, including agreeing an Aligned Incentives Contract with West Kent CCG , which now includes Kent Community Health NHS FT (5, 6)
g. The Trust has introduced a Best Care programme which seeks to bring a consistent approach to transformation and improvement across the Trust (1, 3, 4)
h. The 2018/19 CIP will be delivered via the Best Care programme (1, 3, 4)

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

1. Monthly financial performance reports to the Best Care Programme Board (monthly) TME, Finance and Performance Committee and Board
2. Monthly detailed Best Care Programme report to the Finance and Performance Committee and Trust Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

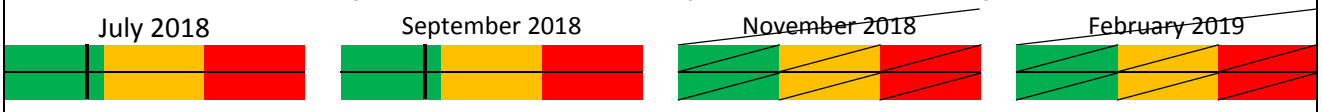
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The financial position is subject to annual external review via the Annual Audit of the financial accounts, which is reported to the Audit and Governance Committee and Trust Board each May

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Finance	Director of Finance	Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[18]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 5 (August 2018), the Trust is ahead of its financial plan

[17] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[18] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective) [19] *Key objective*

5 To ensure a falls rate of no more than 6.0 per 1000 occupied bed days

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

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

1. Failure/inability to meet national best practice standards
2. Lack of full MDT approach to falls prevention
3. Lack of flexibility and suitability of clinical support systems

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust has joined the NHS Improvement (NHSI) Falls Prevention Collaborative (1 & 2)
b. Clear identification of pilot and control Wards to test & check falls prevention strategies (in line with recommendations resulting from point a.)
c. Initially specific focus on one action (lying & standing blood pressure) across all disciplines (2)
d. Review and updating of relevant clinical systems to enable full recording and tracking of interventions via Nerve Centre IT system (3)
e. Ensuring all areas have access to relevant equipment to enable implementation of best practice standards (1)

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

The monthly Trust Performance report submitted to the Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

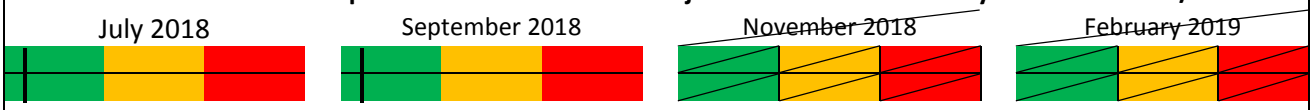
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to falls and gave an overall conclusion of "Reasonable assurance", no recommendations, and the statement that "Testing of a sample of twenty cases confirmed timely recording of Falls incidents and that the information contained in source records and the source data system were consistent with the information reported"

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Nurse	Chief Nurse	Trust Clinical Governance Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19? [20]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The rate of falls for the latest month (month 5, August 2018) is 6.39 (5.33 at Maidstone Hospital and 7.01 at Tunbridge Wells Hospital)
- The rate of falls for the year to date at month 5 (August 2018) is 5.95 (5.91 at Maidstone Hospital and 5.97 at Tunbridge Wells Hospital)

[19] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[20] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[21] *Key objective*

6 To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

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

1. Failure to deliver personalised care (i.e. care planning & delivery not tailored to individual patient need)
2. Prolonged 'trolley time' in A&E, Radiology, Theatres
3. Unscheduled absence/gaps in the Tissue Viability Nurse (TVN) service
4. Failure to prevent the new NHS Improvement (NHSI) guidance on reporting Deep Tissue Injury (issued in June 2018)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Education programmes in place, informed by lessons learnt from Root Cause Analysis (RCA) (1)
b. Good links with wound care supplier representatives who provide local ad hoc training & support in and out of hours (1 & 3)
c. Good awareness of risks, leading to prompt transfer of 'high risk' patients to appropriate bed in A&E (2)
d. Key therapeutic Radiotherapy risks are known and consideration is given to planning transfers to minimise waits (2)
e. Good quality trolley are mattresses in place (2)
f. There is early recognition of high risk patients in Theatres with appropriate pressure relief measures in place (2)
g. There are links with Community TVNs for provision of clinical advice and assessment to telephone triage system (3)
h. There are Key Link Nurses & Ward Managers who can support locally for short periods of time (3)
i. Gap analysis against the new NHSI guidance has shown that the Trust is compliant with 19 of the 28 new recommendations (4)
j. There is a minor impact of new NHSI reporting guidance with the inclusion of Deep Tissue Injury (DTI) data
k. A recruitment process is underway (Sept. 2018) to appoint a Band 8a TVN Lead (to cover unscheduled absence within the TVN team) (3)

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

The monthly Trust Performance report submitted to the Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

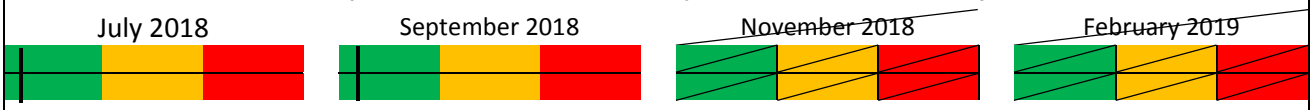
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to Pressure Ulcers and gave an overall conclusion of "Reasonable assurance", although 1 "Urgent" [22] and 2 "Routine" [23] priority recommendations were made, which will be monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Nurse	Chief Nurse	Trust Clinical Governance Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[24]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The rate of hospital pressure ulcers for latest month (month 5, August 2018) is 1.78
- The rate of falls for the year to date at month 5 (August 2018) is 1.62

[21] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[22] The recommendations was to "Ensure that the notes on Datix are maintained up to date to accurately reflect and evidence that the patient has been independently assessed by the Tissue Viability Nurse and that the severity of the harm reported has been verified"

[23] The 2 recommendations were "Process notes held by the Lead Tissue Viability Nurse for populating the monthly Safer Smarter Care Template to be formalised" and "Relevant staff to be reminded that all pressure ulcer incidents are to be recorded on Datix within a timely manner following the occurrence of the incident"

[24] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[25] *Key objective*

7 To deliver the agreed 'lessons learned' plan for 2018/19

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

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

1. The Datix IT system not being able to provide the required functionality
2. The availability of IT resource to complete Datix upgrade(s)
3. Clinical Directorates not being able to release key staff to attend clinical governance meetings
4. The identification of meaningful/measurable metrics to assure that learning is shared and embedded
5. Lack of agreement/support/resource to implement new clinical governance processes proposed (agenda, learning levels, action planning processes)
6. The learning input and output from Datix is not consistently of the right quality to provide clarity for lessons to be learned
7. The new management structure will need to be implemented before the structure of the Clinical Governance process can be finalised (but the critical path will not be affected)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. A meeting was held with Datix for 24/07/18 to discuss issues with functionality and press them for a solution/support to resolve (1)
b. Problems with Datix are reported to their service desk (1)
c. The Interim Director of Health Informatics is involved in discussions, and will oversee upgrades requests and allocate required resource. Assurance has been received for the current upgrade and an IT project manager has been allocated (2)
d. Meetings are being arranged with Directorate clinical governance leads for September to discuss their attendance and cascade strategy from clinical governance meetings (3, 4)
e. Meetings have been held with a wide group (including 2 Non-Executive Directors and other key staff) to devise mechanisms to test for learning/evidencing/embedding and to scope and agree options for recording/metrics (4)
f. The Patient Safety Team will deliver a programme of training on reporting/investigating incidents (6)

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

1. The Learning Lessons Core Team and the documents considered at the Best Safety Board

Do we have all the data needed to judge performance? Yes ☐ No ☒ *Gaps in assurance*

If "No", what other data is needed? The project is still in formulation

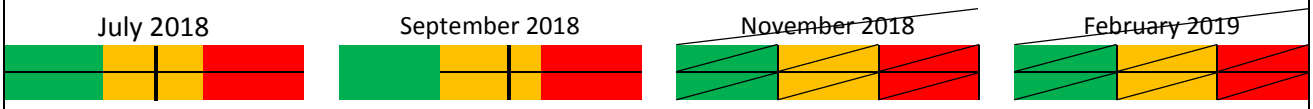
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details: The project is still in formulation

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Best Care Programme Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[26]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- A 'plan B' is in place which will allow manual extraction of data if necessary
- Some investment may be required from the Clinical Directorates
- There are known to be national-level difficulties in achieving clear metrics (including Human Factors benefits)
- Competing priorities have worsened the position slightly

[25] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[26] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[27] *Key objective*

8 To deliver the agreed medical productivity plan for 2018/19

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

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

1. The resource at Directorate level to complete all Job Planning requirements in line with the project timeline
2. The resource to support the project in the timescales set out in the plan overview, including Project Management Office (PMO) and Business Intelligence support
3. Lack of enforcement of local standards at Directorate level for job planning (unwarranted variation)
4. Resistance or lack of support from the Joint Medical Consultative Committee (JMCC)
5. The significant cultural change required to obtain buy in to undertake and implement Best Value Direct Clinical Care (DCC) and Personalised Metrics.
6. If seasonal Job Plans are not well received by the Consultant body and unenforceable
7. Directorate Leadership Teams' ability to deliver significant cultural change and challenging work programme

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Full support given by Core Team, close working with Clinical Directors (CDs) and General Manager, management of targets, and the secondment of the PMO Lead to project (1)
b. Dedicated Business Intelligence resource has been recruited at corporate level which will also support Directorate requirements. The PMO support is also now dedicated (2)
c. The project has the full support of CDs and the Divisional/Directorate management Teams (3)
d. There has been Trust-wide approval of the Job Planning policy/standards/PA allocation table and the Medical Job Planning Consistency Committee (MJPCC) Terms of Reference (4)
e. There has been close working with the JMCC, co-design of the MJPCC Terms of Reference and membership of JMCC representatives on MJPCC (4)
f. The Associate Medical Director will work through the Deputy Medical Directors and CDs to resolve concerns (5 and 7)
g. The project will be a standard agenda item on Clinical Directors' Committee meetings, to keep the Directorate Management Teams informed and updated. This will provide an opportunity to voice concerns and resolve issues arising (6)
h. The Assoc. Medical Director will test out through CDs and develop a workable compromise (7)
i. The Trust has been accepted into wave 2 of NHS Improvement's Medical Productivity workstream

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

1. The Medical Productivity Working Group and Best Safety Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

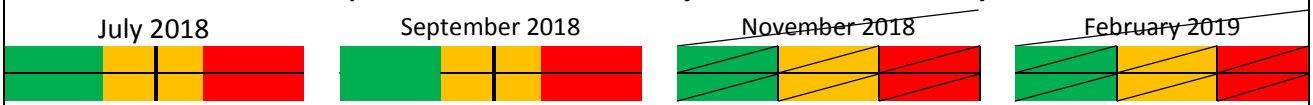
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: Allocate system reports. There will also be Business Intelligence analyst involvement upon commencement of their new role

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Best Care Programme Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[28]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- Directorate resource to complete all Job Plans, load onto system and sign off (still within critical path deadline)
- Initial review of some of the Job Plans going through the sign off process indicates some non-compliance with the standards and may indicate lack of buy-in to the process, or inability to shift culture at Directorate level. The Associate Medical Director is liaising with the relevant Directorates. However, this was expected and will be resolved through the shadow MJPCC in the first year

[27] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[28] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[29] *Key objective*

9 To deliver a vacancy rate of no more than 9%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

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

1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of clarity over the performance required by each Directorate, and the monitoring of such performance
4. If there was inefficiency of recruitment processes
5. If there was a lack of urgency/commitment by recruiting managers
6. If there was uncertainty over the status of vacancies
7. Uncertainty regarding Brexit i.e. the impact on the availability of European recruits

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Implementation of TRAC electronic recruitment system (4)
d. Divisional New Ways of Working Task and Finish Groups (4, 5)
e. Establishment of a New Roles and Apprentices group within the Workforce workstream of the Best Care Programme (1)
f. Establishments and workforce requirements have been reviewed as part of the Business Planning process for 2018/19 (6)
g. Establishment levels are likely to be reviewed as part of the Business Planning for 2019/20 (6)
h. Listening into Action (LiA) Crowdfixing events held during January and February 2018 (4)
i. HealthRoster KPIs have been implemented in order to report on effective rostering of staff and usage of contractual hours & to challenge poor practice (5, 6)
j. Development of further international recruitment initiatives (7)

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

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The 6-monthly review of Ward and non-Ward areas submitted to the Trust Board in March 2018
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)
6. The Nursing recruitment plan (which is monitored via the Executive Team Meeting)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

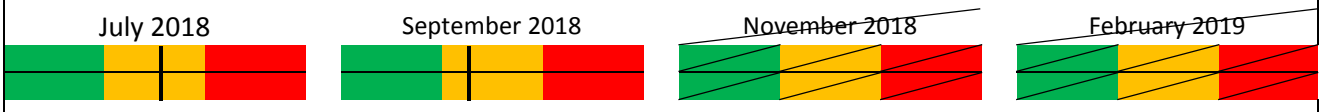
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details:

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[30]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The vacancy rate for the latest available month (month 4, July 2018) was 10.1%
- The latest available vacancy rate for the year to date (at month 4, July 2018) was 10.1%
- The target is therefore not currently being met, but a range of actions are in place to recover the performance

[29] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[30] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[31] *Key objective*

10 To deliver a staff turnover rate of less than 10%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

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

1. A national shortage of certain staff groups creates a more mobile workforce
2. Higher than planned vacancy rates (resulting in more temporary staffing use) typically reduces staff morale
3. Uncertainty arising from Brexit may impact on the retention of EU staff

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (1, 2)
c. Agreement of the Staff Engagement Strategy and associated action plans at the Workforce Committee in March 2018 (1)
d. A Staff Retention group has been established within the Quality workstream of the Best Care Programme (1)

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

1. The Trust Performance Dashboard, which contains the "Staff Turnover Rate (%)"
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the turnover rate)
3. Divisional and Directorate monthly workforce reports
4. Directorate performance dashboards

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

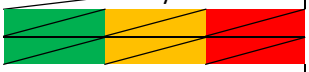
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details: Some internal work has been completed to improve the accuracy and data quality used to calculate workforce KPIs. Further refining work is completed throughout the year.

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[32]

July 2018	September 2018	November 2018	February 2019
			

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The turnover rate for the latest month (month 5, August 2018) was 9.7%
- The turnover rate for the year to date (at month 5, August 2018) was 9.7%

[31] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[32] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Appendix 1: Summary of the status of the Trust's Risk Register

Each risk on the Risk Register has a designated “Manager” and is allocated a review date. The management of the Risk Register is overseen by the Trust’s Risk and Compliance Manager, who instigates formal reviews every 2 months. The full Risk Register is submitted to the Audit and Governance Committee. Red-rated risks are now also subject to detailed review at Executive Team Meetings each quarter, whilst Clinical Directorate-based red-rated risks are discussed as part of the report that Directorates give to the ‘main’ Quality Committee (via the Trust Clinical Governance Committee).

The latest review of red-rated risks at the Executive Team Meeting took place on 17/07/18, and it was recommended that several of the red-rated risks be moderated (and therefore have their risk rating downgraded to either an ‘amber’ or ‘green’ rating). This moderation has not yet been fully completed, but once completed, will affect the risk profile, by reducing the number of red-rated risks and increasing the number of amber- and green-rated rated risks. The pre-moderated Risk Register therefore contained the following risks at 14/09/18:

- 12 red-rated risks
- 58 amber-rated risks
- 19 green-rated risks
- 1 blue-rated risks

The risk matrix and associated guidance has been included in Appendix 2, for reference.

The issues covered by the 12 current red-rated risks should be familiar to the Trust Board and its sub-committees, as these have been previously discussed at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:

- High staffing, vacancies and turnover for Nursing staff in the Specialist Medicine Directorate
- Achieving the Cancer waiting time targets
- The cost pressures associated with the use of temporary staff
- The shortage of Paediatric Specialty and Associate Specialist (SAS) (‘middle grade’) doctors on day shifts for paediatrics
- Nursing staffing levels in Orthopaedics
- The governance arrangements for Point of Care testing
- Medical staffing shortage in Surgery impacting on inability to deliver emergency and elective care
- Impact of staffing levels on ability to sustain accreditation in Microbiology
- Risk associated with failing to learn from incidents
- Risk of no qualified speech and language therapy service to non-stroke neuro patients
- Lack of capacity to assess and treat within clinically recommended timeframes in the Medical Retinal Service
- Turnaround backlogs in Histology due to consultant reporting capacity

As was noted on the cover page of this report, it was agreed at the Audit and Governance Committee in February 2017 that the substance of all red-rated risks in the Risk Register should be accounted for in the Board Assurance Framework (BAF), or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the red-rated risks listed above, it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum.

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

Score / Consequence	CLINICAL OUTCOME / SAFETY	QUALITY	AGREED TARGETS	FINANCE, DAMAGE & LITIGATION	IMPACT ON TRUST - CORPORATE RISK
1 NEGLIGIBLE	No obvious harm Some distress Temporary loss of dignity	Minor non-compliance of standards	No obvious effect	<£2K	No obvious risk
2 MINOR	No-permanent harm Increased length of stay <7 days Minor psychological harm Injury requiring first aid Resolved in <1 Month <3 days work absence	Single failure to meet internal standards Failure to follow procedure or protocol	1% off planned Target Fail to meet national target for 1 quarter	£2K - £20K Litigation unlikely Complaint possible	Local adverse publicity for <1d Clinical service disrupted for <1 day
3 MODERATE	Semi-permanent harm Increased length of stay 7-15 days Increased level of care Injury requires medical attention Resolved within 1 year >3 days work absence	Repeated failures to meet internal standards Single failure to meet national or professional standards Repeated failure to follow procedures or protocols	2% - 4% off planned Target Fail to meet national target for 2 quarters.	£20 K - £1M Litigation possible Complaint received	Local adverse publicity for >1d Clinical service disrupted for >1 day Temporary interruption of clinical service
4 MAJOR / SEVERE	Major permanent harm Increased length of stay >15 days Permanent disability > 10 people affected Major psychological harm Injury requires hospital admission Over 1 year to resolve >10 days work absence	Repeated failure to meet national or professional standards Failure to meet NICE guidelines.	5% - 10% off planned Target Fail to meet national target for >2 quarters.	£1M - £5M Litigation certain Breach of legislation Incident reported to external Agency (SI declared, RIDDOR etc) HSE investigation	National adverse publicity for <1d Clinical service disrupted for >1 day Sustained interruption of clinical service MP concerns
5 CATASTROPHIC	DEATH Many people affected (e.g. cervical screening)	Gross failure to meet national or professional standards	>10% off planned Target Fail to meet national target for >2 quarters by more than 20%.	>£5M Class litigation Major breach of legislation HSE prosecution or prohibition notice	Major national adverse Publicity Public enquiry Loss of clinical service

Guidance on likelihood / probability

Score / likelihood	DEFINITION	TIME SCALE	OCCURRENCE
1 **HIGHLY UNLIKELY**	Cannot believe that circumstances exist now or ever.	Could occur once in a lifetime.	Control measures are in place and will prevent harm from arising. Control measures have been put in place to prevent situation arising again
2 **UNLIKELY**	There is a theoretical risk of the problem causing harm	Could re-occur every few years A single issue	Investigation has been completed and action plan has been developed. Resources are available and guaranteed Project is being managed and timescale is acceptable Proposed control measures will prevent situation arising again.
3 **POSSIBLE**	Risk of harm is considered to be 50/50	Could re-occur annually An occasional issue	Control measures are not followed or ineffective to prevent occurrence Resources are inadequate to prevent occurrence Not known if control measures are effective or adequate. Low confidence the project will be completed or time scale is un-acceptable
4 **LIKELY**	It is only a question of time before harm occurs.	Could re-occur monthly A common issue	Control measures are limited and/ or ineffective. Resources are not available when required. Near misses may be occurring occasionally
5 **CERTAIN**	The risk of harm is considered real and imminent	Certain to re-occur A persistent issue	Circumstances for occurrence exist. Existing practices and processes would not prevent incident from occurring. Near misses may be occurring routinely

Risk grading matrix

	CONSEQUENCE/ SEVERITY				
LIKELIHOOD / PROBABILITY	**None 1**	**Low 2**	**Moderate 3**	**Severe 4**	**Catastrophic 5**
Highly Unlikely 1	**Blue 1**	**Blue 2**	**Blue 3**	**Blue 4**	**Green 5**
Unlikely 2	**Blue 2**	**Blue 4**	**Green 6**	**Green 8**	**Amber 10**
Possible 3	**Blue 3**	**Green 6**	**Green 9**	**Amber 12**	**Red 15**
Likely 4	**Blue 4**	**Green 8**	**Amber 12**	**Red 16**	**Red 20**
Certain 5	**Green 5**	**Green 10**	**Amber 15**	**Red 20**	**Red 25**

Trust Board meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-13 Quarterly mortality data — Medical Director

Summary / Key points

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach (by the end of Quarter 2) and publication of the data and learning points (from Quarter 3 onwards).

This report also provides an update into the further actions that have subsequently been taken to understand and improve our Trust position, as a previous outlier, in regard to the Hospital Standardised Mortality Ratio (HSMR).

This report is based upon the Trust's most recent data, published by Dr Foster for the period June 2017 to May 2018.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, assurance and discussion

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

Mortality Surveillance Report

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS).

Measuring hospital performance is complex. Dr Foster understands that complexity and is clear that HSMRs should not be used in isolation, but rather considered with a basket of other indicators that give a well-rounded view of hospital quality and activity.

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months June 2017 to May 2018 show our HSMR to be 105.8, which is an improvement against last month's position of 108.3.

Figure 1. Rolling 12 Month view

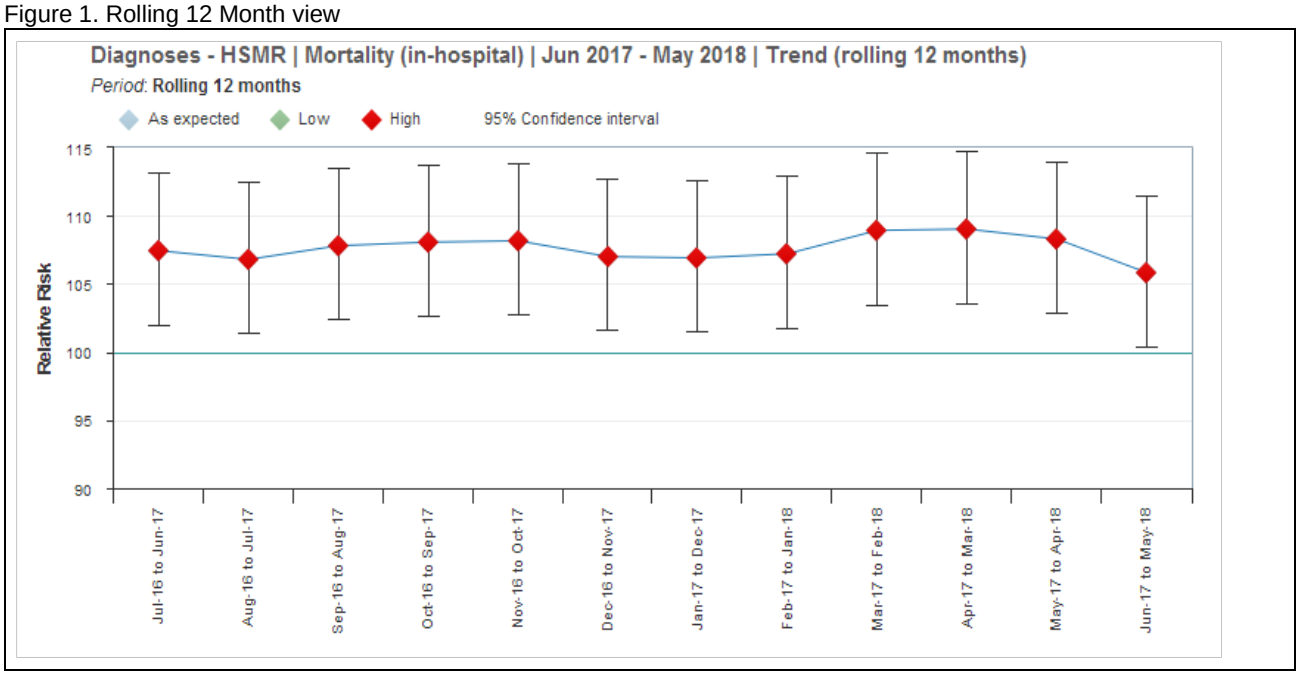
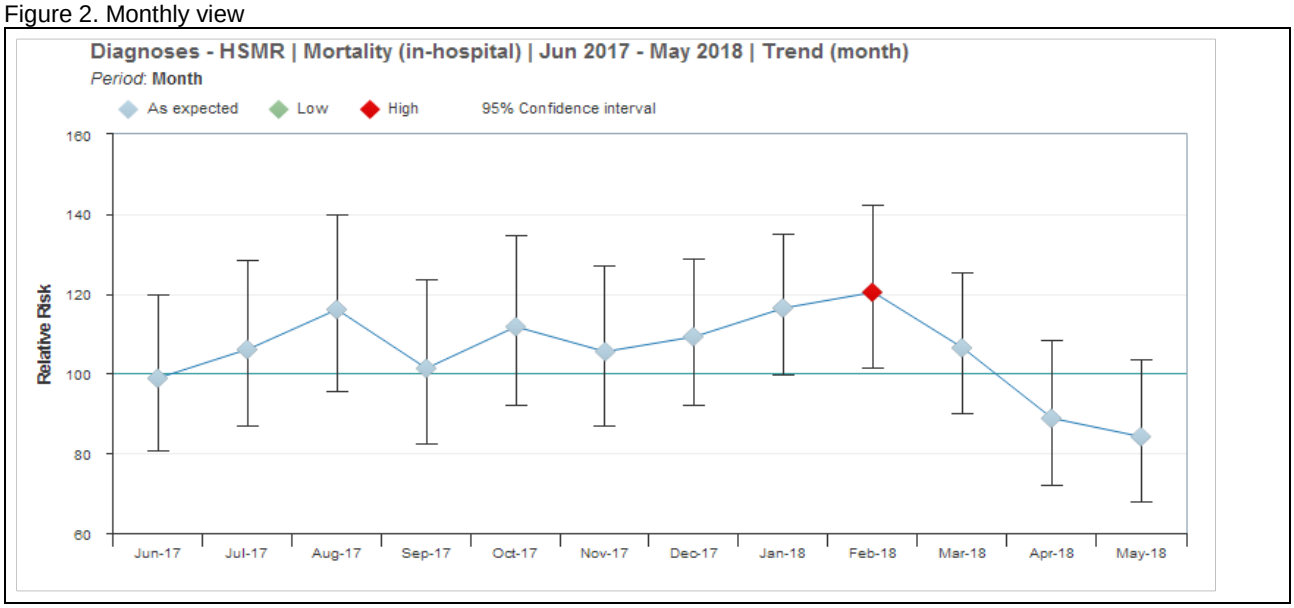


Figure 2. shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so April 2018 in this case, , shows that the Trust's position has decreased to 88.8 from 106.4 in March 2018.

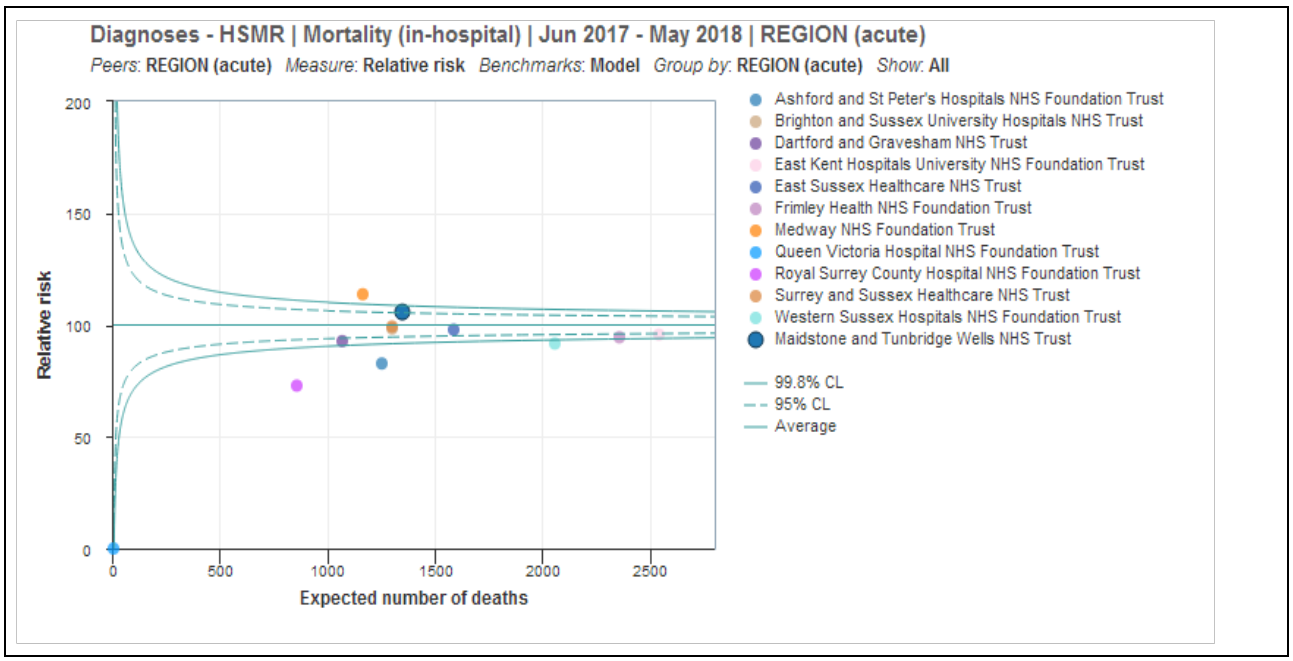
Figure 2. Monthly view



Benchmarking

Dr Foster also enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups, but our local acute peers have been selected below in Fig. 3. This shows the Trust is no longer a major outlier against this group; Medway is the next outlier trust for this period.

Figure 3. Benchmarking against our regional acute peers



Understanding and Improving upon a high HSMR

Guidance from Dr Foster has been instrumental in directing the work of the Mortality Surveillance Group (MSG). In line with this progress has been made, and continues in regard to:-

- *Coding*- poor depth of coding can affect HSMR and it is recommended that coders and clinicians work more closely together.

Expected Deaths- Comorbidities

There are various factors that influence the level of 'expected' deaths assigned to a Trust for the purposes of reporting the HSMR these include; Sex, Age, Diagnosis, type, time and month of admission, Socio-economic factors, palliative care and diagnosis/procedure subgroups. One of the key factors is patients Co-morbidities (based on Charlson score) as this informs the Trust's casemix. Of the 1427 deaths recorded in the period June 2017 to May 2018, 253 had no comorbidities recorded; 17.7% (the previous month was reported as 19.1%).

Figure 4. Deaths with a Charlson score of zero recorded by age

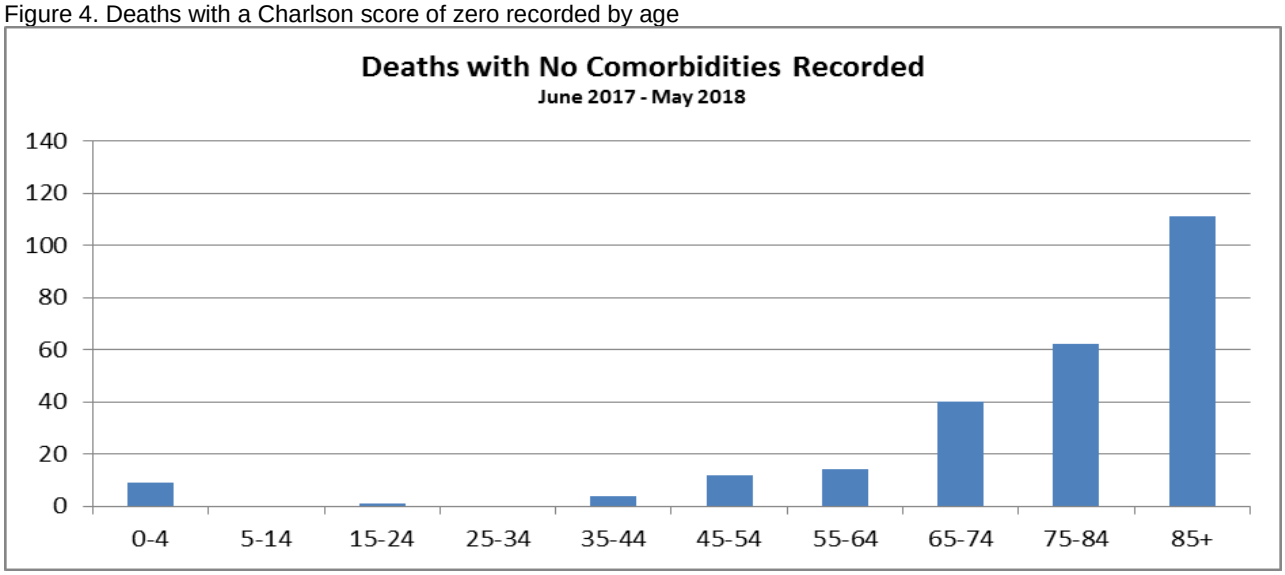
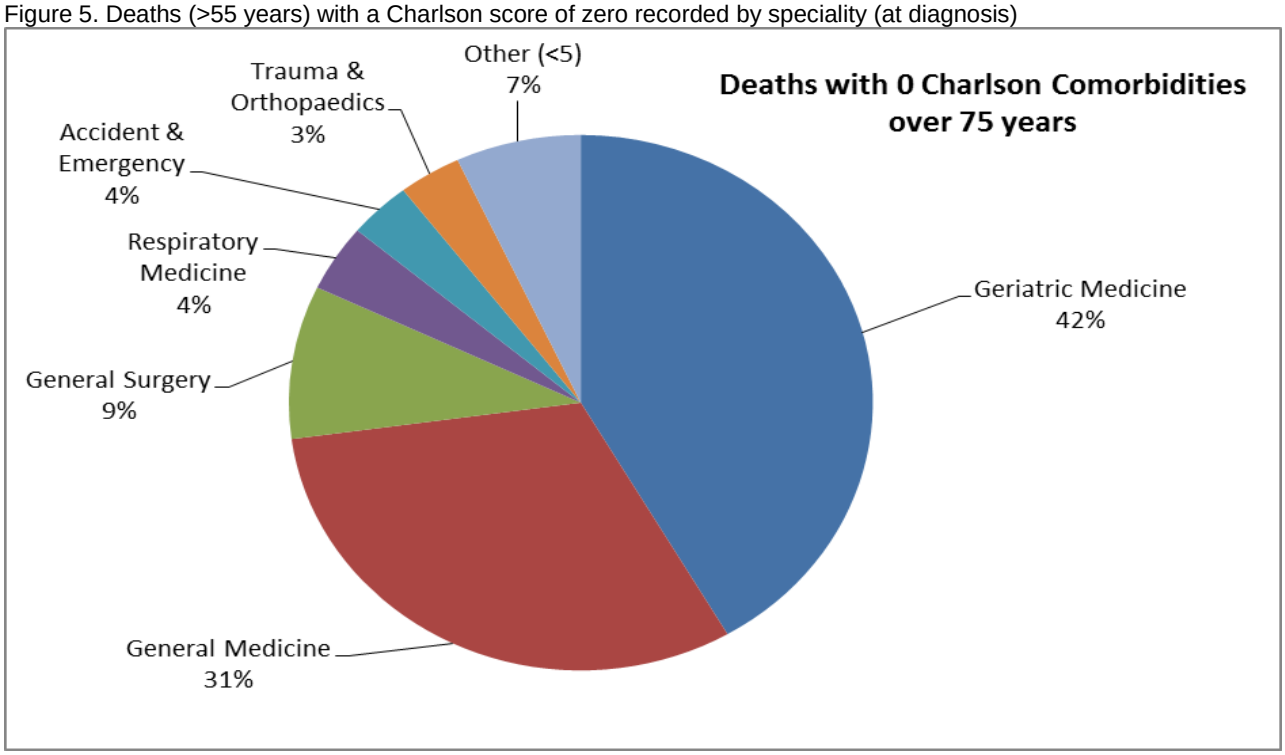


Figure 5. Deaths (>55 years) with a Charlson score of zero recorded by speciality (at diagnosis)



The Trust has appointed a new Head of Clinical Coding and significant progress is being made in regard to our coding of deaths. In addition to the production of Coding information for clinicians she is working with our Directorates to improve their understanding and knowledge of how patients are coded. In particular targeted work with Speciality Medicine is being undertaken to address this potential under-reporting of comorbidities to ensure the 'expected' deaths assigned to the Trust are accurate.

- Process- at this point, consider is there a potential issue with quality of care.

CUSUM (Cumulative SUM control chart) is a method of identifying areas where there are unexpected cumulative numbers of mortalities which have occurred following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The chart below (Fig. 6) demonstrates the diagnosis groups where the Trust has received negative alerts when using a 'high' (99%) detection threshold over the past 12 months.

Figure 6. Dr Foster CUSUM alerts

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 9	106502	1633	1588.9	1.5	102.8				
HSMR (56 diagnosis groups)	1	35082	1427	1348.5	4.1	105.8				
Acute bronchitis	1	1101	36	21.0	3.3	171.5				
Aspiration pneumonitis, food/vomitus	1	225	84	65.3	37.3	128.7				
Cancer of bone and connective tissue	1	15	2	1.4	13.3	140.4				
Cancer of bronchus, lung	1	203	36	23.5	17.7	153.1				
Cancer of liver and intrahepatic bile duct	1	34	7	3.2	20.6	215.9				
Cancer of prostate		279	9	3.9	3.2	229.6				
Congestive heart failure, nonhypertensive	2	653	97	68.3	14.9	142.0				
Pancreatic disorders (not diabetes)	1	330	7	6.3	2.1	110.6				
Pneumonia		1950	303	254.3	15.5	119.1				
Residual codes, unclassified	1	1379	10	12.5	0.7	80.1				
Secondary malignancies	1	616	38	27.5	6.2	138.1				

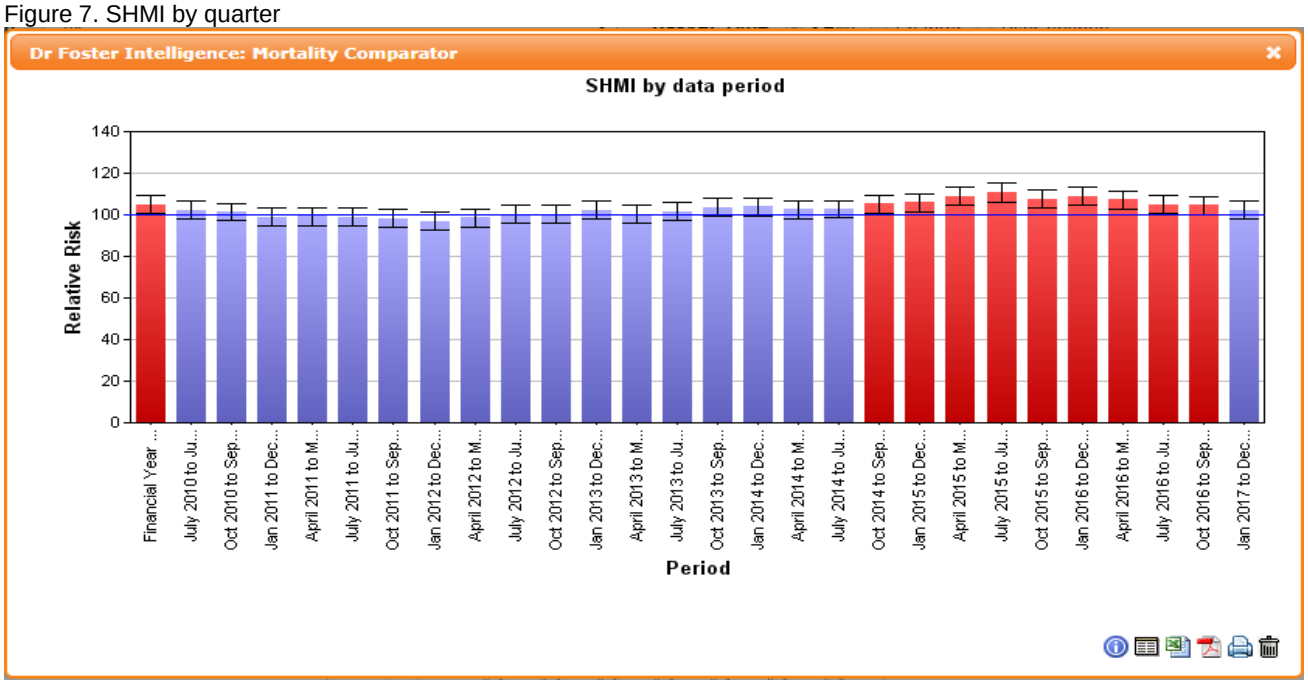
These alerts are regularly discussed at the Mortality Surveillance group with patient level data supplied to the Mortality leads to review. To date fractured neck of femurs, pneumonia, non-Hodgkin's lymphoma and phlebitis have had further reviews undertaken.

Summary Hospital-Level Mortality Indicator (SHMI)

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

SHMI published by HSCIC for the period January – December 2017 shows SHMI as 1.0219 which is banded as level 2 "as expected".

Figure 7. SHMI by quarter



SHMI - Supplementary information: Depth of Coding

In the pack of information provided as part of the SHMI release each quarter, there is information included about depth of coding. As can be seen from the table below, MTWs mean depth for non-

elective admissions is higher than the national average and our local acute peers. This also highlights that our coding of secondary diagnosis is rich as the maximum has been reached.

Figure 8. Depth of Coding

Provider name	Mean coding depth for non-elective admissions	Maximum number of secondary diagnosis codes for non-elective admissions
England	4.4	19
Dartford and Gravesham NHS Trust	3.2	15
East Kent Hospitals University NHS Foundation Trust	3.6	13
Maidstone and Tunbridge Wells NHS Trust	4.6	19
Medway NHS Foundation Trust	4.5	19

SHMI - Supplementary information: Palliative Care Coding

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

Figure 9. Palliative Care Coding

Provider name	Observed deaths	Number of deaths with palliative care diagnosis coding	Number of deaths with either palliative care speciality or diagnosis coding	Percentage of deaths with palliative care diagnosis coding	Percentage of deaths with either palliative care speciality or diagnosis coding
England	293,770	93,957	94,605	32.0	32.2
Dartford and Gravesham NHS Trust	1,570	796	796	50.7	50.7
East Kent Hospitals University NHS Foundation Trust	4,164	1,058	1,058	25.4	25.4
Maidstone and Tunbridge Wells NHS Trust	2,400	741	741	30.9	30.9
Medway NHS Foundation Trust	1,897	490	490	25.8	25.8

SHMI - Supplementary information: Deaths split by deprivation quintile

The pack includes a breakdown of deaths split by deprivation quintile and the following table highlights that proportion deaths at MTW in each. This shows that 2.5 % of our deaths fall in quintile 1 'most deprived', whereas 37.8% of our deaths fall into quintile 5 'least deprived'. This profile is significantly different than the national average and our local acute peers.

Figure 10. Deaths split by deprivation quintile

Provider name	Percentage of deaths in deprivation quintile 1 (Most)	Percentage of deaths in deprivation quintile 2	Percentage of deaths in deprivation quintile 3	Percentage of deaths in deprivation quintile 4	Percentage of deaths in deprivation quintile 5 (Least)	Percentage of deaths where the deprivation quintile cannot be derived
England	20.4	20.2	20.5	19.8	17.5	1.6
Dartford and Gravesham NHS Trust	10.4	20.6	20.0	26.3	21.7	1.0
East Kent Hospitals University NHS Foundation Trust	15.9	21.4	25.3	29.2	7.4	0.8
Maidstone and Tunbridge Wells NHS Trust	2.5	7.8	20.6	30.7	37.8	0.6
Medway NHS Foundation Trust	19.0	27.6	20.6	16.8	*	*

** indicates value suppressed for the purposes of disclosure control*

The Mortality Surveillance Group (MSG):-

The MSG has been operational in its current format since February 2016 and has made consistent progress in improving the reported positon of Mortality reviews, with acknowledgment that 100% compliance needs to be reached.

Figure 11. Trust Position of Mortality Reviews – (Apr - Aug 18)

Trust	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD
No of Deaths	127	126	128	132	124	637
No of Completed Reviews	108	109	109	107	55	488
%age completed reviews	**85.0%**	**86.5%**	**85.2%**	**81.1%**	**44.4%**	**76.6%**

The percentage of mortality reviews completed has dramatically reviewed since the process was changed in October 2017. At this time all Doctors completing the Death Certificate were asked to complete the preliminary screening tool and those completing the Cremation form then undertake the first stage reviews. Those deaths where a burial is preferred then have the first stage reviews completed by the Directorates. This has improved our compliance from 42.9% in September 2017 to 76.6% as above.

Learning from Deaths Project Working Group.

The project group has been operational since May 2017 and set up in response to the National agenda for learning from deaths and last met on the 15th August, 2018. The objectives of the group are:-

- To develop a single database for all mortality data and mortality form recording (including SJR's)
- To improve compliance of completion of all mortality forms
- Implementation of a Trust-wide Mortality Coordinator role to oversee the process and compliance.
- Clarifying the role and effectiveness of the MSG (including the extraction of learning from this process)
- Identify how the responsibility for Duty of Candour issues should be taken forward.
- Clarify the role of the Informatics Team in monitoring and supporting this process.

- Reducing the observed rates of mortality, by identifying the patient deaths in which there was suboptimal care and learning through our revised processes (link to Learning Lessons Project). Record the key learning themes each month.
- Review and develop the monthly mortality report produced by Business Intelligence, (after review in MSG) that feeds the Trust Clinical Governance Meeting, the Quality Committee and the Trust Board.
- Audit the notes of deceased patients who do not progress to SJR. The Trust's policy states "A random sample of expected deaths will be audited by Clinicians, supported by the Clinical Audit Department, twice yearly as a quality assurance mechanism (and reported to the MSG)". Investigate how the Trust can identify patients who die within 30 days of discharge.
- Review and identify the link/process for all 'other' deaths in more 'specialist' categories – ie., perinatal mortality, maternal deaths, child deaths, LEDER for Learning Difficulties.

Recent achievements include:-

- 80.6% of all deaths having been reviewed year to date in July 2018.
- All Mortality review documentation revised.
- Mortality Review Policy revised and updated.
- Development of Mortality review database – Quattro. Sharon Vickers is working with Paul Hooker to refine process.
- Audit of 10% of Mortality Reviews that did not raise any concerns took place on the 8th August, 2018.
- Rollout of Coding information leaflet and coding information workshops.

Next Steps:-

- Work with Directorate Leads to further roll out and explain the roll of the Mortality coordinator and the revised mortality review process.
- Await audit on Congestive Cardiac Failure.
- Work with coding to disseminate learning to clinicians via Clinical Governance sessions.

NHS Learning from Deaths Dashboard

Organisation	Maidstone & Tunbridge Wells NHS Trust
Financial Year	2018-19
Month	June

Learning from deaths dashboard V2.1, updated 08/03/2017

NHS Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

Maidstone & Tunbridge Wells NHS Trust: Learning from Deaths Dashboard - June 2018-19

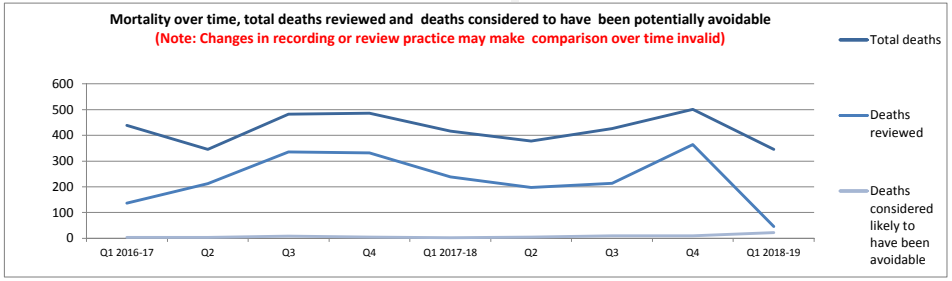
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
118	110	14	13	12	4
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
346	501	45	364	22	10
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
587	1721	108	1014	25	25

Time Series: Start date 2016-17 Q1 End date 2018-19 Q1



Total Deaths Reviewed by RCP Methodology Score

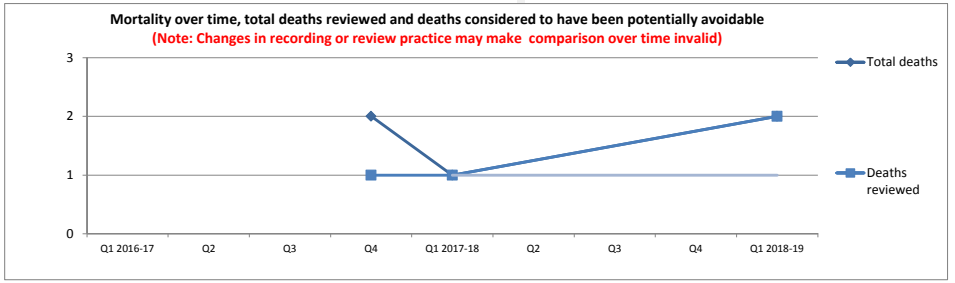
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	12	11.7%	This Month	0	0.0%	This Month	0	0.0%	This Month	91	88.3%
This Quarter (QTD)	3	1.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	19	6.6%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	1.0%	This Quarter (QTD)	262	91.3%
This Year (YTD)	3	0.7%	This Year (YTD)	0	0.0%	This Year (YTD)	22	4.8%	This Year (YTD)	0	0.0%	This Year (YTD)	4	0.9%	This Year (YTD)	429	93.7%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	1	1	1	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	0	2	0	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	1	2	1	1	1

Time Series: Start date 2016-17 Q1 End date 2018-19 Q1



Trust Board meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-14	Review and approval of final proposals for developing a clinically led organisation	Chief Executive

The enclosed final proposals for developing a clinically led organisation were endorsed by the Trust Management Executive on 19/09/18 and are now circulated to the Trust Board for consideration and approval.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/09/18

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

Review and approval

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST (MTW)

DEVELOPING A MORE CLINICALLY LED ORGANISATION

SUMMARY

1. This paper sets out our plans for developing clinical leadership at MTW, supported by an enhanced system of Divisions and Clinical Directorates. The model has been developed with input from staff across the Trust. The vision and priorities for enhanced clinical leadership sets out what we want to achieve and can be used to evaluate and develop the proposed changes as they are implemented.

2. Five new divisions will be established with a consistent approach to clinical and operational management. The composition of Divisions and Clinical Directorates is detailed on pages 4 and 5.

3. This paper also describes meeting arrangements, support from corporate departments and the development of leadership development, talent management and succession planning. Subject to Board approval at the end of September, we will roll out the new management arrangements and support for clinical leaders from 1st November.

WHY WE ARE MAKING THESE CHANGES – OUR JOURNEY TO OUTSTANDING

4. NHS Organisations with high levels of engagement achieve better results and report better staff and patient experience[1]. This has also been our experience at MTW. When clinical staff have been more engaged in leading their departments and tackling problems in partnership with operational managers, results have improved. Recent examples include: the management of acute medicine on both sites; Listening into Action projects; improving the fractured neck of femur pathway and addressing the challenge of GIRFT in orthopaedics[2].

5. Moreover, the opposite has also been true. Lack of clinical engagement has seen problems stagnate and become difficult to resolve.

6. There is a strong appetite for greater engagement and taking on greater responsibility in many clinical departments. The clinical staff at MTW have many of the same qualities, (if not always the development opportunities), as their peers at the most celebrated 'clinically–led' organisations.

7. MTW has an ambition to become and be recognised as an outstanding organisation. This will require successful implementation of our Best Care transformation programme and strategic clinical service plans. Effective clinical leadership and engagement are a pre-requisite for both of these programmes. MTW (like the rest of the NHS) faces ever increasing demand coupled with workforce shortages and constrained finances. These challenges need to be met by innovation in practice led by clinical teams themselves; teams with the authority and capability to act.

[1] Employee engagement & NHS performance, Michael A West & Jeremy F Dawson, The King's Fund, 2012
[2] A national review of adult elective orthopaedic services in England, (Getting It Right First Time), Prof Tim Briggs, British Orthopaedic Association, 2015

VISION & PRIORITIES FOR CLINICAL LEADERSHIP

8. All staff, including clinical staff, need to feel part of and have a stake in the management of their service and the organisation as a whole. Key characteristics of the effective clinically-led organisation we want to develop include:

• Clinical leadership & modelling good practice at all levels in the organisation.	• Clinically-led services are patient-centred and committed to excellence.
• Clinical teams are empowered and supported to act.	• Clinical teams take ownership of problems and find solutions.
• By 'clinical' we mean all professions, working in multi-disciplinary teams.	• Clinical leadership is important work requiring the time, capability, development and resources to get the job done.
• Excellent communication and staff engagement is designed into the system.	• Clinical leadership roles are attractive, 'doable' and career enhancing.
• Clinical leadership applies to the 'whole' of a service, (quality, finance, workforce etc.), and not just some of its 'parts'.	• Clinical leadership teams have a responsibility for the health of the organisation as well as individual patients.

9. In applying these characteristics for MTW we will work to introduce or enhance the following features of our organisation:

- Provide clearer authority, responsibilities and expectations of clinical leadership teams, with more dedicated support from corporate departments.
- Offer clearer incentives for success and consequences for not delivering agreed objectives. 'Consequences' should be primarily supportive and aimed at securing improvement.
- Place emphasis upon improvement at all levels; empowering clinicians and other staff to address opportunities to improve patient and staff experience in their service.
- Have a more consistent and proportionate 'voice' and profile across professions and specialties, (including a greater focus on Allied Health Professionals (AHPs) and scientists).
- Make greater investment in leadership development, talent management and succession planning.
- Create dedicated time and support for greater communication/engagement between clinical leaders and their teams.

10. At the same time we will retain the best features of our organisation as it stands, in particular:

- Support, encourage and motivate our talented operational managers and existing clinical leaders throughout any change process.
- Maintain effective operational control and good clinical governance.
- Embed and develop the Best Care and Listening into Action (LiA) programmes. We will enhance the organisation's capability to implement service improvement building on recent successes such as: ambulatory emergency care; frailty units; GIRFT; 4eyes theatre productivity; etc.
- Develop the Quality, Service Improvement and Redesign (QSIR) Faculty to support the Trust's commitment to train staff in the key principles of the Quality Improvement Methodology.
- Continue the development of innovative new clinical roles.

DEVELOPMENT OF THE MTW APPROACH TO CLINICAL LEADERSHIP

11. The plans set out here follow consultation on proposals over the summer. Key themes within the feedback have helped shape the final plans, in particular:
    - The shaping of MTW's Urgent Care structure
    - The shaping of MTW's Cancer structure
    - Development of Clinical Governance and Quality arrangements for clinical support services
    - Alignment of committees
    - Paediatric and Neonatal Unit nursing
    - Shaping MTW's Diagnostic and Clinical Support Services structure
    - Clarifying roles and continuity of services
    - Enhancing the profile of AHP and Scientific Professions within MTW

12. Feedback received directly from individuals and at group sessions which can help improve MTW's patient and staff experience has been shared with Divisions to include in their quality improvement plans.

MTW's new clinical leadership structure

13. The Trust's new clinical structure that has been developed in collaboration with MTW's healthcare professions, retains the best features of our organisation, and enhances our ability to improve our patient and staff experience.

14. The new structure will:
    - Strengthen clinical leadership with the creation of new roles and greater clinical responsibility
    - Create a more consistent clinical leadership structure throughout the Trust
    - Create clearer and more autonomous divisions and directorates
    - Give these divisions and directorates a stronger clinical voice

STRUCTURES

Chief Operating Officer reporting structure

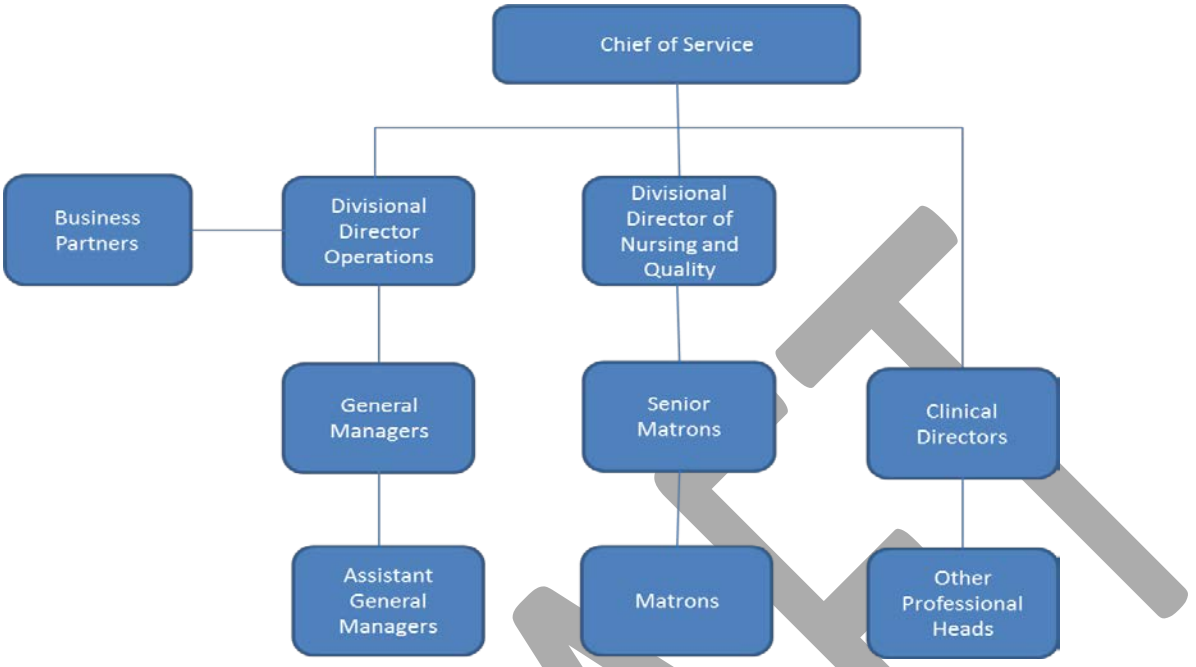
15. The **Chief Operating Officer** supports and oversees the work of the divisional management teams. S/he monitors and manages performance, involving other corporate functions as required. The COO directly manages some functions centrally including: Estates & Facilities; Emergency Planning; Divisional Heads of Performance; Private Patients; and the Best Flow programme. The executive team engages with the 'triumvirate' together as much as possible, reinforcing their shared responsibility for the Division as a whole.

16. A **Deputy COO** role will be established to support the Chief Operating Officer by: i) leading Trust wide programmes of work on behalf of the COO; ii) representing the COO in a range of issues/forums to maximise the 'presence' of the COO in the organisation; iii) deputising for the COO in their absence. The Deputy COO role could be combined with being a Divisional Director of Operations.

Divisional/Clinical Directorate Management Teams

17. MTW's new clinical management arrangements have two tiers; Divisions & Directorates. Each Division and Directorate is led by a clinical management team, (triumvirate), comprising an overall clinical lead, a senior operational manager and a head of nursing, quality and other clinical professions. These roles have equal responsibility and accountability within the Divisions.

18. Each Division and Directorate has a core structure and reporting arrangements. While there is corporate consistency throughout, due to the nature of some Divisions, there are local variations. Below is an example of a core structure:



19. **Divisional Management Teams** work together, (and engage with their staff), to agree annual and strategic plans for their services. They are responsible for communicating these widely and for delivering the objectives set. The Divisional management teams are responsible for all aspects of clinical and operational performance across their directorates. They recruit, retain and hold to account clinical and managerial teams in each directorate. They have devolved authority for all relevant resources including: budgets; workforce; space, facilities & equipment; and improvement support. Key corporate departments will support them with Business Partners.

20. **Divisional Chiefs of Service** carries overall responsibility for leadership and management within their division and provide a level of corporate function. They chair a Divisional Management Board and are supported by a Divisional Director of Operations and a Divisional Director of Nursing & Quality as well as Clinical Directors for each Directorate. Chiefs of Service are normally practising clinicians, devoting two or two and a half days each week to their Chief of Service role for which appropriate funding will be made available for their time. They report to the Chief Operating Officer and maintain professional links to other Members of the Executive Team, notably the Medical Director. Chiefs of Service will be appointed for three year terms.

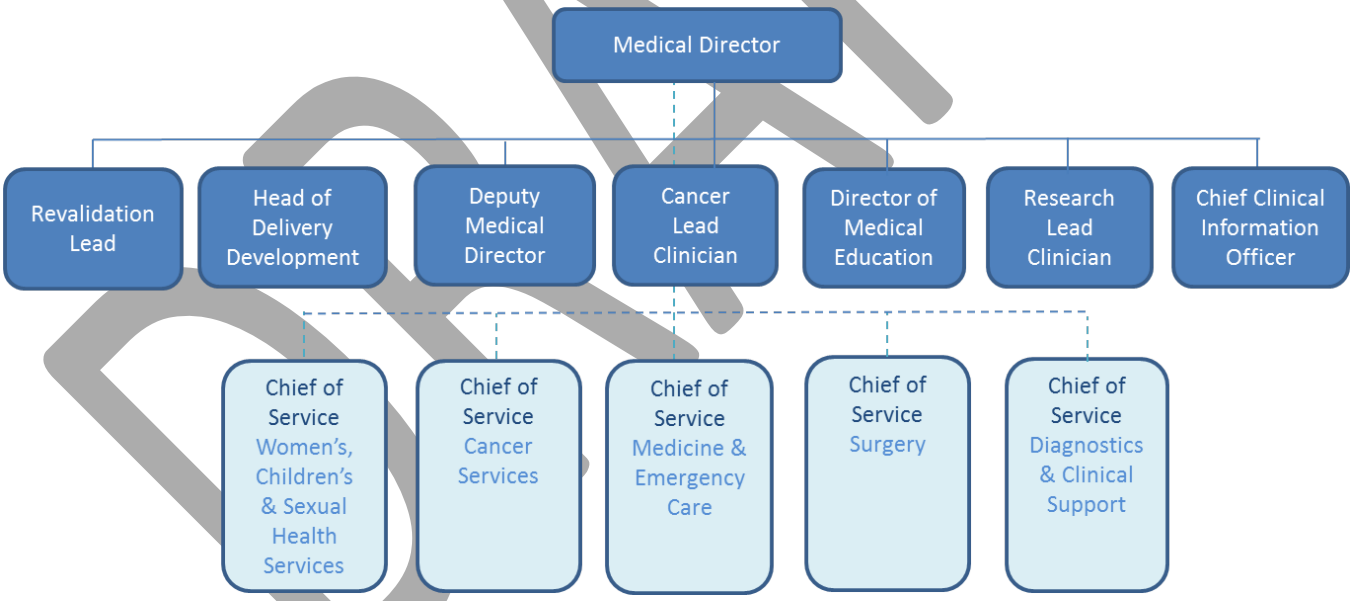
21. **Divisional Directors of Operations** are experienced operational managers capable of delivering challenging operational objectives on behalf of the organisation and of managing substantial budgets, significant numbers of staff and complex clinical operations. The DDOs will be personally responsible for: establishing a comprehensive annual plan for the division; delivery of NHS Constitution Standards in the Division; agreeing and working within an annual budget for income and expenditure, (including workforce and efficiency/CIP requirements); divisional contributions to the Trust's Best Care Programme; communications and engagement within the Division; performance management of Clinical Directorates; leadership of the Directorate General Managers and engagement with corporate Business Partners. They will also participate in the management on call rota.

22. **Divisional Directors of Nursing & Quality** are responsible for line management, budgets and professional standards of nursing, midwifery and clinical professions within the Division (other than medicine). They will be a professionally credible senior leader in nursing, an allied health profession or healthcare science. Their personal responsibilities include: overseeing a framework for clinical governance and quality within the division; line management and professional leadership of nursing, AHPs and healthcare scientists; preparation for CQC inspection; establishing a quality plan and annual objectives for the Division; managing processes within the Division for clinical and other reported incidents, complaints, risk management and ensuring appropriate lessons are learned; participation in the management on-call rota.

Medical Director's Management Team

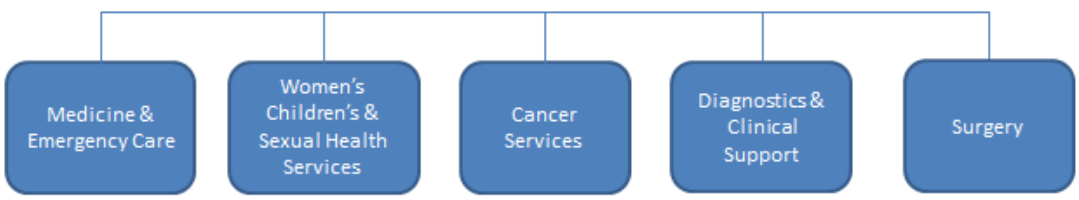
23. The **Medical Director** will be supported by a central team of Deputy Medical Director, Revalidation Lead, Director of Medical Education (DME) and Head of Delivery Development plus the Lead Clinicians for Cancer and Research. The Divisional Chiefs of Service will be primarily responsible for their Division, but they will also take a lead on Trust-wide issues and initiatives on behalf of the Medical Director. The Deputy Medical Director role will assume a high level of responsibility across the organisation, primarily with an internal focus. The Medical Director is responsible for medical engagement, and plays a key role in partnership working with the whole system and strategic requirements (supporting the Director of Strategy, Planning and Partnerships).

24. MTW's new Medical Directorate management arrangement is as outlined below:



COMPOSITION OF DIVISIONS & DIRECTORATES

25. Five clinical Divisions are being established:

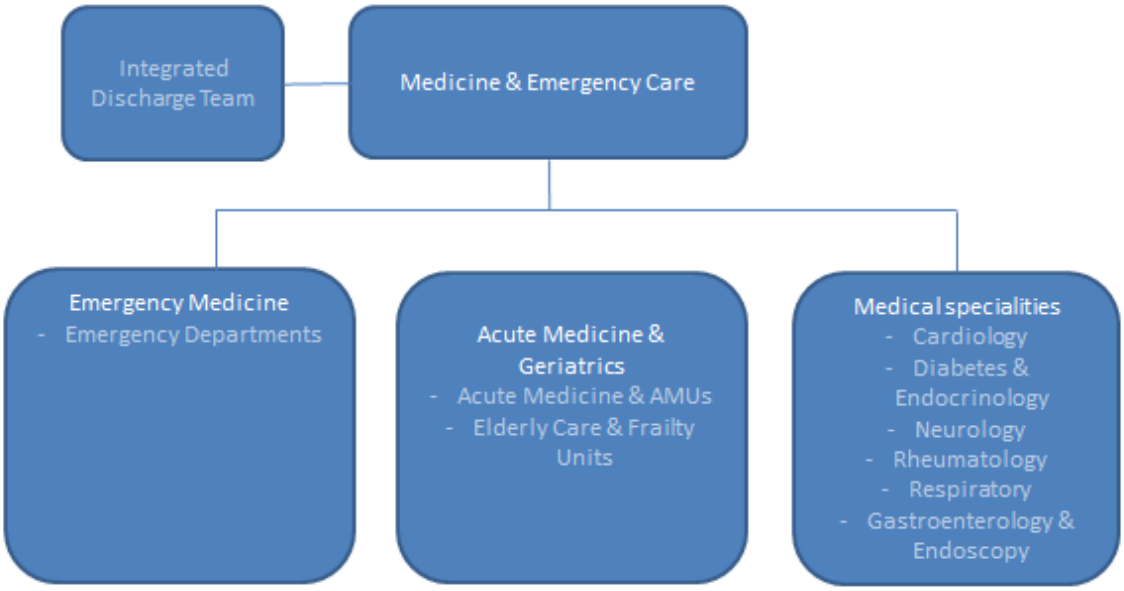


26. Cancer Services has become a division in its own right. This reflects the significance of cancer services within the organisation and the complex partnership agenda to be managed; (both internally between specialties/departments and externally with commissioners, regulators, the Kent Cancer Alliance and partner Trusts).

27. The other principal change is the new Division of Diagnostic & Clinical Support Services. This Division will provide greater managerial focus and resources for these services and also enhance the profile of AHP and scientific professions within the organisation.

28. The summary diagrams that follow show the proposed configuration of Divisions and Directorates. Within each Directorate table there is a list of services. These lists describe which services fit into which Directorate but do not imply a unit of management in their own right.

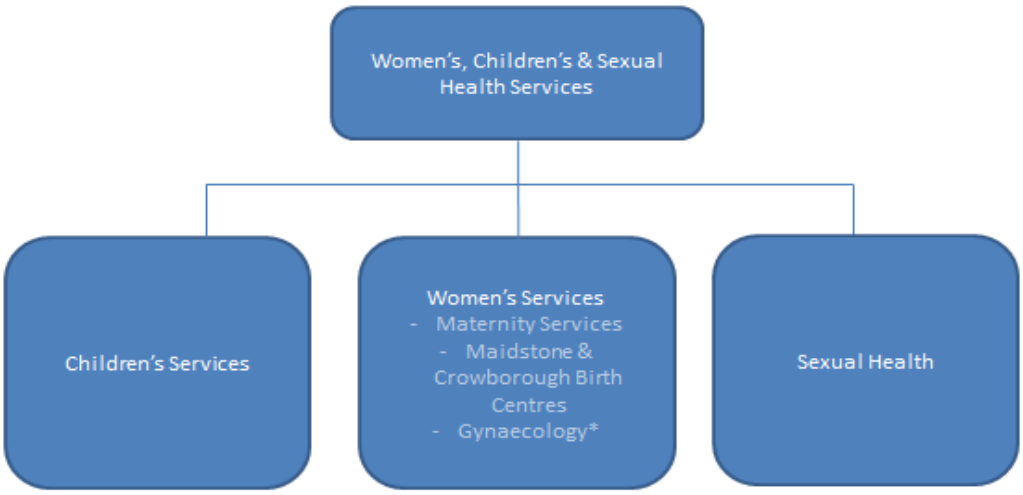
Division of Medicine & Emergency Care



29. The Division will have three directorates in total: Emergency Medicine; Acute Medicine & Geriatrics; and Medical Specialties. Physicians will continue to contribute to the acute medical take where they do now as well as working in their sub-specialty. Other staff such as the Emergency Department Practitioners will also work clinically across two or all three directorates. A key role for the Chief of Service and the three Clinical Directors will be to ensure effective joint working across these directorates in a virtual 'emergency floor', (in partnership with the Division of Surgery). This will be supported by joint governance, training and audit for Acute Medicine and Medical Specialties. Junior doctors and the acute take rota will be managed within the Directorate of Acute Medicine & Geriatrics. The Integrated Discharge Team remains within this Division.

30. There are two reasons for establishing three directorates for Medicine and Emergency Care: i) to provide clinical leadership and management resources that are proportionate to the size of the medical specialties; ii) the operational and staffing issues of the acute medical take can too easily 'crowd out' other important service issues within the medical specialties.

Division of Women's, Children's & Sexual Health Services

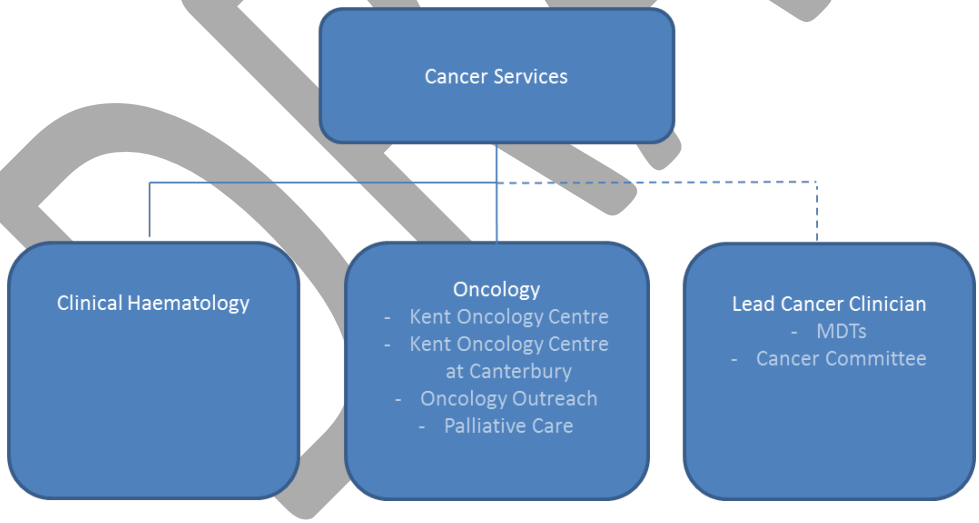


**except Gynae Oncology – part of Surgery & Planned Care Division*

31. The composition of this division is unchanged, however, there are now three separate Clinical Directorates, as this will provide a greater profile and clearer identity for Sexual Health Services.

32. The Divisional management team will ensure there is appropriate professional leadership of children's nursing by having a separate Head of Nursing and Quality for Children's Services and a Head of Midwifery and Quality.

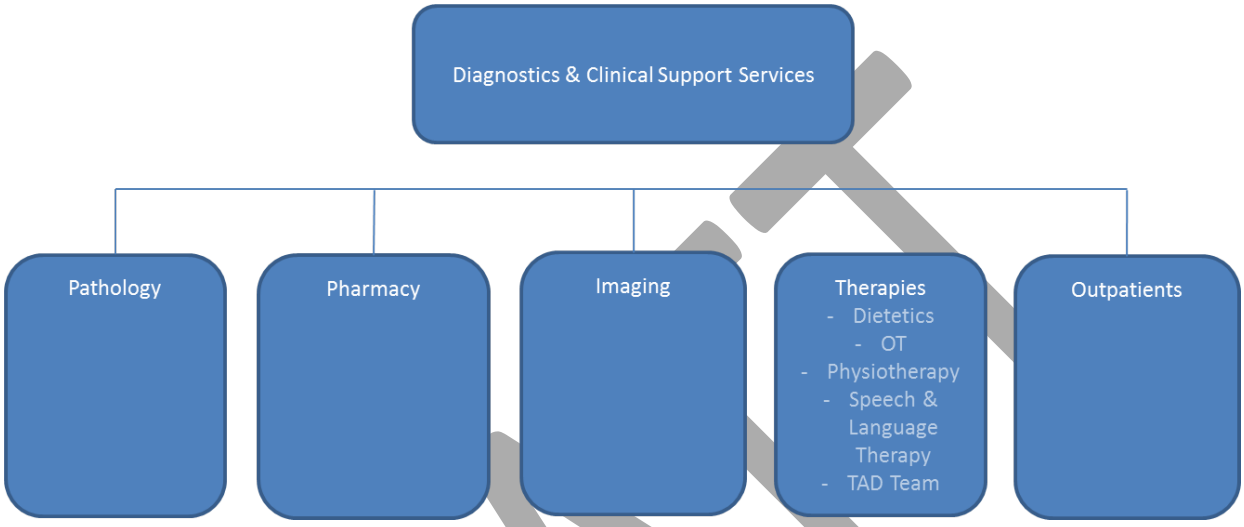
Division of Cancer Services



33. The new Division of Cancer Services, (including Palliative Care) will provide clear leadership for cancer services across the Trust, engage with partners in primary care and other Trusts and also directly manage Oncology and Clinical Haematology. The Trust Lead Cancer Clinician will play a key role in the Divisional management team and will: chair the Trust Cancer Committee; oversee the operation of MDTs; and provide clinical leadership for delivering NHS Constitution standards and NHS England requirements for cancer pathways. The Lead Cancer Clinician will continue to be accountable to the Medical Director for quality standards for cancer patients across the Trust.

34. Clinical Haematology and Clinical/Medical Oncology will be established as separate directorates within the Division of Cancer Services and have a Matron allocated to each directorate. Medical Physics and Radiotherapy staff will be a part of the Oncology Directorate. It is proposed that the Heads of Therapy Radiography and Physics are members of the Divisional management team in a professional capacity. This management team will therefore comprise: the 'triumvirate' of Chief of Cancer Services, Divisional Director of Operations and Divisional Director of Nursing & Quality; the Lead Cancer Clinician; the Clinical Directors of Oncology and Haematology; and the Heads of Physics and Therapy Radiography.

Division of Diagnostic & Clinical Support Services

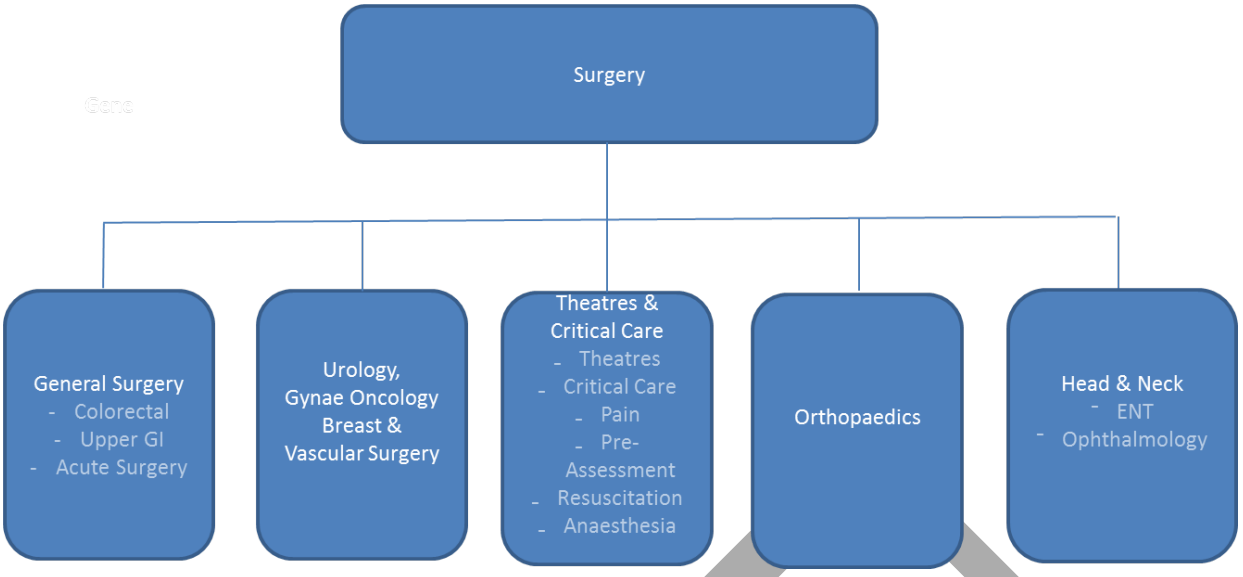


35. The new Division of Diagnostic and Clinical Support Services will have five Clinical Directorates: Pathology; Imaging; Pharmacy; Therapies; and Outpatients (NB speciality outpatients remain within their original directorates, e.g. cancer/oncology, women's and children's). Infection Prevention & Control will report directly to the Trust's Chief Nurse. The Chief of Service for Diagnostic & Clinical Support Services could come from any of the registered professions within the Division. The Division has a relatively small number of registered nurses in relation to other professional groups. The core requirements of a Divisional Director of Quality, (see page 6), could be undertaken by someone with another professional background or could be incorporated into the Divisional Director of Operations role, (so long as that individual was registered with a relevant profession).

    Arrangements for filling this role will be confirmed with the Chief of Service once appointed.

36. The Directorate of Outpatient Services will be structured as a Clinical Directorate. Management of this Clinical Directorate will be provided by a Clinical Director from a relevant specialty who would contribute particularly to raising the profile of outpatient issues and engaging with clinical colleagues from user departments.

Division of Surgery



37. The Division of Surgery comprises the same functions and specialties as the previous Planned Care Division. It contains separate Clinical Directorates for General Surgery and for Urology, Gynae Oncology, Breast & Vascular Surgery. This will provide a dedicated Clinical Director and management team for General Surgery, getting to grips with a large service across two sites, including a focus on acute surgery at TWH. Urology, Gynae Oncology and Breast Surgery are all based at Maidstone and have inter-connected interests in pelvic surgery and cancer. Vascular Surgery also has a base at Maidstone. By managing these services in two Clinical Directorates the needs of individual specialties will be easier to meet.

38. Theatres and Critical Care remains as a single and large Clinical Directorate. This directorate has functioned effectively over a number of years and supports a cohesive Department of Anaesthesia inputting to operating theatres, critical care and pain services. It is, however, proposed to transfer responsibility for Endoscopy alongside Gastroenterology in the Medical Specialties Directorate.

Directorate Management Teams

39. Directorate management teams will follow the same 'triumvirate' format as the Divisions, with specific arrangements for leadership of AHP and scientific professions. As with the Divisions, the directorate management teams will work together, (and engage with their staff), to agree annual and strategic plans for their services. They will be responsible for communicating these widely and for delivering the objectives set. The Directorate management teams will be responsible for all aspects of clinical and operational performance. They will be responsible for all relevant resources including: budgets; workforce; space, facilities & equipment; and improvement support.

40. The summary job roles set out below provide a common starting point for the Directorates. Specific variations will be agreed with the Executive Team; (for example whether to have combined professional and general management posts in Directorates without significant numbers of nursing staff). Each Directorate will have its own Clinical Director. Other roles such as General Manager and Senior Matron may be shared between more than one Directorate.

41. **Clinical Directors** will carry overall responsibility for leadership and management in their Directorate, reporting to the Divisional Chief of Service. They will chair a Directorate management board comprising members of their 'triumvirate' and any clinical leads and senior professional/operational managers as appropriate. Typically Clinical Directors will dedicate two timetabled PAs each week to their role and will be supported by a full-time General Manager and Senior Matron, (or other head of profession). As with Chiefs of Service, Clinical Directors will usually be appointed for three year terms of office.

42. **General Managers** will be responsible for day to day operations across the Directorate. This will include taking lead responsibility for: establishing a comprehensive annual plan for the directorate; delivery of NHS Constitution Standards; agreeing and working within an annual budget for income and expenditure, including efficiency/CIP requirements; directorate contributions to the Trust's Best Care Programme; communications and engagement within the Directorate. The General Managers will be accountable professionally to the Divisional Director of Operations who will provide personal support and development. Their objectives will include leading and/or participating in divisional and corporate programmes of work as well as operations within the Directorate.

43. **Senior Matrons** will be responsible for all aspects of nursing within the Directorate, professional and operational, (including nursing budgets and safe staffing). They will take the lead for quality and risk management, working with the Clinical Director, General Manager and any other clinical/professional leads identified in the directorate. Senior Matrons will be professionally accountable to the Divisional Director of Nursing & Quality who will agree their objectives each year and participate in their appraisal.

44. **Other Heads of Profession** will be identified in a number of Directorates. These roles will include senior professionals in: Audiology; Biomedical Science; Diagnostic Radiography; Dietetics; Medical Physics; Occupational Therapy; Optometry; Orthotics; Pharmacy; Physiology; Physiotherapy; Speech & Language Therapy; Therapy Radiography. Specific professional and line management arrangements will be agreed for each group. In some cases this will entail a full-time leadership position with professional and operational responsibility. In other cases the individuals will have a substantial personal clinical practice and their role as head of profession will not include operational responsibilities.

MEETING ARRANGEMENTS

45. The Trust will conduct formal business through a central 'spine' of the Trust Board, the Executive Team Meeting (ETM) and the Trust Management Executive (TME). All other forums in the organisation will be accountable to one of these three meetings. The vast majority of existing forums are already formally accountable to either the Trust Board or TME, and the proposals will not affect the links between any of these forums. For the forums that are currently not accountable to one of the 3 central spine forums, the Joint Consultative Forum (JCF) and Joint Medical Consultative Committee (JMCC) will be accountable to the ETM via the Director of Workforce, whilst the Junior Doctors' Forum should be accountable to the ETM via the Medical Director. The amended Committee structure is therefore shown in Appendix 1. The membership of the various forums will however need to be amended to reflect the new roles arising from the structure, and this will be implemented by each forum, once the proposed changes have been approved.

46. **Trust Management Executive** will comprise the five divisional 'triumvirates', Clinical Directors, and a number of Trust lead roles, including: Director of Infection Prevention and Control (DPIC); Director of Medical Education; Director of Research; Head of Midwifery; and Trust Lead Cancer Clinician. While this will be a large group it will provide an important channel for communications and engagement in the Trust, as well as scrutinising and approving the budget, capital programme, annual plans and corporate strategy.

The Chiefs of Services will also routinely join exec team meetings, the agenda for which will be refreshed so that the meetings are shorter and more focussed.

SUPPORT FROM CORPORATE DEPARTMENTS

47. The Finance and HR Departments already provide lead individuals to link with each Directorate, to build on this we will develop a 'Business Partner' model in which a senior member of the corporate function joins the divisional management team provide: i) specialist support in a particular area, e.g. management accounting or employee relations; and ii) access to the full range services and advice provided by the whole of that corporate function. We will work with the new Divisional management teams to develop this model further to provide dedicated support to each Division from Estates & Facilities, Finance, HR, Information, IT and the Transformation Team.

48. Developed from the 'business partner' model this support will provide a consistent input and advice throughout the year. The relevant corporate directors will agree the level of resourcing and key outputs at the beginning of each year.

DEVELOPMENT, TALENT MANAGEMENT & SUCCESSION PLANNING

49. The new management arrangements will only achieve the objectives set out at the beginning of this paper if we are able to develop both capacity and capability for clinical leadership. This will need to include robust processes for identifying and developing talent in the organisation and for succession planning.

50. A project is in place to review the organisational development needs to support these objectives and staff who are key within this new model. The new model will draw together a mix of core Leadership programmes bespoke to MTW incorporating and embedding key organisational objectives, business critical skills, bespoke in-house and external personal development opportunities and tools to support managers in talent management and succession planning. This will build upon the QSIR and LiA methods already developed within the Best Care Programme.

51. The new model will be presented to the Trust Board in September (following TME). Provision is being made in the financial plans from FY19/20 to ensure these programmes are properly funded. The first tranches of development will be commissioned and get under way during the current financial year, FY18/19

IMPLEMENTATION

52. An outline timetable for implementation of these changes is described below. Individuals will be 'slotted in' to posts that are substantially the same as the role they currently occupy. All staff in a general management or nursing management role will be offered a position in the new structure at their current grade. No-one will have to apply for their current job and no-one will be asked to take a role at a lower grade. A proposed matching of existing staff to general management, nursing and heads of profession posts in the new structure will be confirmed by 28 September.

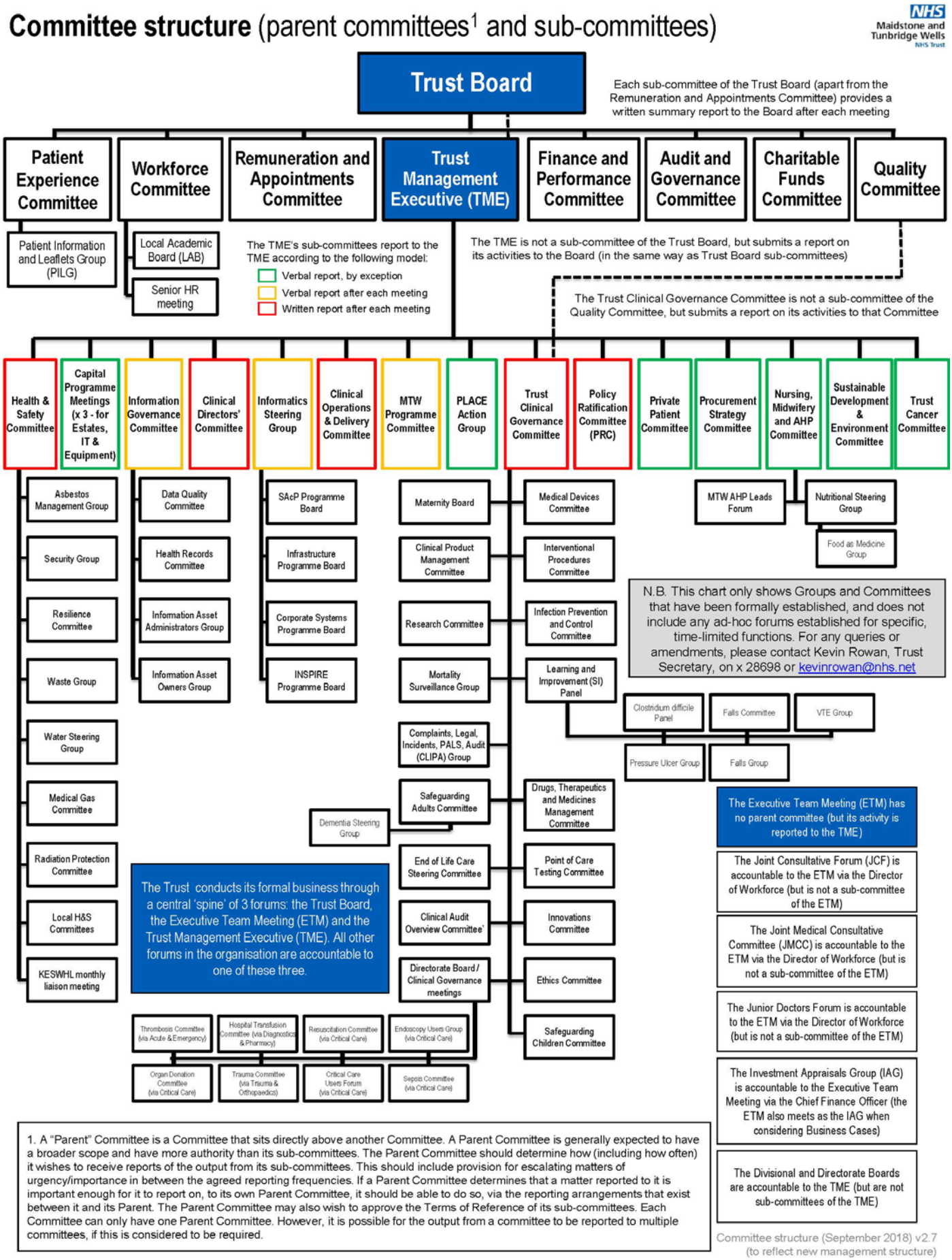
53. The most significant changes in roles will be for Clinical Directors and Chiefs of Service. Where these roles are substantially the same as an existing role the current postholder will have the right to complete their term of office. Where new clinical leadership roles are being created these will be open to internal competition.

- 19/09/18 TME agreement sought of final revised paper
- 20/09/18 Communications to all staff to raise awareness of TME agreed changes/feedback thank you
- 24/09/18 Implementation Group to agree Talent Management Gap/Leadership Development option
- 27/09/18 Board agreement sought of TME approved final revised paper
- 27/09/18 Communications to TME colleagues following Board ratification
- 28/09/18 Communications to all staff and external partners following Board agreement
- 01/10/18 Advertise CD and COS posts – internal only
- 01/10/18 Where other vacant posts in structure (not COS or CD) advertise externally
- 01/10/18 – 12/10/18 Selection process - using final TME paper, map over where relevant staff affected slot in - higher level plan regards JD change management, staff comms + 2wk formal consultation
- 01/10/18 – 15/10/18 Advertise any vacant posts (not COS or CD) externally
- 01/10/18 – 08/10/18 Advertise for vacant posts (COS and CDs) – agree interview panel
- 08/10/18 – 12/10/18 COS, CD shortlist and interview
- 12/10/18 – 16/10/18 COS, CD confirm posts
- 15/10/18 – 17/10/18 Shortlist any vacant posts (not COS or CD)
- 16/10/18 – 21/10/18 Advertise externally any vacant CD and COS posts
- 18/10/18 – 25/10/18 Interview any vacant posts (not COS or CD) – interview panel depends on role
- 22/10/18 – 28/10/18 COS, CD shortlist and interview any vacant posts
- 25/10/18 – 26/10/18 Confirm posts of appointments to any vacant posts (not CD or COS)
- 01/11/18 - Agree COS support model
- 01/11/18 – new structures and meeting arrangements take effect

REVIEW

54. A review of the first six months of operation of these developments will be undertaken in April 2019. This will assess progress towards the vision and priorities set out at the beginning of this document and get feedback from across the organisation on how well the new arrangements are working and where further work and improvement is required.

APPENDIX 1: Updated Committee Structure



APPENDIX 2: Job Description – Chiefs of Service

Divisional Chief of Service_JD MS.pdf

APPENDIX 3: Job Description – Divisional Director of Operations

Divisional Director of Operations_JD Draft.

APPENDIX 4: Job Description – Divisional Director of Nursing & Quality

Divisional Director of Nursing and Quality_

Version Control: *Details of approved versions*		
Issue:	***Description of changes:***	***Date:***
0.1 – 0.7	*Initial Drafts via M.Scott, Task & Finish Group (commenced 10/07/2018), Executive Team, C.Tsatsaklas and including Staff Consultation (10-31/08/2018) changes*	*19/09/2018*
0.8	*Draft to Trust Management Executive Meeting 20/09/18 - approved*	*20/09/2018*
0.9	*TME approved draft to TNF Group 20/09/18 – minor insertions agreed (M.Scott/C.Tsatsaklas)*	*20/09/2018*
0.10	*TME and TNF Group approved final draft paper to Trust Board 27/09/18*	*27/09/2018*

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust
Job Description

Job title:	**Divisional Chief of Service**
Responsible for:	**Allocated Division**
Site:	**Cross-site**
Hours:	**4 - 5 PAs / 15 - 18.75 hours per week**
Reports to:	**Chief Operating Officer**
Accountable to:	**Chief Executive**
Contract Term:	**Three years**

Job summary: Divisional Chiefs of Service will carry overall responsibility for leadership and management within their division. This will include establishing a comprehensive annual plan, management of budgets and contributing to the Trust's Best Care Programme. They will participate in weekly executive meetings, attend the monthly Trust Management Executive meeting and chair the Divisional Management Board. They will demonstrate visible and credible leadership, role modelling Trust values. Patient safety and the patient experience will be placed at the centre of all divisional activity.

Working relationships:

- Trust Executive Team
- Non-Executive Directors
- Chief Operating Officer
- Divisional Directors of Operations
- Divisional Directors of Nursing and Quality
- Clinical Directors
- Directorate Managers and Matrons
- Corporate Departments
- Research and Development Leads
- Trade Union Representatives
- CCG and partner provider leads
- NHSI
- STP

Budget responsibilities: Accountable for the divisional budget. Subject to division, budget accountability will be approximately:
Cancer Services £48m
Diagnostics and Clinical Support £55m
Women's, Children's and Sexual Health Services £38m
Surgery £91m

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Medicine and Emergency Care £88m

Key result areas:

Operational Leadership

- Lead the Divisional Director of Operations, Director of Nursing and Quality and the wider divisional management team
- Lead operational plans to support the Trust's strategic objectives. This will include responsibility for the achievement of the relevant key performance and access targets, contractual obligations including CQUINS and all CQC standards
- Liaise with Chief of Service colleagues, Divisional Directors of Operations and Divisional Directors of Nursing and Quality to ensure activities across the Trust are fully co-ordinated, integrated and aligned with corporate strategy
- Lead the annual planning cycle for the division
- Secure effective use of financial and non-financial resources including the workforce within the division ensuring these are deployed to provide maximum patient benefit
- Lead the development and delivery of cost improvement programmes
- Develop opportunities for revenue generation within the division
- Develop systems to provide clinical information to staff to enable them to benchmark and audit their practice to support improvements in patient experience
- Be a leader within the Quality Improvement movement within the Trust and be active in continuously improving the services within the framework and methodology to maximise and sustain success
- Establish and maintain regular communication with staff in the division, lead on staff engagement and foster a culture that encourages openness, innovation and transformation
- To act, where appropriate, as the spokesperson for the division both internally and externally
- Oversee performance management across the division
- Agree a system of delegated responsibility with the division
- Foster an open and inclusive style of management, encouraging team working and good working relationships

- Promote a culture where governance and risk management are seen to be everyone's responsibility
- Implement the Trust strategy on infection prevention within the division
- Support the divisional response to patient complaints and PALS to ensure prompt and accurate responses
- Ensure lessons are learned from complaints and PALS enquiries and that these act as an opportunity for improving patient experience and clinical care
- Actively participate in the Best Care Programme

Professional Leadership

- In partnership with the Divisional Director of Operations and Divisional Director of Nursing and Quality, identify and make provision for the training and development of staff
- Develop robust succession plans in accordance with the Trust's approach to developing and managing talent
- Promote research activity in the division and ensure this is delivered in line with the Trust's research strategy/policy
- Ensure the highest standards of clinical effectiveness in the division, considering local and national recommendations Eg NICE guidelines, college guidelines or national reports
- Ensure a healthy and safe working environment for divisional staff in accordance with health and safety legislation
- Review and develop divisional strategies for clinical governance in line with Trust policy and be responsible for delivery of these within the division – this includes clinical audit, clinical risk management and public and patient involvement

Strategic Leadership

- Support the development of service and corporate strategy ensuring divisional input
- Ensure the Trust's vision and values are part of everyday practice across the Division
- Work with the Divisional Director of Operations and Divisional Director of Nursing and Quality to continually review the performance of the division. Reviewing and where necessary redesigning services. Where necessary engaging with colleagues in partner organisations
- Chair and fully participate in the Divisional Management Board

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- Actively participate in the Trust regular executive meetings and monthly Trust Management Executive
- Help shape emerging strategy ensuring the patient is central to the organisation's future plans and service developments
- Ensure that Directorates within the Division are adopting best practice to support the Trust's objective to become 'outstanding'
- Promote effective communications and engagement across the division, including ensuring that all managers and clinicians in leadership roles make a 'shop floor commitment' in their personal objectives

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General

- Lead Trust wide initiatives and projects as agreed
- Represent the division or the Trust at local or national meetings
- Participate in medical staff appointment panels

Job description agreement:

Signature of post holder:_____ Date: _____

Name: _____

Signature of manager: _____ Date: _____

Name: _____

Maidstone and Tunbridge Wells NHS Trust

Statement:

1. This job description is a broad reflection of the current duties. It is not necessarily exhaustive and changes will be made at the discretion of the manager in conjunction with the post holder.
2. Time scales for achievement and standards of performance relating to the duties and responsibilities identified in this job description will be agreed via the annual appraisal process with the post holder.
3. As an employee of Maidstone and Tunbridge Wells NHS Trust, the post holder will have access to confidential information. Under no circumstances should this be disclosed to an unauthorised person within or outside the Trust. The post holder must ensure compliance with the requirements of the Data Protection Act.
4. As an employee of the Trust, the post holder will be required to adhere to all Trust policies including Equal Opportunities where all employees are expected to accept individual responsibility for the practical implications of these policies.
5. The post holder is required to take reasonable care for the health and safety of themselves and others that may be affected by what they do while at work.
6. This post may require the post holder to travel across the Trust sites in the course of fulfilment of their duties.
7. The Maidstone and Tunbridge Wells NHS Trust has a no smoking policy
8. Clinical Governance: You will be expected to take part in the processes for monitoring and improving the quality of care provided to patients. This includes risk management and clinical audit. If you engage in clinical research you must follow Trust protocols and ensure that the research has had ethical approval. You will be expected to ensure that patients receive the information they need and are treated with dignity and respect for their privacy.
9. All staff should be aware of their responsibilities and role in relation to the Trust's Major Incident Plan.
10. INFECTION CONTROL AND HAND HYGIENE - All Trust employees are required to be familiar with, and comply with, Trust policies for infection control and hand hygiene in order to reduce the spread of healthcare-associated infections. For clinical staff with direct patient contact, this will include compliance with Trust clinical procedures and protocols, including uniform and dress code, the use of personal protective equipment policy, safe procedures for using aseptic techniques, and safe disposal of sharps. All staff are required to attend mandatory training in Infection Control and be compliant with all measures known to be effective in reducing healthcare-associated infections.
11. All staff are required to fully participate in learning and development opportunities and ensure they remain compliant with statutory and mandatory training requirements throughout their employment with the Trust
12. All staff are required to fully comply with the NHS Code of Conduct.

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13. **SAFEGUARDING CHILDREN -** Everyone employed by the Trust regardless of the work they do has a statutory duty to safeguard and promote the welfare of children. When children and/or their carers use our services it is essential that all child protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow the child protection procedures and the Trust's supplementary child protection guidance which is accessed electronically on the Trust's Intranet site. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend child protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's child protection training guidance.
14. **SAFEGUARDING ADULTS -** Everyone employed by the Trust regardless of the work they do has a duty to safeguard and promote the welfare of vulnerable adults. When patients and/or their carers use our services it is essential that all protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow Trust policies in relation to safeguarding vulnerable adults. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend vulnerable adult protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's vulnerable adult protection training guidance.
15. All staff are required to provide the highest levels of service in their work and to adopt the highest standards of behaviour as stated and implied in the Trust Values of PRIDE.

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Chief of Service
Person specification

AREA	ESSENTIAL	DESIRABLE (for grading purposes this information is not taken into account)
Qualifications	• GMC/NMC/HCPC registered • Masters level post graduate education or equivalent professional experience in a senior clinical leadership role • Evidence of regular and up to date CPD	• Management training
Experience/ Knowledge	• Significant experience of medical or clinical leadership within the NHS as a Consultant or similar non-medical grade for example, but not limited to, Consultant Nurse, Consultant Midwife, Consultant Paramedic, Consultant Radiographer, Consultant Physiotherapist other Consultant AHP • Experience of leading and developing people • Experience of service development and shaping healthcare strategy • Understanding of the current challenges and opportunities facing the delivery of healthcare	• Experience of leading a clinical division • Previous member of an executive committee • Clinical experience within one or more of the division's specialties • Experience of reviewing and agreeing job plans
Skills	• Financial management • Risk management and clinical governance • Excellent oral and written communication skills • Ability to work collaboratively	•
Attributes	• Visionary leader with ability to energise others • Inclusive leadership style • Willing and able to participate as a team member • Role model Trust values	•
Additional requirements	• Travel between two Trust sites and off site meetings as required	•

Maidstone and Tunbridge Wells NHS Trust

Date written ……..

Appendix 3

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust
Job Description

Job title:	**Divisional Director of Operations**
Band:	**Band 8D or 9**
Responsible for:	**Division of Cancer Services** **Division of Women's, Children's and Sexual Health** **Division of Diagnostics and Clinical Support** **Division of Surgery** **Division of Medicine and Emergency Care**
Site:	**Cross-site**
Hours:	**37.5 hours per week**
Reports to:	**Divisional Chief of Service**
Accountable to:	**Chief Operating Officer**

Job summary:
Managerially accountable to the Divisional Chief of Service, The Divisional Director of Operations will be personally responsible for: establishing a comprehensive annual plan for the division; delivery of the NHS Constitution Standards in the division; agreeing and working within an annual budget for income and expenditure, including efficiency/CIP requirements; divisional contributions to the trust's Best Care Programme; communications and engagement within the division; performance management of Clinical Directorates; leadership of the directorate General Managers and engagement with corporate Business Partners.

Working relationships:

- Trust Executive Team
- Non-Executive Directors
- Chief Operating Officer
- Divisional Chiefs of Service
- Divisional Directors of Operations
- Divisional Directors of Nursing and Quality
- Clinical Directors
- Corporate Departments
- Research and Development Leads
- Trade Union Representatives
- CCG and partner provider leads
- NHSI
- STP

Budget responsibilities: Accountable for the budgets across several service areas.

Maidstone and Tunbridge Wells NHS Trust

Key result areas:

Overall

- Be responsible for the operational performance and support the strategic development of the Directorates within the respective division. This will include responsibility for the achievement of the relevant key performance and access targets, contractual obligations including CQUINS and all CQC standards.
- Provide strong business leadership across the division
- Ensure the Trust vision and values are part of everyday practice across the Division
- Be accountable for setting and maintaining an annual capacity plan for the Directorates in line with the key corporate objectives, changes in demand for services and contractual obligations contained within the Trust's annual business plan.
- Have joint responsibility with the Divisional Chief of Service and other Divisional Directors of Operations, Clinical Directors and Executive Team for driving forward corporate and cross-cutting programmes of work and seamless service delivery.
- Work closely with the Executive Directors to shape and implement the corporate objectives for the organisation.
- Ensure with the Divisional Chief of Service strategic alignment across the organisation and particularly across the Divisions.
- Monitor and review business and service performance at all levels across all dimensions of care and delivery, reporting on performance directly to the Trust Management Executive, and instituting recovery plans and remedial action plans where necessary.
- Lead the development and implementation of major delivery and transformation plans to affect the service strategy including those involving cross divisional and external partnership working, to support improved patient pathways.
- Have an external focus to facilitate greater working across the Health and Social Care Community including CCGs, Community Care Trusts and Social Services.

Leadership

- To manage substantial budgets, significant numbers of staff and complex clinical operations.
- To drive through the delivery of ambitious targets to continually improve performance within the Division.
- Support the Divisional Chief of Service and Clinical Directors to develop Directorate strategies and ensure alignment with the Trust's overall strategy and Integrated Business Plan.
- Introduce new and innovative business management strategies to maximise the organisational efficiency, income and effectiveness of the Division.
- Provide professional support and leadership to the Division's management teams.
- Ensure that all staff in the Division are clear about what is expected and are working together in successful teams to achieve the Trust's vision.

Maidstone and Tunbridge Wells NHS Trust

- Lead on the implementation of innovations and improvement for Divisions participating in the monthly Trust Management Executive and leading work programmes as required. This will include undertaking all necessary research to facilitate the best outcomes for the Trust, which may include complex audits.
- Develop and maintain effective working relationships with clinicians across the Trust to facilitate a patient safety approach to service developments and service improvements.
- Ensure that services are effectively delivered within the resource plan agreed.

Service Quality

- Be a leader within the Quality Improvement movement within the Trust, and be active in continuously improving the services within the framework and methodology to maximise and sustain success.
- Ensure patient safety, experience and clinical outcomes are central to service delivery
- Lead on the development of challenging and ambitious service strategies, anticipating future needs with the Divisional Chief of Service and Clinical Directors for each Directorate
- Challenge existing practices, ensuring that progressive solutions, which take into account models of best practice, are incorporated into service plans
- Ensure that all income required to support delivery of the service is identified and that budgets are realistic
- To support the Chief Finance Officer, in negotiating with external agencies, where appropriate, to secure additional income for new services and to agree supporting Service Level Agreements and infrastructure
- Work with Community, Social Care and Academic partners to ensure that delivery plans support the wider healthcare agenda including improvements in equality and access
- Work closely with Divisional Chiefs of Service Clinical Directors, clinicians and support services in other parts of the Trust to ensure delivery plans are compatible and to maximise opportunities for more efficient ways of working
- Support clinicians to deliver service improvement projects that deliver improved clinical outcomes for patients, reduced waiting times and more efficient use of resources ensuring the process for Quality Impact Assessment is embedded in practice.

Performance Management

- To ensure the provision and delivery of high quality, efficient and effective services within the directorates and across the Trust meeting CQC relevant quality indicators for the Division.
- Participate in the development of capital schemes including planning and to lead the implementation of the operational elements of these schemes to the agreed objectives and timescales.
- Support the Divisional Chief of Service and Clinical Directors to ensure each Directorate has clearly defined performance objectives supported by a management regime to deliver continuous improvement.

- Ensure that activity and other data is captured accurately and analysed in a timely manner enabling accurate forecasting trends and anticipating issues that could affect service delivery.
- Develop and implement effective reporting arrangements within the Directorate Management teams to accurately record and monitor performance against local and national targets and to pro-actively manage any variances
- Provide regular reports to the Divisional Chief of Service and Chief Operating Officer with assurance that appropriate follow up actions will be completed. This will include significant report writing, data analysis and presentation of highly complex information to a wide range of key stakeholders, including Board members.
- Ensure the Division delivers a financial performance in line with the Trust's agreed financial plan, including CIPs, and to explore and implement actively opportunities for cost improvement and maximised income.

Standards and Requirements for Healthcare Organisations

- Work closely with clinicians and managers to ensure that Directorates within the Division are providing optimum quality of care in line with national healthcare standards.
- Under the leadership of the Divisional Chief of Service and Clinical Directors, ensure that the Division meets or exceeds relevant Care Quality Commission (CQC) fundamental standards for registration and continues to comply with licensing requirements and local healthcare targets, including the "well led" domain expectations
- Ensure that Directorates within the Division are adopting best practice to support the Trust's objective to become 'outstanding'

Research and Development

- Ensure that the Division contributes as applicable and appropriate towards the Trust's Research Strategy.
- Promote medical/clinical research activity in line with the Trusts strategic plan.
- Ensure that opportunities for medical/clinical research and audit at specialty level are maximised to support the improvement of clinical outcomes and patient experience.
- Ensure that research and audit activity is conducted in line with Trust standards, and that results are shared with other specialties as appropriate.

Quality Governance and Risk

- Promote a culture where governance and risk management are seen to be everyone's responsibility.
- Help ensure that appropriate and necessary Divisional resources are made available to describe and deliver an annual Governance Plan, including relevant clinical audit activity.
- Help ensure that patient safety is at the centre of Divisional planning, analysis and delivery.
- Ensure that Directorates within the Division employ robust risk management and systems for clinical quality and safety improvement.

- Promote clinical information for benchmarking and audit to improve patient experience.
- Help develop and implement effective systems to record and monitor governance and risk information, and to provide reports to the Trust's Trust Management Executive, Quality Committee and Clinical Governance Committee as well as other appropriate Board sub committees.
- Ensure that systems are in place to deliver accurate and timely statutory information (e.g. Data Protection and Freedom of Information).

Communication

- To establish effective two way channels of communication within The Divisions.
- To foster a culture of openness and transparency at all levels in the Division.
- To establish excellent communication with other managers in the Trust and wider healthcare community to ensure that services are integrated.
- Regularly meet with clinical and non-clinical staff to ensure they remain engaged in the Trust's vision for delivering excellence in all we do.
- Ensure that good practice is rapidly shared within the Division and wider organisation where appropriate.
- Effectively manages communication with internal and external stakeholders consisting of highly complex, sensitive and contentious information.
- Promote effective communications and engagement across the Division, including a 'shop floor commitment' as part of your annual objectives.

Human Resources

- Regularly review the Division workforce plan to ensure it has the right numbers and the right level of knowledge skill and expertise skill to deliver services in the most effective and efficient way.
- Ensure that managers are supported to lead, motivate and develop staff.
- Ensure that managers have been trained in core HR policies such as Equality and Diversity, Discipline, Recruitment, Workforce Change, and are competent to deal with HR issues.
- Ensure that all staff in the Division receive a quality annual appraisal and have a Personal Development Plan which supports the Trust's excellence agenda.
- Ensure staff in the Division work within the requirements of the European Working Time Directive and employment legislation.
- Promote a culture where staff feel empowered and accountable for service improvement at local level.

Education and Teaching

- Ensure that all staff in the Division receive appropriate training and on-going development to enable them to competently and safely fulfil their roles.

- Ensure that training is accessible to all clinical and non-clinical staff, recognising the diverse needs of the workforce.
- Promote learning opportunities in a wide range of formats to improve multi-disciplinary and flexible working.
- Ensure that the Divisions provide opportunities for talent to be developed.
- Promote a culture of lifelong learning.

Planning and organisational

- In partnership with the Divisional Chief of Service be responsible for the creation and execution of long term strategic plans for the Division, involving the Directorates in the creation to ensure engagement from the outset. Ensuring engagement from external stakeholders (e.g. CCGs), and clearly identifying inter-dependencies with other corporate functions.

Policy / Service development

- Responsible for ensuring all required policies are in place and fit for purpose across all Directorates within the Division.

- Responsible for identifying potential service developments, leading these through the development and implementation stages in conjunction with Directorate leads, and evaluating their success embedding learning for future developments and projects.

Physical effort

- The post will require light physical effort with the frequent requirement to sit in a restricted position.

Mental and emotional effort

- There is a frequent requirement for concentration with the likelihood for frequent interruption. The post will also have a requirement for occasional prolonged concentration.
- The post holder will have frequent exposure to distressing and emotional circumstances. This will be in a variety of forms, including imparting unwelcomed news to staff, patients, relatives (including dealing with escalated patient complaints and hearing disciplinary and grievances). The post holder will also have occasional exposure to highly distressing/emotional circumstances.

Working conditions

- Frequent use of VDU and occasional exposure to unpleasant working conditions.

Other Duties (role specific)

- Lead Trust-wide initiatives and projects as required
- Take part in Trust-wide Senior Manager Rota including 7-day duty management rotas,
- Represent the Division or Trust at local or national meetings

Maidstone and Tunbridge Wells NHS Trust

- Participate in medical appointment panels

General – the post holder will be required to participate in an on-call rota and therefore needs to have a full clean UK driving licence.

Job description agreement:

Signature of post holder:_____ Date: _____

Name: _____

Signature of manager: _____ Date: _____

Name: _____

Statement:

1. This job description is a broad reflection of the current duties. It is not necessarily exhaustive and changes will be made at the discretion of the manager in conjunction with the post holder.

2. Time scales for achievement and standards of performance relating to the duties and responsibilities identified in this job description will be agreed via the annual appraisal process with the post holder.

3. As an employee of Maidstone & Tunbridge Wells NHS Trust, the post holder will have access to confidential information. Under no circumstances should this be disclosed to an unauthorised person within or outside the Trust. The post holder must ensure compliance with the requirements of the Data Protection Act.

4. As an employee of the Trust, the post holder will be required to adhere to all Trust policies including Equal Opportunities where all employees are expected to accept individual responsibility for the practical implications of these policies.

5. The post holder is required to take reasonable care for the health and safety of themselves and others that may be affected by what they do while at work.

6. This post may require the post holder to travel across the Trust sites in the course of fulfilment of their duties.

7. The Maidstone & Tunbridge Wells NHS Trust has a no smoking policy.

Maidstone and Tunbridge Wells NHS Trust

8. Clinical Governance: You will be expected to take part in the processes for monitoring and improving the quality of care provided to patients. This includes risk management and clinical audit. If you engage in clinical research you must follow Trust protocols and ensure that the research has had ethical approval. You will be expected to ensure that patients receive the information they need and are treated with dignity and respect for their privacy.

9. All staff should be aware of their responsibilities and role in relation to the Trust's Major Incident Plan.

10. INFECTION CONTROL AND HAND HYGIENE **-** All Trust employees are required to be familiar with, and comply with, Trust policies for infection control and hand hygiene in order to reduce the spread of healthcare-associated infections. For clinical staff with direct patient contact, this will include compliance with Trust clinical procedures and protocols, including uniform and dress code, the use of personal protective equipment policy, safe procedures for using aseptic techniques, and safe disposal of sharps. All staff are required to attend mandatory training in Infection Control and be compliant with all measures known to be effective in reducing healthcare-associated infections.

11. All staff are required to fully participate in learning and development opportunities and ensure they remain compliant with statutory and mandatory training requirements throughout their employment with the Trust

12. All staff are required to fully comply with the NHS Code of Conduct.

13. **SAFEGUARDING CHILDREN -** Everyone employed by the Trust regardless of the work they do has a statutory duty to safeguard and promote the welfare of children. When children and/or their carers use our services it is essential that all child protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow the child protection procedures and the Trust's supplementary child protection guidance which is accessed electronically on the Trust's Intranet site. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend child protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's child protection training guidance.

14. **SAFEGUARDING ADULTS -** Everyone employed by the Trust regardless of the work they do has a duty to safeguard and promote the welfare of vulnerable adults. When patients and/or their carers use our services it is essential that all protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow Trust policies in relation to safeguarding vulnerable adults. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend vulnerable adult protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's vulnerable adult protection training guidance.

15. All staff are required to provide the highest levels of service in their work and to adopt the highest standards of behaviour as stated and implied in the Trust Values of PRIDE.

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Divisional Director of Operations
Person specification

AREA	ESSENTIAL	DESIRABLE
Qualifications	• First degree or equivalent • Evidence of post-qualification study/professional development to doctorate level or equivalent senior management experience. • Evidence of regular and up to date CPD.	• Senior Leadership training • Management training
Experience/ Knowledge	• Significant experience of working at a senior management level. • Extensive knowledge of the NHS in the acute sector with up to date knowledge of operational and clinical services • Experience of working competently in an acute healthcare or equivalent setting in a senior operational delivery / management position. • Demonstrable knowledge of National and Local NHS; and changing national infrastructure. • Evidence of advanced leadership qualities • Evidence of presenting complex information to internal and external groups in an understandable way. • Evidence of successful leadership, management and engagement of clinical teams to introduce change. • Strategic report writing skills and experience • Experience of policy critique and writing to ensure fit for purpose. • Experience of liaising with CCGs in relation to commission of provision of services. • Ability to analyse, interpret and manipulate complex data, to facilitate operational delivery decisions to support key performance targets. • Experience of successful delegated budget management and evidence of achieving financial and finite resource targets.	• Understanding of more than one specialist area in health care. • Project management experience

Maidstone and Tunbridge Wells NHS Trust

	• Proven track record of achieving challenging healthcare targets. • Experience of leading and delivering significant programmes of change within an NHS setting.	
Skills	• Ability to analyse complex problems and develop practical and workable solutions to address them. • Able to perform complex audits to improve service delivery • Demonstrate a common sense approach, when advising and influencing internal and external colleagues. • Articulate with highly developed communication skills with the ability to network and build relationships at all levels, including interpersonal skills, liaison and negotiation skills. • Computer literacy (Excel; Microsoft Word; PowerPoint; email) with advanced keyboard skills • High level of work organisation with the ability to meet strict deadlines, within resources available. • Able to develop and implement policy, guidelines and complex projects from initiation to completion. • Well-developed IT skills to understand, analyse, manipulate, manage and present reports on complex performance data, highlighting cross-Directorate inter-dependencies. • Excellent communication skills, written and oral. • Ability to build and sustain successful teams. • Able to work collaboratively with partner organisations. • Ability to manage conflict. • Ability to critically analyse complex financial and clinical data sets. • Business focused; Sensitive to clinical and political demand. • Innovative thinker with the ability to cut through barriers to change. • Exceptional organisational skills • Proven record of pro-active performance	

Maidstone and Tunbridge Wells NHS Trust

	management.	
Attributes	• (Motivated and enthusiastic with excellent interpersonal skills. • Assertive yet approachable. • Personal drive and initiative • Able to work independently and meet tight deadlines. • Ability to think strategically and see the "global picture" • Self-belief • Self-awareness • Personal integrity • Commitment • Able to demonstrate positive behaviours against the Trust values • Evidence of good attendance record • Ability to cope with a demanding workload and changing deadlines • Able to demonstrate personal resilience	
Additional requirements	• Travel between the two Trust sites and off site meetings as required • Ability to work flexible hours and fulfil commitments of operational command role, as well as support for major incidents. • Able to participate in an on-call rota. • Able to demonstrate a positive work/life balance.	

Date written:

Appendix 4

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust
Job Description

Job Title:	**Divisional Director of Nursing and Quality**
Band:	**Band 8c or 8D**
Division:	**Medicine and Emergency Care** **Surgery** **Cancer Services** **Women's Children's and Sexual Health**
Site:	**Maidstone or Tunbridge Wells with Cross Site Working**
Hours:	**37.5hrs**
Reports to:	**Divisional Chief of Service**
Accountable to:	**Chief Operating Officer**
Professionally Accountable to:	**Chief Nurse**

Job Summary:

The Divisional Director of Nursing and Quality is responsible for the line management and professional standards of nursing and clinical professions within the division (other than medicine). Their personal responsibilities include: overseeing a framework for clinical governance and quality within the division; line management and professional leadership of nursing, AHPs and healthcare scientists; preparation for CQC inspection; establishing a quality plan and annual objectives for the division; managing processes within the division for clinical and other reported incidents, complaints, risk management and ensuring appropriate lessons are learned.

The post holder is part of the core team which develops and delivers nursing services across the Trust to meet corporate objectives. The post holder will take corporate responsibility for the areas of nursing and quality assigned by the Chief Nurse, for example tissue viability, continence care, falls and nursing workforce.

The post holder may be required to deputise for the Chief Nurse on occasion.

Working relationships:

Maidstone and Tunbridge Wells NHS Trust

- Trust Executive Team
- Non-Executive Directors
- Chief Operating Officer
- Divisional Chiefs of Service
- Divisional Directors pf Operations
- Divisional Directors of Nursing and Quality
- Clinical Directors
- Directorate Managers and Matrons
- Corporate Departments
- Research and Development Leads
- Trade Union Representatives
- CCG and partner provider leads
- NHSI
- STP
- Patient Community Groups
- GPs
- Local authorities
- Audit and inspection bodies

Budget responsibilities:

Overall responsible for
• Ensuring appropriate pay and non-pay budgets are agreed with matrons for wards and department nursing and associated staff needed for running the wards safely.
• Ensuring that regular and effective budget management & monitoring process are in place for each ward.

• Regular reviews are undertaken with matrons in relation to their delivery against establishments, temporary staffing controls and general budget management.

The post holder will:

- Be responsible for the operational and strategic development of quality and patient experience at divisional level, ensuring that governance systems are in place and that high quality patient services are being developed and delivered.

- Provide leadership and be accountable for the delivery of the national and local standards as well as the objectives for the specific directorates.

- Work closely with the Chief Nurse, Divisional Chief of Service, Clinical Directors, Divisional Director of Operations to set, implement, monitor and enforce standards across the division, and with accountability for compliance with best professional practice.

Maidstone and Tunbridge Wells NHS Trust

- Within the Division oversee the management of all aspects of
  - the nursing and other clinical professions (excluding medicine) budgets,
  - nurse and other clinical professions (excluding medicine) recruitment
  - employee relations
  - appraisal
  - statutory & mandatory training

  Ensure the necessary planning, controls, monitoring and reporting systems are in place across the various teams that make up the management of the division.

- Be aware of and respond to any issues that impact on the nursing & quality issues that would affect the delivery of the operational objectives.

- Take an active lead in Trust, local and national projects to both promote and develop nursing and other clinical professions (excluding medicine) across the Trust

- To represent the Trust in external fora for operational and strategic nursing issues

- Provide professional leadership to all nurses within the Trust.

- Participate in the management on-call rota

MAIN DUTIES AND RESPONIBILITIES

1. <u>Performance Management</u>

- As a member of the division senior leadership team, to jointly lead the development and implementation of the business strategy and delivery plan by contributing strategic and best practice direction for the services provided by a specific group of directorates, including

  - Innovation in clinical service and patient care
  - Opportunities for external partnership working,
  - Developing clinical quality standards,
  - The delivery of the Trust's equality and diversity strategy.

- Support (& deputise for them in their absence) Divisional Director of Operations in delivering all agreed outputs.

Maidstone and Tunbridge Wells NHS Trust

- Support the Clinical Directors, Matrons and General Managers in their operational role, especially holding matrons to account for delivery of their service objectives and participate in joint appraisals.

- Oversee in liaison with the Directorate Management Teams, the resolution of day-to-day clinical or management issues, especially as they relate to quality & safety or governance issues.

- Provide effective intervention and corrective action where clinical quality or professional standards are at risk of falling below expected levels (eg coaching nurses and developing corrective plans).

- Provide effective intervention & corrective action where clinical quality or professional standards are at risk of falling below expected levels (e.g., coaching nurses and developing corrective plans).

2. <u>Risk & Clinical Governance</u>

- Work with the patient safety team to access sources of patient feedback, including complaints, PALS concerns, F&F Test, patient surveys and compliments to implement improvement in patient care and experience.

- Within the division take management responsibility for the development and application of systems, control processes and risk management arrangements that ensure full compliance with internal and external governance procedures and to benchmark against best practice requirements.

- Lead and manage the arrangements in place to manage complaints, incidents and risk, ensuring that trend analyses of all complaints and adverse incidents and establish action plans to mitigate future risks are undertaken.

- Lead the management of the division to ensure that all aspects of risk and clinical governance are robustly and effectively managed, by:
  - Ensuring that the systems, control processes and risk management arrangements are fit for purpose and comply with internal and external governance and best practice requirements;
  - Ensuring effective systems are in place to monitor the timeliness and appropriateness of the resolution of complaints and issues from patients, staff, suppliers, other internal and external service providers and partner organisations, and with a particular focus on infection control.
  - Intervening as required and escalating areas of concern regarding patient safety and care to the Divisional Chief of Service, Chief Nurse & Chief Operating Officer.

- Ensure transparency of the audit process so that governance and risk are managed.

Maidstone and Tunbridge Wells NHS Trust

3. Professional Leadership and Staff Management

- Provide visible nursing leadership, monitoring patient feedback and standards of care at ward and department level with regular visits to clinical areas and regular days spent on the wards.

- Be an effective leader of change, embedding a culture of continuous quality improvement, innovation and use of technology that meets the changing needs of patients and users.

- Work with the Chief Nurse and Deputy Chief Nurses to help shape, develop and deliver the Nursing, Midwifery and Allied Health Professionals Strategy.

- Provide clear clinical and business leadership within the division ensuring that all professional staff are appropriately managed and developed and that they are therefore efficient, engaged, and highly motivated.

- Develop the matrons, ward managers and specialist nurses across all wards, services and specialities in management and service delivery (e.g., how to optimise use of resources against acuity models, effective practice development);

- Implement robust systems to ensure the nursing workforce is fit for purpose in relation to health and wellbeing and stat & mandatory training, specialist training, leadership skills / competence and health care support worker / assistant development

- Support the Chief Nurse to regularly review the nursing establishments, leading in their areas, and challenging and supporting the review as a senior nursing leadership team across other areas to ensure the safe, effective and efficient use of the nursing workforce to support operational and performance delivery

- Ensure establishments relate to specific requirements ensuring best possible clinical and performance outcomes.

- Undertake regular appraisal and provide professional development for matrons and other senior nurses, escalating areas for Trust wide development to the Chief Nurse.

- Develop leadership, capabilities and attitudes at all levels, as exemplified by senior staff

- Play an active role in career and succession planning and lead on the future direction for the development of the Trust senior nursing staff.

- Take a lead for trust wide nursing or safety projects and/or programmes as agreed by the Chief Nurse.

- Operate as a senior role model for nursing professionals across all departments, services, specialities and wards.

- Oversee, monitor, enforce and actively participate in good recruitment, performance management, personal development and communications practice within the organisation

- Develop career progression and succession planning arrangements that enable staff to move between departments, specialities and wards to support organisation-wide workforce planning.

4. Communication

- Lead communications to ensure the active two-way flow of corporate and local information to all staff within a group of directorates and organisation wide as appropriate.

- Represent the Trust, and act as ambassador, in public forums or with partner and stakeholder organisations including the delivery of presentations, conduct of negotiations and participation in debates.

- Recognise when intervention is needed to support, sensitive, complex or emotive, meetings with patients, relatives and the public on any matters relating to either patient care of service issues and escalate appropriately.

- Represent the Trust in media events, conducting interviews and making statements as required

- Promote effective communications and engagement across the Division, including a 'shop floor commitment' as part of your annual objectives.

5. Financial Management

- Establish effective financial controls and monitoring systems in relation to nursing budgets within the directorate's service and ward cost centres. This includes Bank & Agency use and expenditure and recruitment & retention among professionals/nurses:

  - ensuring that managers and those with responsibility for budgets understand the Standing Financial Instructions (SFIs), the finance management system and how to monitor and manage all budgetary resources with particular emphasis on (but not limited to) the management of workforce related costs

Maidstone and Tunbridge Wells NHS Trust

- ensuring all resources are deployed to achieve best outcome with reference to the performance contract and business planning

6. Strategy and Service Improvement

- With the Divisional Chief of Service, CDs, Divisional Director of Operations and directorate management teams ensure that there is a cohesive service strategy and a robust plan for service development and improvement which is bought into by all.

- Oversee service improvement projects and development programmes that contribute to the effectiveness and efficiencies of patient services, providing both professional and clinical advice as necessary.

- On behalf of the Trust to liaise with external stakeholders, interested parties and bodies, professional associations and work closely with them in the best interests of Trust service development, professional practice and patient care. This will include giving presentations, conducting sensitive discussions on complex issues and media interviews.

- Ensure that Directorates within the Division are adopting best practice to support the Trust's objective to become 'outstanding'.

7. R&D, Education and Training

- Lead and participate in the development of both Trust-wide Nursing and Midwifery research and development programmes

- Lead in the development of & implementation of education and training programs and contribute to the Trust Clinical Education Strategy as a professional lead.

- Lead, commission and monitor the development and implementation of the Division's training programme, and the delivery of multi-disciplinary programmes, interfacing and integrating these to the maximum extent possible with the programmes of academic partners and external partner organisations

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Job Description Agreement:

Signature of post holder:_____ Date: _____

Name: _____

Signature of Manager: _____ Date: _____

Maidstone and Tunbridge Wells NHS Trust

Name: _____

Maidstone and Tunbridge Wells NHS Trust

Statement:

1. This job description is a broad reflection of the current duties. It is not necessarily exhaustive and changes will be made at the discretion of the manager in conjunction with the post holder.

2. Time scales for achievement and standards of performance relating to the duties and responsibilities identified in this job description will be agreed via the annual appraisal process with the post holder.

3. As an employee of Maidstone & Tunbridge Wells NHS Trust, the post holder will have access to confidential information. Under no circumstances should this be disclosed to an unauthorised person within or outside the Trust. The post holder must ensure compliance with the requirements of the Data Protection Act.

4. As an employee of the Trust, the post holder will be required to adhere to all Trust policies including Equal Opportunities where all employees are expected to accept individual responsibility for the practical implications of these policies.

5. The post holder is required to take reasonable care for the health and safety of themselves and others that may be affected by what they do while at work.

6. This post may require the post holder to travel across the Trust sites in the course of fulfilment of their duties.

7. The Maidstone & Tunbridge Wells NHS Trust has a no smoking policy.

8. Clinical Governance: You will be expected to take part in the processes for monitoring and improving the quality of care provided to patients. This includes risk management and clinical audit. If you engage in clinical research you must follow Trust protocols and ensure that the research has had ethical approval. You will be expected to ensure that patients receive the information they need and are treated with dignity and respect for their privacy.

9. All staff should be aware of their responsibilities and role in relation to the Trust's Major Incident Plan.

10. INFECTION CONTROL AND HAND HYGIENE **-** All Trust employees are required to be familiar with, and comply with, Trust policies for infection control and hand hygiene in order to reduce the spread of healthcare-associated infections. For clinical staff with direct patient contact, this will include compliance with Trust clinical procedures and protocols, including uniform and dress code, the use of personal protective equipment policy, safe procedures for using aseptic techniques, and safe disposal of sharps. All staff are required to attend mandatory training in Infection Control and be

compliant with all measures known to be effective in reducing healthcare-associated infections.

11. All staff are required to fully participate in learning and development opportunities and ensure they remain compliant with statutory and mandatory training requirements throughout their employment with the Trust

12. All staff are required to fully comply with the NHS Code of Conduct.

13. **SAFEGUARDING CHILDREN -** Everyone employed by the Trust regardless of the work they do has a statutory duty to safeguard and promote the welfare of children. When children and/or their carers use our services it is essential that all child protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow the child protection procedures and the Trust's supplementary child protection guidance which is accessed electronically on the Trust's Intranet site. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend child protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's child protection training guidance.

14. **SAFEGUARDING ADULTS -** Everyone employed by the Trust regardless of the work they do has a duty to safeguard and promote the welfare of vulnerable adults. When patients and/or their carers use our services it is essential that all protection concerns are both recognised and acted on appropriately. You have a responsibility to ensure you are familiar with and follow Trust policies in relation to safeguarding vulnerable adults. You have a responsibility to support appropriate investigations either internally or externally. To ensure you are equipped to carry out your duties effectively, you must also attend vulnerable adult protection training and updates at the competency level appropriate to the work you do and in accordance with the Trust's vulnerable adult protection training guidance.

15. All staff are required to provide the highest levels of service in their work and to adopt the highest standards of behaviour as stated and implied in the Trust Values of PRIDE.

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Maidstone and Tunbridge Wells NHS Trust
PERSONAL SPECIFICATION

Divisional Director of Nursing & Quality

Criteria	Essential	Desirable	Assessment
Education & Qualifications	• An MSC level nursing qualification/post graduate management qualification or equivalent experience. • First level registered Nurse (or relevant professional registration) • Broad clinical experience relevant to the post • Comprehensive record of continuous professional development to mainatin up-to-date knowledge at the highest level of the nursing profession	• Management qualification (e.g. MBA) or equivalent leadership experience	Application
Experience/ Knowledge	• Extensive experience in a senior nursing leadership role • Demonstrable previous success in leading and delivering change and performance with and through multiple and diverse clinical teams, by engaging them in the strategic direction and delivery plans, establishing clear work priorities with them, delegating effectively, ensuring a capability to deliver, monitoring performance and giving feedback • Proven ability to analyse complex and sensitive problems and to develop and successfully implement practical and workable solutions to address them • Ability to think and plan strategically, tactically and creatively, and to prioritise work programs in the face of competing demands • Ability to collaborate	• Proven experience in a similar role in another Acute Hospital • Senior experience of the service delivered by the recruiting Division	Application / Interview / References

	constructively with internal and external partners to create the conditions for successful partnership working • A good understanding of the changing NHS environment		
Skills	• Well developed leadership and influencing skills with the ability to enthuse, motivate and involve individuals and teams, and have them understand the Trust's and your performance expectations • Ability to be intellectually flexible and to look beyond existing structures, ways of working, boundaries and organisations to produce more effective and innovative service delivery and partnerships • Excellent inter-personal skills with the ability to posiitv;ley interact in difficlt, emotove and potentially hostile situations • Highly developed communication skills with the ability to deliver presentations and represent the Trust in the media • Sound political judgement and astuteness in understanding and working with complex policy, and diverse interest groups, and common sense in knowing when to brief 'up the line' • A commitment to improving patient services through an ability to sustain a clear performance focus on achieving demanding goals		Application / Interview / References
Personal Qualities	• A strong sense of personal and team accountability coupled with a clear understanding of the boundaries around delegated authority • High level of work organisation, self-motivation, drive for performance and improvement • Personal resilience to the		Interview / References

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	emotive and antagonistic situations • Flexibility in approach and attitude • Open and honest style with unquestioned integrity		

Trust Board meeting September 2018

NHS
Maidstone and Tunbridge Wells NHS Trust

9-15 Responsible Officer's Annual Report 2017/18 — Medical Director

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

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The Board is asked to review the report and approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation. Attached to the report is a response to a query from NHSE regarding an apparent low appraisal rate.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2018).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

ANNUAL REPORT: MEDICAL APPRAISAL AND REVALIDATION AT MTW

1. Executive summary

Maidstone and Tunbridge Wells NHS Trust (MTW) is responsible for providing an annual appraisal to all doctors who have a prescribed connection. Of the 388 MTW doctors with such a connection, 349 completed an appraisal in the 2017/18 appraisal year ending 31.03.18. This is an overall appraisal rate of 90%. The rate varied with the grade of doctor: 97% consultants and 83% staff and associate specialists had an appraisal and 72% of the trust grade/locums and other grades had an MTW appraisal. As at 31st May 2018, all doctors who had a prescribed connection to MTW had undertaken an annual appraisal unless a deferral had been agreed by the Deputy RO.

Quality assurance of the appraisal process was maintained with 20 appraisal output forms (30%) being reviewed with the NHS England tool for reviewing appraisal outputs. A random sample of the 15 portfolios of supporting information of MTW doctors were reviewed against NHS England standards to audit the information being submitted to the appraisal process.

The national phased roll out of the medical revalidation instigated in 2012 allocated all registered doctors to have been revalidated by March 2016. This resulted in a large drop in the numbers of doctors whose revalidation fell due in 2016 and 2017. During 2017/18, the MTW advisory panel met monthly to advise the Responsible Officer (RO) about these recommendations as they fell due through the year. The RO made 12 positive revalidation recommendations, 8 deferral recommendations and no recommendations of 'non-engagement' to the General Medical Council (GMC).

2. Purpose of the report

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

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The purpose of revalidation is to give assurance to patients, employers, doctors and regulators that doctors are up to date, fit to practice and safe within their entire scope of practice (not just their NHS work). This paper seeks to give Board assurance that MTW meets its statutory requirements surrounding appraisal and revalidation of its doctors.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;

- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The Responsible Officer has a defined overall responsibility for the management of all aspects of medical appraisal and revalidation. At MTW aspects of this are delegated to a deputy medical director who acts as the Trust's appraisal lead. The appraisal lead has been formally recognised as the Deputy RO. Administrative support is provided by the Medical Director's office. Although systems for medical appraisal have been a requirement since 2001 these were overhauled at MTW in 2008. New systems of monitoring and quality assurance have evolved since then, as national guidelines have developed and clarity around the revalidation process has emerged.

Appraisers have been trained either internally or through external providers and updated annually, just prior to the commencement of the annual appraisal round.

Quality assurance processes are led by the appraisal lead. There is no designated HR lead for medical appraisal and revalidation processes.

The MTW 'Revalidation Advisory Group' met to assist the responsible officer with making and documenting revalidation recommendations for MTW doctors. The group has terms of reference and consists of the medical director, the deputy medical directors and previously the associate director of workforce. The group met approximately monthly and triangulated the appraisal records, as well as any information about complaints, claims, incidents and disciplinary issues concerning the doctor whose revalidation is due. The RO may make only one of 3 recommendations:

- A positive recommendation to revalidate
- A recommendation to defer revalidation for up to one year
- A notification that a doctor has not engaged adequately with the appraisal process.

Data about all doctors connected to MTW is kept on a spreadsheet which is regularly updated with information about previous appraisals and any concerns about their practice. This list is adjusted as doctors new to MTW establish a prescribed connection through a list held on the 'GMC connect' website. Changes are cross referenced with Medical Staffing, the Director of Medical Education and with clinical directorates to ensure that the link is appropriate and reflects the true employment status of the doctor.

Data on appraisal and revalidation processes is supplied to the regional team of NHS England on a quarterly basis by the appraisal lead.

Benchmarking of appraisal and revalidation processes also takes place through RO and Appraisal Lead attendance at Regional network meetings (3 times per annum).

a. Existing Policy and Guidance

- MTW Appraisal and Revalidation Policy 2016
- MTW Management of concerns about the performance of doctors policy 2011
- MTW Back on track policy 2012
- NHS England appraisal policy 2014
- GMC: supporting information for appraisal and revalidation 2013

- GMC: framework for revalidation 2012

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

- 388 doctors connected to MTW as at the end on 31.03.18
- 349 doctors had a completed appraisal (90%)
- 232/239 consultants (97%); 82/99 SAS doctors (83%) and 36/50 of other doctors (72%) completed an appraisal.

(See also **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

74 MTW doctors are listed on the MTW list of approved appraisers, (8 SAS doctors and 66 consultants). Two appraisers left, two stepped down and seven new appraisers were trained in 2017/18.

MTW appraisers are invited to attend one of two appraiser update sessions held in the autumn by the appraisal lead prior to the start of the "appraisal season". The content is determined by the gaps noted in previous reports and input form national guidance. All appraisers are given a collection of documents summarising the issues addressed, along with suggestions for the forthcoming appraisals.

Appraisers received personal feedback about their performance in the yearly round with anonymised comments from their appraisees.

The RO or the Deputy RO attended 3 of the 3 regional RO network meetings.

c. Quality Assurance

Outline of MTW quality assurance processes:

For the appraisal portfolio:

- Review of 5% of MTW medical appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate.
- Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard -by whom and sign offs. An MTW defined checklist is used to ensure that appraisal outputs meet minimum standards required for certification of completion.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs. A flag is used on the appraisal spreadsheet to identify any pieces of information that the RO has asked the doctor to discuss at appraisal, to ensure a written reflection is present.

For the individual appraiser:

- An annual record of the appraiser's participation in update meetings and/or confirmation of receiving and assimilating the Deputy RO's update into their practice.
- 360^0 feedback from doctors for each individual appraiser. A standard questionnaire is sent out to each appraisee upon receipt of the appraisal output. This is collated on a spreadsheet and used to feedback to appraisers in an anonymised format at the close of the appraisal round.

For the organisation:

- Feedback about Trust processes is sought from all doctors completing an appraisal
- Scrutiny of all the appraisal outputs by the appraisal lead and RO permits an overview of themes, risks and concerns to be formulated.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

The MTW appraisal system is electronic. In MTW adopted the new national Medical Appraisal Guide ('MAG') forms produced by the NHS England in 2016. This is an interactive pdf which can be downloaded from the NHS England website and is available from the MTW RO office. Supporting information can be uploaded into the MAG form. Adoption of the form was not problematic and permitted a less paper based process compliant with national best practice.

The Medical Director's office holds spreadsheet information about MTW doctors on shared Q drive in the clinical governance section. These are password protected documents.

Portfolios of supporting information are held by the doctor and shared with the appraiser prior to the appraisal meeting. At completion of the appraisal the portfolio is returned to the doctor who is required to keep until completion of the relevant revalidation cycle. The completed appraisal forms are held on the Q drive in the clinical appraisal folder.

Doctors are reminded of their information governance responsibilities not to include patient or colleague identifiable information in their appraisal portfolios. At the close of the appraisal round appraisers are reminded of their responsibility not to retain any paper or electronic record of the appraisals they have undertaken. No appraisal related information governance breaches were notified.

e. Clinical Governance

Medical appraisals are evidence based through the requirement for doctors to produce a portfolio of supporting information to demonstrate they are up to date in their entire scope of practice. Designated bodies are expected to assist this process by the provision of corporate data to support individual doctor's appraisals. This process is at present immature. The RO/Deputy RO keep a record (on the Q drive) of issues that they are aware of, but it remains the responsibility of the individual doctor to find the data and bring it to the appraisal. The following data sources are available:

- Dr Foster data
- Results of clinical, network based and national clinical audits
- Workload and productivity data is available in some specialties but may be team based or consultant based, so not applicable to other grades.
- Data about income generation for the Trust by clinical teams
- Clinical governance meeting information, attendance and contribution at clinical governance meetings.
- Complaints, litigation and claims data.
- Information about participation in statutory and mandatory training
- A doctor may be directed by the RO to bring information and evidence of personal reflection about a specific complaint, incident, claim, coroner's inquest or disciplinary issue to his appraisal and its inclusion is monitored.

6. Revalidation Recommendations

12 MTW doctors were given a positive revalidation recommendation in the 17/18 year. 8 doctors had deferred recommendations and there are no doctors 'on-hold' because of on-going GMC processes. No 'non-engagement' notifications were made.

The common cause of deferral of revalidation was the absence of sufficient information on which to make a recommendation. Often this was the absence of formalised patient feedback through the MTW 360 appraisal system or poor evidence of participation in quality improvement activity.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

MTW detailed recruitment processes require the credentialing and performance of background checks. Fair recruitment and selection is part of the Trust's wider commitment to equality of opportunity in employment and effective recruitment, selection and appointment of staff are key elements in ensuring the Trust's workforce have the skills and capabilities to achieve its business aims.

Formal transfer of information from one RO to the next is becoming more widespread and has certainly improved the transfer of clinical governance information in both the NHS and the private sector.

The Trust's recruitment policy and procedure outlines recruiting personnel obligations and clear processes to ensure that the Trust selects the best person for the job, in a process which is fair, open and transparent, and compliant with legislation, best practice and NHS Employers Employment Standards, and NHSLA Frameworks. The policy applies to the recruitment and selection of all Trust medical staff, irrespective of the contractual status of the vacancy, clinical speciality, or seniority.

Employment checks are an on-going requirement for Trust staff, and will be applied in relation to internal moves and promotions within the Trust.

Professional registration and entitlement to work / remain in the United Kingdom are also monitored via monthly reports, and utilisation of on-line checking systems.

Equally relevant employment checks are carried out in relation to medical temporary staff who are utilised within the Trust via agencies in order to ensure that current / valid professional registration is in place and checklists placed on file / available for audit.

Although no formalised system of language checking has been instigated, communication competency forms part of the interview process which is also attended by a member of the HR team.

See **Annual Report Template Appendix E**

8. Monitoring Performance

The Trust governance structures are in place and allow scrutiny of clinical performance throughout the organisation. Data on clinical outcomes, morbidity and mortality, readmissions and length of stay are regularly interrogated for clinical directorates allowing monitoring of clinicians performance.

9. Responding to Concerns and Remediation

Concerns regarding clinicians are handled under the umbrella of MHPS (maintaining high professional standards), and our Trust policies that encompass that national guidance. As appropriate, clinical or capability concerns are handled with advice from NCAS (National Clinical Advisory Service).

The Trust has a remediation policy, to address deficiencies of performance that are identified.

10. Risk and Issues

- At MTW, the appraisal rate is reported as less than 100%, however this is due to a small number of late appraisals (ie after end of March 2018). We have a rigid rule that no doctor is allowed to miss out an appraisal in any year without the agreement of the RO/Deputy RO.
- Systems to ascertain the appraisal and revalidation status of doctors employed on fixed term contracts and other new appointees has led to considerable improvement in this area although the appraisal rate still lags behind that of substantive medical employees.
- A reliable consistent mechanism that provides appropriate summary of Trust governance information about an individual doctor is still lacking and was identified as a risk in previous year's reports. This would allow all MTW doctors to include a statement of significant complaints and incidents in their portfolio that can be discussed with the appraiser and reflections and learning documented at appraisal. Current systems largely rely on the doctor remembering to declare adverse episodes and appraisers would much prefer to see a statement of such episodes provided by the trust to every doctor.
- There has been a major improvement in the consistency with which doctors declared their entire scope of practice and the supporting evidence they present in non-NHS roles.
- Doctors are required to present declarations from independent hospitals about current complaints or incidents. There is no effective means of monitoring compliance and this presents a risk to the RO's ability to have a complete knowledge of a doctor's performance.
- The weakest observed aspect of appraisals was documenting the reflection of the doctor. With the annual updates, it is hoped that this will improve.

11. Board Reflections

- MTW has a high rate of medical engagement with the statutory requirements around appraisal and revalidation.
- The RO/Deputy RO attend update training to keep the Trust at the forefront of effective appraisal and revalidation systems.
- Regulatory bodies can take action against a Trust should they suspect that the systems in place lack assurance of quality.
- These systems represent a major commitment of time, effort and professionalism for our trained appraisers.
- There is scope for improvement in the quality of medical appraisals.

12. Corrective Actions, Improvement Plan and Next Steps for 18/19

- MTW will continue to use the national MAG form for appraisal.
- The documentation of reflective practice will continue to be an area of focus.
- Medical staffing and clinical governance teams will build on the improving assistance and support to the Medical Director's office so that the administrative burden of this process is minimised and appropriate assurance given.
- Doctors need to value the appraisal process and understand how the MTW utilises the information that is gleaned from it. There needs to be renewed focus on appraisee training.

13. Recommendations

The Board is asked to accept this report and to approve the statement of compliance confirming that the Trust as a designated body, is in compliance with the regulations governing appraisal and revalidation (Appendix F)

Annual Report Template Appendix A: Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the ‘appraisal due window’	6
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	4
Suspension during the majority of the ‘appraisal due window’	0
New starter – unknown previous appraisal history	22
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	74
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B: Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		349
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	15	15
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	15	15
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	15	15
Patient feedback exercise: Has a patient feedback exercise been completed? (in this appraisal or within this revalidation cycle)	15	14
Colleague feedback exercise: Has a colleague feedback exercise been completed?	15	14
Review of complaints: Have all complaints been included?	15	15
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	15	15
Is there sufficient supporting information from all the doctor's roles and places of work?	15	14
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	15	A random pattern of timing for the Colleague and Patient feedback was encountered.
Appraisal Outputs		
Appraisal Summary	20	20
Appraiser Statements	20	20
PDP	20	20
Comments: The standard was felt to be acceptable in all case and excellent in a few. The following themes were detected: 1. Good reflection observed – major improvement on previous years. 2. Full scope of practice documented but not always supported by documentation 3. The timing of the Patient and colleague feedback is not planned to provide ideal feedback to the appraisee		

Annual Report Template Appendix C: Audit of revalidation recommendations

Revalidation recommendations between 1st April 2017 to 31st March 2018	
Recommendations completed on time (within the GMC recommendation window)	12
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	12
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor’s revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	
Other	N/A
Describe other	N/A
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix D: Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months				
Conduct concerns (as the primary category) in the last 12 months	1	1		2
Health concerns (as the primary category) in the last 12 months				
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All DBs				
TOTALS				1
Other Actions/Interventions				

Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	0
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Annual Report Appendix E: Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	25
Temporary employed doctors	291
Locums brought in to the designated body through a locum agency	491
Locums brought in to the designated body through 'Staff Bank' arrangements (including doctors already employed by MTW but working bank shifts)	518
Doctors on Performers Lists	We do not hold this information
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	None
TOTAL	

A Framework of Quality Assurance for Responsible Officers and Revalidation

Appendix E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Appendix E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Appendix F – Statement of Compliance

Designated Body Statement of Compliance

The Board of Maidstone and Tunbridge Wells NHS Trust (MTW) has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Peter Maskell, Medical Director fulfils these requirements for MTW.

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

   Comments: This is maintained on the GMC Connect website and regularly checked by the Revalidation Manager

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: 74 medical appraisers are recognised by the Trust for this role.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: annual update sessions are held by the appraisal lead and there are strong quality assurance systems that permit feedback of performance to appraisers.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: The new national MAG form is used at MTW and all medical practitioners complete an annual appraisal

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The Trust provides some data to the individual practitioner but this is an area where the Trust will aim to provide more data and supporting information relevant to their practice

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: These areas are covered by existing Trust processes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: At MTW RO to RO communication is triggered by the recruitment of any new doctor establishing a prescribed connection to MTW. There is regular contact between MTW's RO and ROs at local independent providers. Ad hoc communication is conducted as circumstances dictate.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: At MTW all mandatory pre-employment checks are carried out prior to start date to ensure that all licensed medical practitioners are qualified and experienced as appropriate for their role.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes – see actions emerging from the annual report.

Signed on behalf of the designated body

Name: Miles Scott,

Chief Executive

Signed: _ _ _ _ _ _ _ _ _ _

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

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Trust Board meeting – September 2018

NHS
Maidstone and Tunbridge Wells NHS Trust

9-16	**Health & Safety Annual Report, 2017/18 (incl. agreement of the 2018/19 programme and Board annual refresher training on Health & Safety, Fire safety, and Moving & Handling)**	**Chief Operating Officer / Risk and Compliance Manager**

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

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2018/19
- Formerly delegate the management to the Health and Safety Committee.

This Annual Report provides:

- A review of the Trust's Health and Safety performance for 2017/18
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2018/19
- Identifies the strategy and action plan for the next year and going forward

The data shows that around 31% of reported injuries relate to staff, contractors and visitors and 68% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

The report includes an Appendix, "What does the Board need to know?", on the basis that this provides the necessary instruction for the Trust Board i.e. above and beyond what individual Executives may be required to do, as part of their mandatory training. This covers Health & Safety, Fire safety, and Moving & Handling. The Risk and Compliance Manager will be in attendance at the Trust Board meeting to respond to any queries Board Members may have on this, or any other aspect of the report.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To approve the work programme for 2018/19

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2018/19

Requested/ Required by:

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

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

Other contributors: Head of Fire, Safety and Compliance,
Occupation Health Manager,
Local Security Management Specialist,
Radiation Protection Adviser,
Falls Prevention Practitioner,
Vascular Access Specialist Practitioner

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

Directorate: Quality and Governance

Health and Safety – Annual Board Report and Programme for 2018

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2017/18. • Assessment against objectives and KPI's set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPI's for 2018/19. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

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

Contents

1. Executive Summary

Introduction

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2018/19
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2017/18.
- Assessment against objectives and KPI's set in the previous year.
- Discussion of the key health and safety issues identified within the year.
- Discussion document for the Board to determine the objectives and KPI's for 2017/18.
- Identifies the strategy and action plan for the next year and going forward.

Staff, contractor and visitor incident statistics make up 15.8% of the total incidents reported, which is dominated by patients incidents (71.2%). There are many programmes and initiatives for patient safety so this report concentrates on staff safety only.

Highlights

- Specific objectives have been completed from 2016/17, though there remain a number of areas where ongoing objectives have been carried over.
- Overall reporting rates have increased by 14% compared with 2016/17.
- Injury rates have decreased by 39% and the number of incidents reported under RIDDOR decreased by 35% from 37 in 2016/17 to 24 in 2017/18.
- Sharps injuries decreased by 31%, though this was the largest injury category (23%). There were more RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV). There remains under reporting when compared with Occupational Health referrals.
- Violence and aggression injuries saw a 50% decrease.
- Falls accounted for 18% of injuries with a 39% decrease.
- There has been a decrease in moving and handling injuries as well as injuries as a result of collisions, traps or being struck by something.
- Occupational ill health Datix reporting remains low and has seen a decrease.

Health and Safety Executive

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

In December 2017 an Improvement Notice was issued to the Trust following a scheduled inspection to the CL3 Laboratory at Maidstone Hospital. This was rescinded upon re-inspection.

2. Introduction

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

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

Staff, contractor and visitor incident statistics make up 15.8% of the total incidents reported. This group, however, make up 30.8% of the total injuries. These have been divided into groups based on severity:

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

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 94.4% of the total injuries fit into these categories. This allows for bench marking against all industry and the health sector:

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

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

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

3. Review of Objectives and Programme set for 2017/18

In September 2017 the Trust Board agreed a programme for 2017/18:

Action	Leads	Progress and Comments
Health and Safety Management		
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Head of Fire, Safety and Compliance (Estates)	System providers have not provided necessary upgrades to Synbiotix despite numerous assurances. Potential alternatives are being explored.
Through training and manager awareness increase the number of RIDDOR incidents reported to HSE within required timescales.	Head of Fire, Safety and Compliance (Estates)	75% compliance, which is a decrease from 2016/17. There has been an increase in the proportion of over 7 day injuries which has had an effect on the % of reports submitted within HSE timescales.
Increase overall reporting rates for staff/ public/ Trust incidents on Datix following 13% decrease in 2016/17	Risk and Compliance Manager	There was a 14% increase in reporting rates in 2017/18.

Action	Leads	Progress and Comments
Through analysis of incident data, safe systems and risk assessment, as well as increased awareness campaign, reduce the number of traps, struck and collision type incidents	Head of Fire, Safety and Compliance (Estates)	Increased focus in training and Governance Gazette article. There was a 38% reduction in these types of incidents.
Falls		
Continue with awareness and training to further reduce staff falls.	Falls Prevention Practitioner/ Risk and Compliance Manager/ Head of Fire, Safety and Compliance (Estates)	Training and awareness has continued throughout year. Notices issued during higher risk periods, e.g. icy weather. A range of traffic management measures have been introduced in the past year such as knee fencing and new pedestrian walkways to discourage use of unauthorised routes. 41% reduction in reported injuries from staff falls
Slip, trip and falls incidents involving members of public. Investigations into RIDDOR incidents to be carried out by Trust H&S Advisor (now Head of Fire, Safety and Compliance (Estates) wherever possible.	Head of Fire, Safety and Compliance (Estates)	Head of Fire, Safety and Compliance (Estates) has taken lead in investigating these types of incidents. Other measures put in place to discourage use of unauthorised paths. Reduction from 9 RIDDOR incidents involving members of the public in 2016/17 to 0 in 2017/18.
Radiation Protection		
Control of Electromagnetic Fields at Work Regulations 2016	Radiation Protection Advisor/ EME and Technical Services Manager	A risk assessment tool was developed and the majority of equipment in the Trust has been assessed and declared safe. The last phase of the project will be to carry out more detailed assessments on the remaining small number of generic equipment types which have not been assessed.
Compliance with revised legislation: The Ionising Radiations Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Radiation Protection Advisor	An action plan has been developed and is being monitored. Compliance with the previous regulations leads to compliance with much of the new regulation. The action plan is progressing and there are a number of points which have been completed. There are a variety of working groups completing other actions.
Violence and abuse		
To continue with the programme of access control upgrade at Maidstone Hospital	LSMS	The upgrade was completed end of 2017
To continue with the programme of CCTV roll out at MGH	LSMS	The installation was completed in 2017 and additional cameras continue to be added as required
To ensure security team is fully trained in missing patient procedures, control and restraint and dementia awareness	LSMS and Corps of Security; Lead Nurse Dementia	Missing patient procedures have been covered but continue to be updated with reflective practice after events. Control and restraint training will be completed August 2018 Dementia awareness has been delivered through 1:1 training via LSMS and Lead Nurse Dementia. This is ongoing training.
Moving and Handling		
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	M&H Co-ordinator	External provider to review status of moving and handling assessments and training provision
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.		

Action	Leads	Progress and Comments
Improve knowledge of clinical staff for the sizing of patient hoist slings, correct fitting to the hoist sling bars, positioning of sling bar and lift strap.		This is partly covered in the Falls Prevention and Moving and Handling training.
Improve staff awareness of the actions to take following a patient fall, correct equipment selection for a variety of scenarios including immobilisation, correct use of individual equipment items and compatibility of items that can be used together appropriately and correctly.		This is covered in the Falls Prevention and Moving and Handling training. Previously jointly provided by Moving and Handling Co-ordinator and Falls Prevention Practitioner. Currently provided by the Falls Prevention Practitioner.
A consistent standard of training delivery to all staff likely to be involved with the care, treatment, handling and transfer of patients with suspected or actual spinal injury this patient group is in place.		Partly covered by the Falls Prevention And Moving and Handling session. Training and competency document provided to staff.
Sharps		
The sharps task and finish group will continue to use all means to change staff attitude and the embedded medical sharps culture.	Head of Fire, Safety and Compliance (Estates)	The Sharps Group has continued to meet. More work has been carried out to identify gaps in knowledge and staff attitude towards safety sharp usage.
Analyse the injury data for 2016/17 and compare with previous data set. Highlight learning.	Risk and Compliance Manager	Sharps injury numbers have continued to reduce however it remains a significant cause of injury. RIDDOR incidents related to exposure to known BBV are up, which is a concern.
Continue to review new safety devices in the market place across the Trust.	Vascular Access Specialist Practitioner	The trust has acquired as a temporary replacement for unavailable stock, a safety Huber needle and a safety arterial blood gas syringe with needle. We are also in the process of trialling a safety cannula for the paediatric department to replace their current non-safety device.
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Vascular Access Specialist Practitioner	Trust wide training was conducted by the company representatives for the safety butterfly needle which surveys identified was being incorrectly activated by a large percentage of trust staff, despite indicating confidence with their use of safety devices.
Occupational Health		
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Risk and Compliance Manager	A safety alert was subsequently determined not to be the most appropriate method of increasing awareness. This was discussed at the Health and Safety Committee as reporting levels remain low and much work is being carried out across the Trust to raise awareness of stress.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Head of Fire, Safety and Compliance (Estates)	This is covered on statutory and mandatory health and safety training.
Encourage staff and their managers to report work related stress and other ill health events through Datix.	Occupational Health Manager	Part of all consultations in OH now address the question of incident reporting via DATIX.
Review current health surveillance and its necessity undertaken by Occupational Health and other representatives in the Trust	Occupational Health Manager	Discussions with department managers have taken place alongside workplace visits to review current working practices and hazard avoidance / removal processes. This has helped identify the need for continued surveillance and on which staff within the

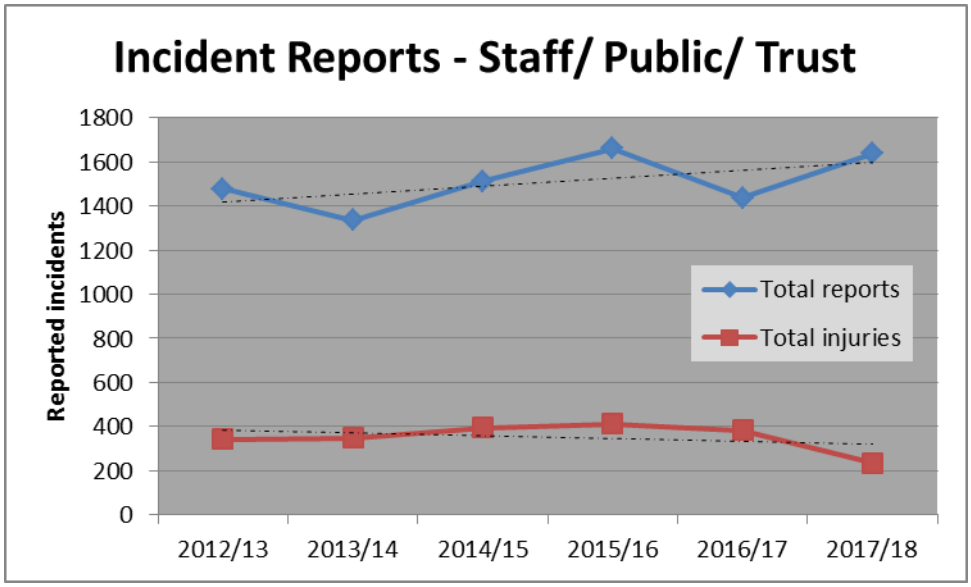
Action	Leads	Progress and Comments
		department require it.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Occupational Health Manager	Managers are made aware at the point of any referral of their responsibility in keeping risk assessments up to date. During health surveillance cycles, risk assessments are reviewed.

4. Statistics for 2017/18

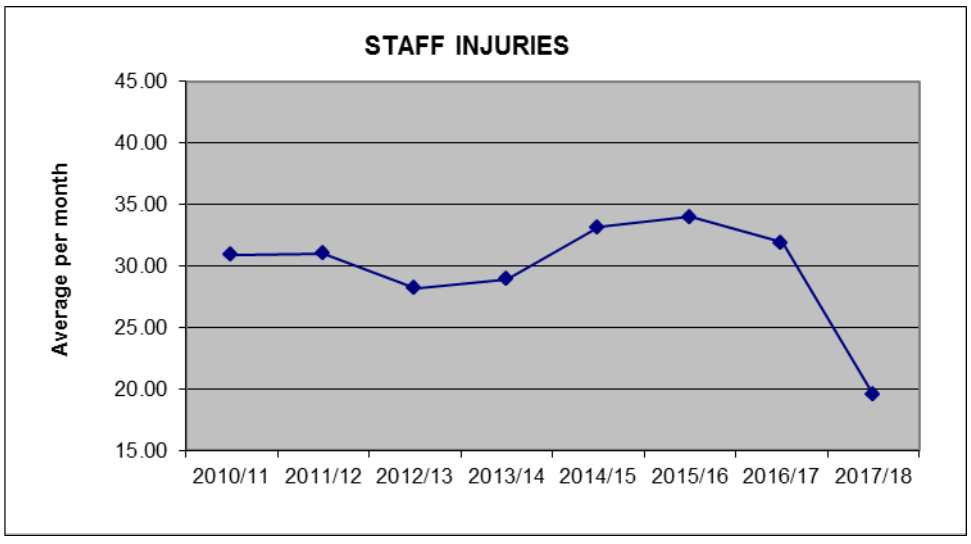
The Datix incident database was interrogated for all non-patient injuries for the period of 01/04/17-31/03/18.

4.1. Reporting

There were 1638 staff/ public/ Trust incidents reported in 2017/18. This is a 14% increase from 1436 the previous year and a return to the levels reported in 2015/16.



The ratio of reports to injuries has increased significantly to 7 reports for every injury from 3.8 reports per injury in 2016/17.

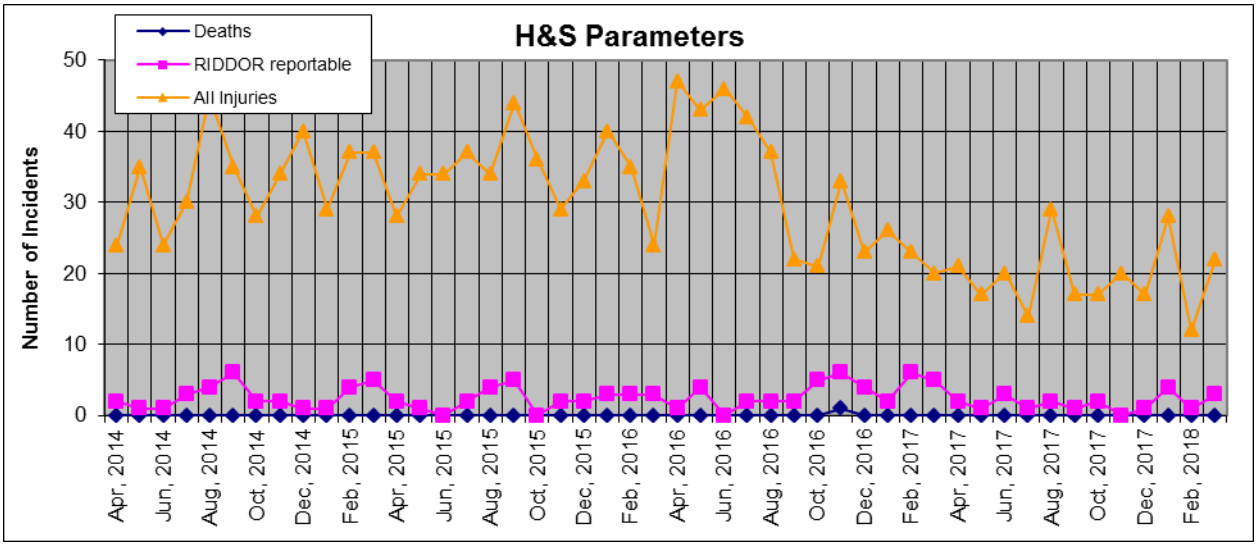


The total number of staff/ public/ Trust injuries reported dropped by 39% to 234 from 381. This figure makes up 30.8% of total injuries.

4.2. Injuries

The data for 2017/18 has been compared with the data from previous 3 years.

The Trust submitted 24 RIDDOR reports in the year at an average of 2 per month. This is a significant decrease from 3.08 the previous year. 75.0% of RIDDOR reports were submitted on time, a decline from 86.5% for 2016/17.



The increase in overall reporting rates, combined with a reduction in injury rates by 39% and RIDDOR reportable incidents by 35%, is an encouraging trend.

Two-thirds of RIDDOR reports were over 7 day injuries and this has been a factor in a larger proportion not being reported within the required timescales. Of these 16 incidents, 9 were primarily caused by moving and handling (8 during patient handling, 1 non-patient handling), 5 were related to slips, trips and falls, with the remaining 2 caused by trap and crush injury.

There has been a significant decrease in the number of specified injuries, down to 3 from 14 in 2016/17. There were no RIDDOR incidents involving members of the public, compared with 9 in 2016/17.

RIDDOR Category	Year reported			
	2014/15	2015/16	2016/17	2017/18
7 Day injury	25	16	20	16
Specified injury	6	10	14	3
Dangerous occurrences	1	1	3	4
Accidental death	0	0	0	1
	32	**27**	**37**	**24**

All four of the dangerous occurrences were reported as exposure to known blood borne virus (BBV). The accidental death relates to an incident which took place in November 2016, but was not reported to the HSE until April 2017.

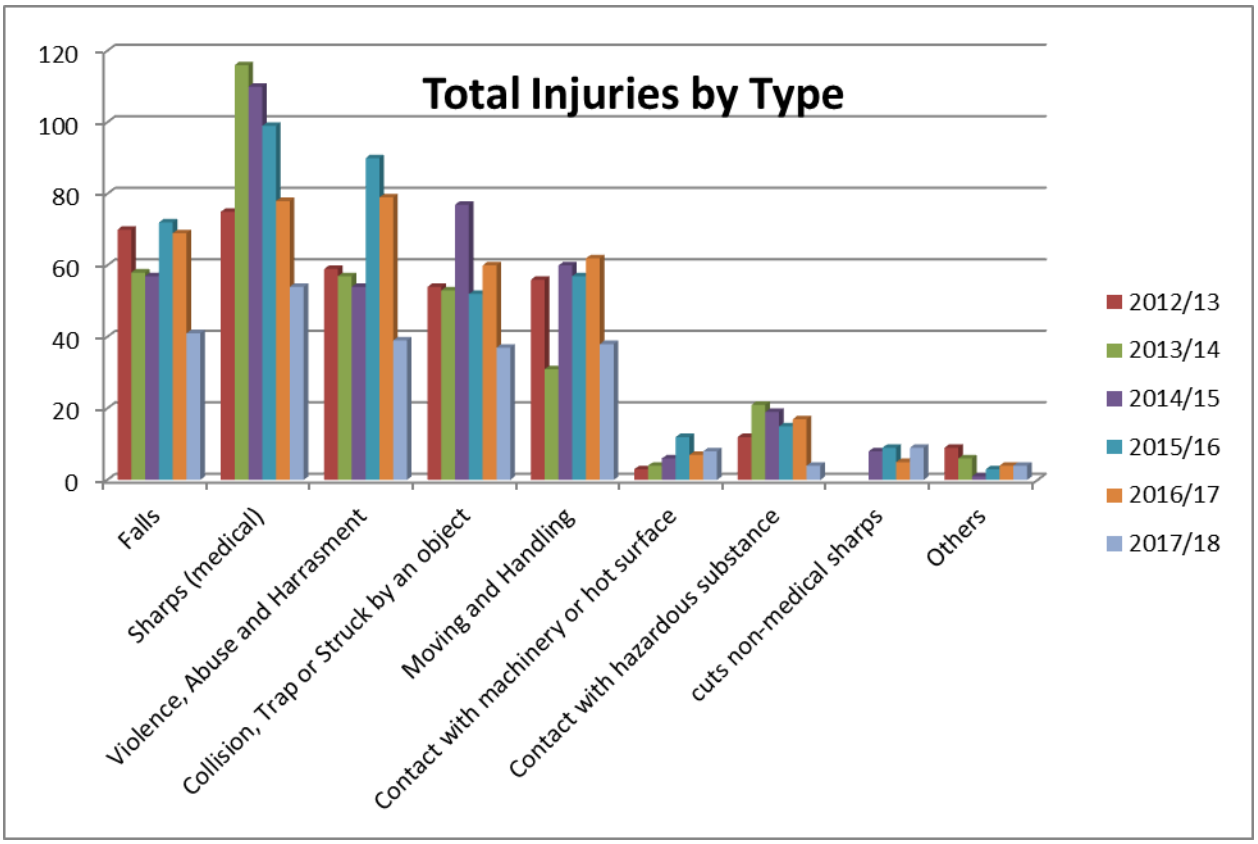
4.3. Categories of incidents resulting in injury

The seven largest categories make up 96.6% of all staff injuries. Two have increased and five have shown a decrease.

	2016/17	2017/18	% of total	Change
Falls	69	41	18%	**-41%**
Sharps (medical)	78	54	23%	**-31%**
Violence, abuse and harassment	79	39	17%	**-51%**
Collision, trap or struck by an object	60	37	16%	**-38%**
Moving and handling	62	38	16%	**-39%**
Contact with machinery or hot surface	7	8	3%	**+14%**
Contact with hazardous substance	17	4	2%	**-76%**
Cuts non-medical sharps	5	9	4%	**+80%**
Others	4	4	2%	**0%**
	381	**234**		

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

The chart below compares 2017/18 injuries by type with the previous five years:



The top five categories have all seen a significant reduction. While sharps are the largest category with 23% of total injuries, there has still been a 31% reduction when compared with 2016/17. There does, however, remain a discrepancy between sharps injuries reported and occupational health attendances (see 6.4.3 below).

4.4. Injuries by Directorate/ Specialty

The table below shows injuries by directorate/ specialty (% change in total injuries compared with 2016/17 shown in brackets):

Directorate/ Specialty	Total Injuries	Falls	Sharps (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others
A&E	22 (-60%)	0	8	7	2	3	1	1		
Corporate, Clinical Governance and Nursing	12 (-54%)	2		1	5		2		1	1
Critical Care	18 (-25%)	3	7	3	1	2	1		1	
Estates and Facilities	27 (-53%)	7			9	5	3	1	1	1
Women's Children's and Sexual Health	26 (-26%)	4	6	2	7	3		1	2	1
Surgery	12 (-61%)	1	6	1	1	2			1	
Head and Neck	4 (-43%)	1	1			2				
Cancer, Haematology and Radiology	18 (+20%)	4	4		2	6			1	1
Pathology and Pharmacy	13 (-52%)	5	6			1		1		
Planned care	13 (+44%)	1	5	1	4	2				
Specialist Medicine and Therapies	56 (-27%)	9	8	21	6	9	1		2	
Trauma and Orthopaedics	13 (+-0%)	4	3	3		3				
Total	**234**	**41**	**54**	**39**	**37**	**38**	**8**	**4**	**9**	**4**

The size of the respective directorates and the activities undertaken has a clear influence on the number and nature of injuries that occur. Most directorates have seen significant reductions in the number of reported injuries with only Cancer, Haematology and Radiology and those incidents reported under ‘Planned care’ seeing an increase from 2016/17. These figures are discussed in more detail in **Section 6** below.

4.5. Occupational ill health

2 incidents of occupational ill health were reported on Datix. This is a decrease from 2016/17.

Ill health	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Skin and dermatitis	3	1	0	0	0	0
Work-related stress	0	0	0	1	0	1
Occupational respiratory disease	0	0	0	0	1	0
Environmental causes of ill health	1	0	1	0	3	1
Total occupational ill health	**4**	**1**	**1**	**1**	**4**	**2**
Others (not occupational)	5	2	2	6	10	5

To raise awareness the need to report work place ill health via Datix is stressed during statutory and mandatory health and safety training. Staff are advised at the point of assessment to report occupational ill health via Datix. In addition, the Occupational Health Team liaises with the Risk and Compliance Manager and Head of Fire, Safety and Compliance on cases of occupational ill health that require specialist advice and guidance. However, these measures alone will not significantly increase reporting and more work is required.

5. Benchmarking

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

	RIDDOR rate per 100,000 employees
All industries (2016/17)	263
Health sector (2016/17)	384
MTW 2012/13	383
MTW 2013/14	232
MTW 2014/15	329
MTW 2015/16	324
MTW 2016/17	479
MTW 2017/18	**358**

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

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

Type of Trust	Total RIDDORs	Employees	RIDDOR Rate (per 100,000 staff)	
MTW	24	6701	**358**	2017/18
Health sector (HSE national data)			**384**	2016/17
Acute and Community Trust 1	8	3860	**207**	2017/18
Acute and Community Trust 2	32	7131	**448**	2017/18
Community NHS Trust 1	14	5500	**254**	2017/18
Hospices & Community Service	16	4250	**376**	2017/18
Private Healthcare Hospital 1	0	410	**0**	2017/18
Private Healthcare Hospital 2	1	530	**188**	2017/18
HMRG Average			**347**	2017/18

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

6. Key Health and Safety Areas

6.1 Falls

Falls account for 18% of staff/public/Trust injuries. The number of injuries from falls this year has decreased by 41% to 41. Staff account for 83% of injuries and members of the public 17%. The number of slips, trips and falls incidents reported (including near misses and no harm incidents) actually increased by 6% to 119, so the decrease in injuries cannot be attributed to a reduction in reporting rates.

Specialist Medicine and Therapies is the directorate with the most slip, trip and fall injuries, with 9.

Estates and Facilities had the second highest number with 7, though this is a significant improvement when compared to 24 in 2016/17. The number and severity of slips, trips and falls involving members of the public has reduced significantly, with 0 RIDDOR incidents compared with 9 in 2016/17. A range of traffic management measures have been introduced in the past year such as knee fencing and new pedestrian walkways to discourage use of unauthorised routes.

Falls prevention is a key patient safety agenda item for the Trust. Focused work has been carried out to increased staff awareness on the importance of reducing risk of falls in general. This includes environmental as well as personal risk factors.

6.2 Violence and Abuse

Injuries from violence accounts for 17% of all injuries and was the third highest cause of injury in 2017/18 with 39 incidents. This is a 51% decrease when compared with 2016/17. The number of incidents reported (including near misses and no harm incidents) remained steady, increasing by 2% to 217, and this was the highest directly health and safety-related incident category by number of incidents.

The LSMS has been encouraging the reporting of violence and abuse irrespective of capacity of the patient. This allows the Trust to see a truer picture of events including threatening behaviour and assault. Datix shows there were 144 assaults on staff by patients and these were all related to the patient's capacity or mental health. Staff have reported their reluctance to report patients with dementia as they feel the aggression is not the patient's fault. Whilst this is true, the lack of reporting can lead to lack of resourcing and support. It can also lead to lack of information sharing, which may in turn lead to further assaults.

Staff have been subjected to violent attacks by patients, and in many cases wards have been unable to source a Registered Mental Health Nurse (RMN) to special their patients, even if the patient is under section or under a Deprivation of Liberty Safeguard. Often a CSW or a security officer is left alone with a violent patient, and neither of these staff groups is adequately skilled to deal with this type of patient.

Security officers can be requested to support ward staff in the event of managing a violent patient, but this needs to be collaborative.

By the end of August 2018 the security team will all be trained in control and restraint techniques. The training is being provided by the security department at Guy's and St Thomas' and is accredited by MAYBO.

6.3 Moving and Handling

Moving and handling incidents account for 16% of staff injuries. There was a 39% decrease in injuries, in line with the overall trend.

The Moving and Handling Co-ordinator retired in August 2017, with training covered by an external provider since January 2017.

6.4 Sharps/ splash

6.4.1. Medical sharps

Injuries from medical sharps fell by 31% from 78 to 54. The overall number of reported incidents (including near misses and those recorded as no obvious harm) fell by 17% to 95.

In 2016/17 there were three RIDDOR reportable sharps/ splash dangerous occurrences. In 2017/18 there were four, with two needle stick injuries, one eye splash, and one direct contact with open wound where exposure to BBV was confirmed. To date there has been no HSE follow up on these incidents.

A Trust wide survey was instigated by the Sharps/Splash Group into use of safety sharps and incident reporting. It was found that a majority of those surveyed were not conversant with the correct use of safety sharps, however most were aware of the need to report incidents involving sharps. The Sharps/Splash Group will continue to promote sharps safety and change the embedded culture.

The Vascular Access Specialist Practitioners have continued to train all new medical staff, through induction programmes, for Blood Cultures and where appropriate in Venepuncture and Cannulation. Sharps injuries and best practice in handling medical sharps is discussed. Practical skills stations facilitate competency assessment and serve to highlight poor practice.

Nursing staff attending study days on Intravenous Therapy, Venepuncture and Cannulation and Central Venous Access Devices also receive training on sharps injuries and best practice in handling medical sharps. Staff are provided with a selection of supervised clinical skills stations with high staff to student ratios, to practise their technique in a safe and supported environment.

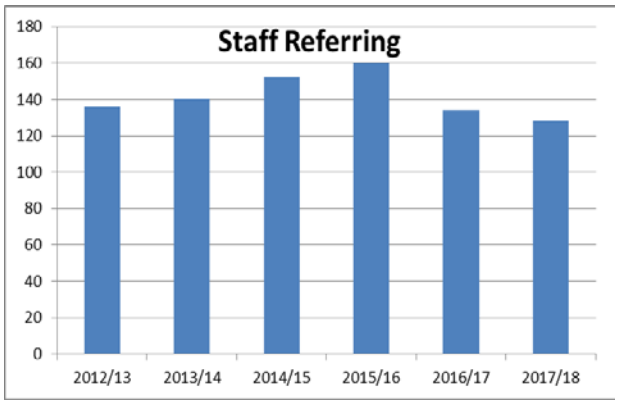
Every opportunity to engage company representatives in the Trust wide training of staff in the correct handling and disposal of medical sharps has been undertaken, especially coinciding with either the introduction of a new medical sharp or the change of an existing medical sharp device. Company- led Trust wide training is viewed as an essential element when considering new devices for trial and potential introduction to the Trust.

6.4.2 Eye Splash Injury

While only 4 injuries were reported, including near misses and those recorded as 'No obvious harm', there were 26 eye splash incidents in the Trust, an increase from the 21 eye splash incidents reported in 2016/17. One was reportable under RIDDOR due to exposure to known BBV.

6.4.3 Sharps/ Contamination Injury Comparisons

Occupational Health reported that 128 staff had been referred following sharps/contamination injury. This was compared against Datix incidents and it was found that only 75 of those that attended occupational health had also completed a Datix form. In addition, there was a proportion that had completed a Datix report but not attended OH.



There were also 37 incidences were the Datix submission was completely incorrectly and an injury was suffered but it was reported as 'no harm'.

More education is required on the need to report sharps/ splash incidents accurately.

6.5 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, bad housekeeping and rushing around and are often associated with moving and handling activities. In 2016/17 there were 60 injuries. This year this has decreased by 38% to 37 injuries. Estates and Facilities are the largest reporter with 24% of the total, though their total has decreased by 44% when compared with 2016/17.

This reduction is in line with the lower injury rates seen elsewhere, though there has also been a reduction in the number of incidents reported by 29%. Whether these trends can be attributed to increased emphasis and awareness or if it is down to staff not reporting is unclear.

6.6 Machinery, Hot Surfaces and Fluids

Burn/scald injuries has remained steady, with 8 injuries compared with 7 in 2016/17.

7. Health and Safety Executive Inspections and Investigations in 2017/18

7.1 Trust Inspection

During a recent HRMG meeting, a HSE operations manager announced that the HSE plan to inspect two Trusts in the South East during 2018/19, one acute trust and one mental health trust. The focus will be on two main areas – moving and handling and violence and aggression.

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

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

The memorandum of understanding between the HSE and CQC means that the CQC is the primary enforcing agency for certain incidents reported under RIDDOR.

7.2 Investigation Visits

An Improvement Notice was issued to the Trust following a scheduled inspection to the CL3 Laboratory at Maidstone Hospital in December 2017. An action plan was out into place and following re-inspection in February 2018 the Improvement Notice was rescinded.

7.3 HSE Priorities, Projects and Targets

The HSE's 5 year "Helping Britain Work Well" strategy will continue in 2018/19, focusing on the highest-risk sectors and widening the reach of the campaign to new audiences.

The next phase of the Health and Work programme, with its focus on reducing levels of occupational lung disease, musculoskeletal disorders and work-related stress will be delivered.

Proactive inspection of health care organisations will take place in 2018/19, concentrating on moving and handling and violence and aggression.

8. Summary and Conclusions

- Specific objectives have been completed from 2016/17, though there remain a number of areas where ongoing objectives have been carried over.
- There were 1638 staff/ public/ Trust incidents reported in 2017/18. This is a 14% increase from 1436 the previous year and a return to the levels reported in 2015/16.
- Our data shows that around 31% of reported injuries relate to staff, contractors and visitors and 68% relate to patients.
- The Trust submitted 24 RIDDOR reports in the year at an average of 2 per month.
- The increase in overall reporting rates, combined with a reduction in injury rates by 39% and RIDDOR reportable incidents by 35%, is an encouraging trend.
- There has been a significant decrease in the number of specified injuries reported under RIDDOR, down to 3 from 14 in 2016/17. There were no RIDDOR incidents involving members of the public, compared with 9 in 2016/17.

- The increase in the proportion of over 7 day injuries has contributed to late reporting to the HSE, but more vigilance on the part of all involved in the process is required.
- Sharps were the largest single injury category, with 23% of total. The overall reporting rate for sharps was 17% lower than 2016/17.
- All four of the dangerous occurrences reported were as a result of exposure to known blood borne virus (BBV), with 2 needle stick, 1 eye splash and 1 direct contact to open wound.
- Comparing reported sharps and splash injuries with occupational health attendances indicates only 58.6% that attended OH reported the incident on DATIX.
- Falls accounted for 18% of reported injuries with a 41% decrease. It remains a key focus area for the Trust.
- Violence and aggression reported injuries saw a 51% decrease, going from the top injury category in 2016/17 to third in 2017/18. This is with an increase in overall reporting by 2%.
- There has been a decrease in reported moving and handling injuries.
- Occupational ill health Datix reporting remains low. This is not unusual but ongoing vigilance and communication to raise reporting levels is needed.

9. Objectives for 2018/19

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Health and Safety Management (Head of Fire, Safety and Compliance)					
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Determine viability of Synbiotix and comparable systems By 31/12/18	Head of Fire, Safety and Compliance (Estates)	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Minimum of 75% compliance with aspiration towards 85% - 90%. This takes into consideration that this will be major revision of system.
Through training and manager awareness increase the number of RIDDOR incidents reported to HSE within required timescales.	Increase reporting rate to 90% and achieve this for the year end.	Head of Fire, Safety and Compliance (Estates)	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Aim for 90% of RIDDOR incidents to be reported on time.
Through training, communications and feedback raise awareness of what constitutes harm and no harm when reporting incidents, particularly violence and aggression and sharps/ splash incidents	By 31/03/19	Head of Fire, Safety and Compliance (Estates)	Risk and Compliance Manager	Datix reports monitoring and approval; Health and Safety Committee	Increase in correct reporting through the monitoring and close out of Datix incidents.
Proactive accident and incident prevention by introduction of planned Health and Safety/ Fire Safety Inspections including all satellite areas	Throughout 2018/19	Head of Fire, Safety and Compliance (Estates)	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	90% compliance year end with inspection plan.
Falls (Falls Prevention Practitioner)					
Continue with awareness and training to further reduce staff falls.	(The focus of the falls team is on reducing Patient falls)	Falls Prevention Practitioner / Risk Health and Safety Team	Trust H&S Advisers	Continue with regular refresher training. All falls will be investigated	Continue with awareness and training to further reduce staff falls.
Slip, trip and falls incidents involving members of public.	Throughout the year	Head of Fire, Safety and Compliance	Risk and Compliance	Progress will be monitored by lead,	Objective measure of investigation quality

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Investigations into incidents to be carried out by Head of Fire, Safety and Compliance wherever possible.			Manager	through RIDDOR panels and reported to the H&S committee	
Environmental Hazards to be reviewed annually by departments and wards.	Annual review	Department/ward Manager	Risk and Compliance Manager	Monitored by Directorates, Divisions	Hazard profile checklist completed and relevant risk assessment in place.
Radiation Protection (Radiation Protection Advisor)					
Control of Electromagnetic Fields at Work Regulations 2016	Throughout the year	Radiation Protection Adviser / EME and Technical Services Manager	Risk and Compliance Manager	Progress will be monitored by leads and reported to the H&S committee.	Risk assessments and work plans have been developed for the remaining items of Medical Equipment to complete the assessment of the full Trust inventory. There is a process for assessment of new devices.
Compliance with revised legislation: The Ionising Radiations Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Throughout the year	Radiation Protection Adviser	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Completion of objectives in accordance with the Trust action plan.
Violence and abuse (Trust Security Manager)					
To continue with the programme of access control upgrade at Maidstone Hospital and identify areas of weakness at TWH	Identify areas most vulnerable and work with departmental leads. Identify funding. April 2019	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	Additional access control in key areas and a reduction in risk and vulnerability to these areas
To continue with the programme of CCTV roll out at MGH and at TWH	Areas of weakness have been identified and a roll out programme costed. April 2019	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	CCTV installed in areas of weakness

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA	Provide 1:1 sessions and utilise Trust specialists. April 2019	Trust Security Manager and Corps of Security	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	All security staff trained in areas identified
Moving and Handling					
External provider to review status of moving and handling assessments and training provision before Moving and Handling objectives can be set					
Sharps/Splash (Sharps/Splash Working Group)					
The Sharps/Splash working group will continue to use all means to change staff attitude and the embedded medical sharps culture	Throughout the year	Head of Fire, Safety and Compliance (Estates)	Sharps/Splash Working Group	Sharps/Splash Working Group will report to medical device and H&S committees.	Decrease sharp injuries again this year.
Analyse the injury data for 2017/18 and compare with previous data set. Highlight learning.	By August 2018	Risk and Compliance Manager	Sharps/Splash Working Group		
Continue to review new safety devices in the market place across the Trust.	Ongoing in 2018/19	Vascular Access Specialist Practitioners	Procurement	Sharps/Splash Group will report to medical device and H&S committees.	Compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013.
Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Complete in 2018/19	Vascular Access Specialist Practitioner	Sharps task and finish group.	Sharps/Splash Group will report to the H&S committee.	Reduce injuries as a result of lack of training
Occupational Health (Occupational Health Manager)					
Increase awareness of the need to report work place stress and other ill health events on Datix	Complete throughout 2018/19	Head of Fire, Safety and Compliance (Estates)/ Risk and Compliance Manager	Learning and Development	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Encourage staff and their	Complete	Occupational Health	Occupational	Reported to H&S	Comparison of numbers

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
managers to report work related stress and other ill health events through Datix.	throughout 2018/19	Manager	Health Department	Committee via Occupational health report.	referred to numbers reported.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Complete throughout 2018/19	Occupational Health Manager	Risk Lead	Reported to H&S Committee via Occupational health report.	New job roles / practices identified for health surveillance or PPE / risk avoidance where possible.
Reduce the gap between sharps / splash injuries reported on DATIX and the OH system.	Complete throughout 2018/19	Occupational Health Manager	Risk Lead	Reported to H&S Committee via OH reporting and DATIX reports.	Only 58.6% attending OH reported on DATIX. Aim to significantly reduce this figure.

Appendix A

2018/19 Training update - What does the Board need to know?

1. Health and safety

1.1. Healthcare prosecutions 2017/18

Following the change in the sentencing guidelines, as described in the 2017/18 Annual Board Report, the level of fines has increased. The following notable prosecutions by the HSE and the CQC of NHS Trusts took place in 2018/19:

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
06/17	Surrey and Borders Partnership NHS Foundation Trust	05/14	Patient suffering from mental-illness fell to his death from a hospital's industrial chimney	£300,000 + costs	HSE	*Management of absconding patients and failure to learn* A series of failures to ensure the risk associated with absconding was properly managed. Inadequate communication and failure to make appropriate changes following at least 9 previous incidents.
07/17	United Lincolnshire Hospitals NHS Trust	04/12	Patient died after falling on exposed metal post on standing aid hoist	£1m + costs	HSE	*Training and monitoring* No systems for training and monitoring how staff used the standing aid hoist.
10/17	Southern Health NHS Foundation	12/15	Patient fell from a low roof and sustained serious neck	£125,000 + costs	CQC	*Failure to learn*

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
	Trust		injuries			7 patients had previously tried to abscond over same low roof.
11/17	Shrewsbury and Telford Hospital NHS Trust	06/11-11/12	Five patients sustained fatal injuries after falling during 18 month period	£333,333 + costs	HSE	*Lack of supervision* Lack of close supervision of those in confused mental state and poor communication about the measures to stop patients falling.
12/17	Chelsea and Westminster NHS Trust and Imperial College London	10/11	Geneticist found dead. He had been lone working freezing blood samples and entered room to fill flask of liquid nitrogen. The local exhaust ventilation (LEV) had been switched off.	Chelsea and Westminster £70k + costs; Imperial College £80k + costs	HSE	*Lack of safe systems of work and inadequate maintenance* No system to prevent LEV being switched off, inadequate maintenance of equipment and allowing lone working with liquid nitrogen.
03/18	Southern Health NHS Foundation Trust	04/12	Patient found slumped and unconscious having used phone cord as ligature. Died a short time later.	£950,000 + costs	HSE	*Failure to learn* There had been a history of patients using phone cords as ligature. Previous H&S Audit identified the risk but was not acted upon.
		07/13	Patient died after suffering epileptic seizure in bath	£1.05m + costs		*Lack of supervision* There had been a number of

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
						warning signs and patient should not have been allowed to take bath alone.
04/18	Royal United Hospitals Bath NHS Foundation Trust	07/15	Patient died from legionnaires' disease contract on ward.	£300,000 + costs	HSE	*Lack of monitoring/ testing* Annex where incident took place was on separate loop of water system. This was unknown and the required legionnaires' checks and tests between 2009 and July 2015 did not take place.

Only prosecutions involving NHS Trusts have been outlined above. There have also been a number of prosecutions involving private health and social care providers from which learning can be obtained. Whether the same kinds of incidents could take place at MTW need to be considered and, if they could, the further mitigation that is required. If the Trust is assured that suitable and sufficient controls are in place then these need to be monitored and maintained.

1.2. ISO 45001:2018

A new international standard for Health and Safety Management Systems was launched in April 2018. In the UK this replaces OSHAS 18001, with OSHAS 18001 accredited organisations having 3 years to 'migrate' to the new standard.

The main change is that ISO 45001 concentrates on the interaction between an organization and its business environment while OHSAS 18001 was focused on managing OH&S hazards and other internal issues. It is more process based and considers opportunities in addition to risks as well as the views of external stakeholders.

Senior management commitment requires stronger evidence than in the previous standard, as does the requirement for consultation with staff.

Currently the Trust's Estates and Facilities Department is OHSAS 18001 accredited. The nature of the new standard might make it difficult for a single department/ directorate to receive accreditation to the new standard. Interserve, who manage the TWH estate, are already ISO 45001 accredited.

2. Moving and Handling

In 2017/18 over 56% of Trust RIDDOR reportable over 7 day injuries were linked to moving and handling. As the ratio of specified injuries decreases through the risk reduction strategies outlined in the Annual H&S Board Report, the proportion of RIDDOR incidents caused by moving and handling increases.

The HSE will be inspecting selected acute Trusts in 2018/19 with a focus on moving and handling. The Trust needs to remain vigilant to ensure its moving and handling risk control strategy, which is faced on a daily basis by a variety of staff groups, is fit for purpose and protects staff and patients.

2.1. Training

Training in moving and handling is part of the statutory and mandatory programme and compliance can be monitored, but training alone is unlikely to reduce the risk.

2.1.1. Effective training

Practical training which is task-based and is in, or accurately simulates, the work environment has been found to be more effective in changing behaviour than technique or education-based training (Burke et al, 2006; HSE, 2007; McDermott et al, 2012).

2.1.2. Health priority plan

The HSE's new health priority plan for musculoskeletal disorders (MSDs) aims for a shift in emphasis away from manual handling training and up the hierarchy towards risk elimination or reduction through work design and organisation (Pinder, 2018).

2.2. Risk assessment

The HSE's plan is not a new concept as is evident by the Moving and Handling Operations Regulations (1992) themselves and their requirement to avoid hazardous manual handling so far as is reasonably practicable. Where it cannot be avoided it must be assessed and measures put in place based on the assessment to reduce the risk. There is clear guidance given on how to do this, however, hazardous moving and handling tasks are not always consistently assessed.

The TILE (TASK, INDIVIDUAL, LOAD, ENVIRONMENT) acronym is well-known and is given in theory on most training courses and in most training packages. It provides structure to both dynamic and formal risk assessments. The Trust's moving and handling risk assessments should consider these elements. Generic moving and handling risk assessments were formerly reviewed by the Moving and Handling Coordinator and are overdue for review (see **9.0 Objectives for 2018/19** in Annual Report).

2.3. Incident management

In terms of reactive risk management, investigations into moving and handling-related incidents can tend to focus on the training element, without first considering what it was about the task itself, work environment and other psycho-social factors that could have been contributory factors. There are plans to roll out both investigation and root cause analysis training in 2018/19. Wider reaching investigation should lead to recommended controls higher up the hierarchy of risk control which do more for more in reducing the risk.

2.4. Summary

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

3. Fire Safety

A recent external audit into the Trust's fire risk management systems and processes recommended that in addition to a Fire Policy and Procedure a Fire Safety strategy was required. An outline of the objectives and key Board-level roles and responsibilities is outlined below.

3.1. Fire Safety Strategy

The aim of the strategy is the provision and maintenance of a safe environment for all staff, visitors, relevant persons and patients throughout the Trust in order to reduce the risk to loss of life, personal injury, as well as property and business losses.

The Trust is committed to protecting the health, safety and welfare of staff, patient's visitors and all relevant persons, its assets, business activities and opportunities against fire. It is the intention of the Trust in respect of every building in order to meet the objectives:

- Provide and maintain passive and active fire protection measures according to the purpose or use of the building, the number of occupants and the activities undertaken therein;
- Carry out a fire risk assessment to assess buildings and process fire risks, the existing preventative and proactive measures and identify areas for improvement;

- Prepare an action plan identifying the requirements of fire safety in accordance with the fire risk assessment;
- Establish a programme of works to improve or maintain the existing fire safety specifications;
- Prepare and keep under review building specific fire safety plans;
- Establish clear lines of responsibility and authority for day to day fire safety management;
- Identify competent persons with the responsibility for initiating the fire evacuation procedure and provide information and assistance to the fire service;
- Carry out regular reviews on all fire risk assessments.

3.2. Roles and Responsibilities

Chief Executive (Responsible Person)

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

Chief Operating Officer

Has nominated responsibility for drawing up and maintaining comprehensive fire precautions, fire policies, fire strategies, programmes of improvements to include in the Trusts annual business plan, and will involve managers at each level of the Trust in the process as appropriate.

References

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McDermott, H., Haslam, C., Clemes, S., Williams, C., and Haslam, R. (2012) Investigation of manual handling training practices in organisations and beliefs regarding effectiveness, *International Journal of Industrial Ergonomics*, 42, 2, 206-211.

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Trust Board meeting – September 2018

NHS
Maidstone and Tunbridge Wells NHS Trust

9-17	Ratification of Health & Safety Policy and Procedure	Chief Operating Officer / Risk and Compliance Manager

"Ratification" of a policy is the act of giving final authorisation for a policy's use within the Trust. Ratification is usually only given by the Trust's Policy Ratification Committee (PRC), but under the Trust's "Reservation of Powers and Scheme of Delegation", the Trust Board reserves the authority to ratify 3 Trust-wide policies: The Risk Management Policy and Procedure, the Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies"), Health & Safety Policy and Procedure.

The latter is due for its routine review, and has been duly reviewed/revised, consulted and approved (by the Health and Safety Committee). For policies that are ratified by the Trust Board, the Policy Ratification Committee (PRC) undertakes a review, and considers whether to recommend that the Board ratifies the document. That PRC review took place on 19/07/18 and the policy and its Appendices are now submitted for ratification.

Which Committees have reviewed the information prior to Board submission?

- Health & Safety Committee, 10/08/18
- Policy Ratification Committee, 19/07/18

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

Ratification

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

Maidstone and Tunbridge Wells NHS Trust

Health and Safety Policy and Procedure

Target audience:	All Trust staff
Author:	Risk and Compliance Manager **Contact details:** Ext. 24581; **email:** rob.parsons@nhs.net
Other contributors:	Head of Fire, Safety and Compliance
Executive Lead:	Chief Operating Officer
Directorate:	Corporate
Specialty:	Corporate (Risk)
Supersedes:	Health and Safety Policy and Procedure (Version 11.0: July 2015)
Approved by:	Health and Safety Committee, 7th June 2018
Recommended for ratification by:	Policy Ratification Committee, 19th July 2018
Ratified by:	The Trust Board, 27th September 2018
Review date:	September 2022

Maidstone and Tunbridge Wells NHS Trust

Document history

Requirement for document:	• To state the Trust's and management commitment to health and safety • To set out the organisational health and safety management structure • To identify and indicate health and safety responsibilities • To meet Health and Safety at Work etc. Act 1974 Section 2(3) duties • To meet the NHS staff council Workplace Health and Safety Standards
Cross references (external):	1. Health and Safety at Work etc. Act 1974. Available at: www.legislation.gov.uk/ukpga/1974/37/contents 2. Management of Health and Safety at Work Regulations 1999. Available at: www.legislation.gov.uk/uksi/1999/3242/contents/made 3. Safety Representatives and Safety Committees Regulations 1977. Available at: www.legislation.gov.uk/uksi/1977/500/contents/made 4. Health and Safety (Consultation with Employees) Regulations 1996. Available at: www.legislation.gov.uk/uksi/1996/1513/contents/made 5. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Available at: www.legislation.gov.uk/uksi/2013/1471/contents/made 6. Provision and Use of Work Equipment Regulations (PUWER) 1998. Available at: www.legislation.gov.uk/uksi/1998/2306/contents/made 7. Health and Safety Executive (HSE) (2013) *Leading health and safety at work,* INDG417, HSE. 8. Health, Safety and Wellbeing Partnership Group (2013) *Workplace health and safety standards*, The NHS Staff Council.
Associated documents (internal):	• Approval Policy and Procedure for Research and Development [RWF-OPPPCS-NC-CG35] • Artificial Optical Radiation Safety Policy and Procedure [RWF-OPPPCS-NC-CG15] • Bomb and Suspect Package Policy and Procedure [RWF-OPPPCS-NC-EST1] • Bullying and Harassment Policy and Procedure [RWF-OPPPCS-NC-WF24] • Central Alerting System Policy and Procedure (CAS) [RWF-OPPPCS-NC-CG24] • Clinical and Professional Registration Policy and Procedure [RWF-OPPPCS-NC-WF56] • Control of Substances Hazardous to Health (COSHH) Policy & Procedure [RWF-OPPPCS-NC-CG16] • Display Screen Equipment Policy and Procedure [RWF-OPPPCS-NC-CG17]

	• Environmental Disinfection Policy and Procedure [RWF-OPPPCSS-C-PATH11] • Fire Safety Policy and Procedure [RWF-OPPPCS-NC-CG4] • First Aid in the Workplace Policy and Procedure [RWF-OPPPCS-NC-CG41] • Guidance on Risk Register Administration and Review [RWF-OPPPCS-NC-CG14] • Hand Hygiene Policy and Procedure [RWF-OPPPCSS-C-PATH13] • Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] • Induction Policy and Procedure [RWF-OPPPCS-NC-WF19] • Infection Prevention and Control Policy and Procedure [RWF-OPPPCSS-C-PATH15] • Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Policy and Procedure [RWF-OPPPCSS-C-RAD1] • Ionising Radiation Safety Policy and Procedure [RWF-OPPPCS-NC-CG18] • Lone Worker Policy and Procedure [RWF-OPPPCS-NC-FH1] • Major Incident Plan [RWF-OPPP-CS-NC1] • Management and Prevention of Sharps/Splash Injuries Policy and Procedure (incorporating Blood Borne Virus Exposure [RWF-OPPPCS-C-WF5] • Management of Legal Claims Policy and Procedure [RWF-OPPPCS-NC-CG30] • Management of Stress at Work Policy and Procedure [RWF-OPPPCS-NC-WF3] • Medical Devices Policy and Procedure [RWF-OPPPCS-NC-EST2] • Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1] • Policy and Procedure for Application of the Construction, Design & Management Regulations (CDM) to Trust Estates Project Works [RWF-OPPPCS-NC-EST4] • Policy and Procedure for Management and Prevention of Non-Patient Slips, Trips and Falls [RWF-XXXXXX-XX-XX] • Policy and Procedure for Management of Concerns and Complaints [RWF-OPPPCS-NC-CG31] • Policy and Procedure for the Control of Contractors [RWF-OPPPCS-NC-EST5] • Policy and Procedure for the Management and Prevention of Slips, Trips and Falls for the Adult Patient [RWF-OPPPCS-NC-CG20] • Policy and Procedure for the Management of Violence and Aggression [RWF-OPPPCS-NC-FH8] • Policy and Procedure for the Management of Water Hygiene [RWF-OPPPCS-NC-EST9]

	• Policy and Procedure for the Moving and Handling of Patients and Loads [RWF-OPPPCS-NC-FH11] • Policy and Procedure on Being Open / Duty of Candour [RWF-OPPPCS-NC-CG2] • Research Adverse Event and Safety Reporting Policy and Procedure [RWF-OPPPCS-NC-CG36] • Research Misconduct and Fraud Policy and Procedure [RWF-OPPPCS-NC-CG37] • Resilience Policy and Procedure [RWF-OPPCS-NC-TM25] • Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedure [RWF-OPPPPS-C-TIO3] • Risk Assessment Policy and Procedure [RWF-OPPPCS-NC-CG6] • Risk Management Policy and Procedure [RWF-OPPPCS-NC-CG13] • Safeguarding Adults at Risk of Harm Policy and Procedure [RWF-OPPPCS-C-NUR5] • Safety of Electrical Appliance Policy Procedure and Policy (SEAP) [RWF-OPPPCS-NC-EST8] • Security Policy and Procedure [RWF-OPPPCS-NC-FH3] • Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] • Smoke Free Policy and Procedure [RWF-OPPCS-NC-TM37] • Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) [RWF-OPPPCS-NC-WF33] • Statutory and Mandatory Training Policy and Procedure [RWF-OPPPCS-NC-WF22] • Supporting Staff Involved in Traumatic and Stressful Incidents, Complaints or Claims Policy and Procedure [RWF-OPPPCS-NC-WF59]

Keywords:	Health and Safety	Safety	Risk
	H&S		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Major rewrite	February 2006
2.0	Minor changes	April 2007
3.0	Revised Management and Committee structure	August 2008
4.0	Includes recommendations made by the HSE in October 200	March 2009
5.0	Annual update with only minor changes	March 2010
6.0	Includes changes for Tunbridge Wells Hospital at Pembury	January 2011
7.0	Annual update with only minor changes	January 2012
8.0	Minor changes made following HSE Inspection and advise	May 2012
9.0	Reviewed - Minor changes made following operational restructure	March 2013

Maidstone and Tunbridge Wells NHS Trust

Version control:		
Issue:	**Description of changes:**	**Date:**
9.1	Included TOR for H&S committee as an appendix	November 2013
10.0	Reviewed - Minor changes made to meet workplace H&S Standards	March 2014
11.0	Reviewed - Minor changes made	July 2015
12.0	Reviewed - Formatted into new policy and procedure template. Structural changes made and repetition removed.	July 2018

Maidstone and Tunbridge Wells NHS Trust

Summary for

Health and Safety Policy

Maidstone and Tunbridge Wells NHS Trust (MTW or the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (HSWA 1974) and all associated legislation enabled under the Act. The Trust is committed to safeguarding the health and safety of its employees, patients, visitors, volunteers, contractors and others who are affected by its activities. The Trust seeks to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

Managers, employees and other stakeholders will work together to make their environment as safe as is reasonably practicable both for themselves and others. The Trust expects all managers and staff to be involved in the development and implementation of its health and safety policies and procedures through active joint consultation.

The use of risk assessment to identify, assess and manage all risks arising from the Trust's undertakings is the key to health and safety management within the Trust. Where unforeseen risks result in adverse incidents these will be investigated and action taken to significantly reduce the likelihood of recurrence.

The Trust will ensure that adequate resources are allocated for health and safety as required; identified from approved Trust policies and fully considered risk assessments.

The Trust will cooperate and coordinate its activities with that of the Kent and East Sussex Weald Hospital Limited (KESWHL) to ensure an environment that is as safe as is reasonably practicable for the Tunbridge Wells Hospital at Pembury.

Maidstone and Tunbridge Wells NHS Trust

Contents

1.0 Introduction, purpose and scope

Maidstone and Tunbridge Wells NHS Trust (MTW or the Trust) recognises its responsibilities under the Health and Safety at Work etc. Act 1974 (HSWA) and all associated legislation enabled under the act. The Trust is committed to safeguarding the health and safety of its employees, patients, visitors, volunteers, contractors and others who are affected by its activities.

This policy is prepared in accordance with Section 2(3) of HSWA 1974 that employers with five or more employees must produce a written health and safety policy. It is the policy of the Trust to provide safe and healthy working conditions and to enlist the active support of all staff in achieving this.

It is the duty of all staff to ensure strict compliance with this policy and other associated policies and procedures. Failure to do so could lead to disciplinary action.

This policy is supported by many other specific policies and procedures. Many of the Trust's health and safety arrangements are encompassed within these documents. The relevant documents are listed in the references section.

2.0 Definitions/glossary

Term	Definition
Competent Persons	The Trust employs adequate numbers of Competent Persons to assist in undertaking the measures necessary to comply with health and safety legislation. These are individuals with specialist skills, knowledge and qualifications that are assessed by external bodies such as the 'Institute for Occupational Safety and Health' (IOSH).
Directorate Risk Leads	Each directorate will have a nominated Directorate Risk Lead. The Risk Lead will have delegated responsibility for health, safety and welfare on behalf of their directorate.
Interserve Facilities Management (FM)	Contracted by Kent and East Sussex Weald Hospital Limited (KESWHL) at Tunbridge Wells Hospital as responsible for: • Building maintenance and the life cycle of the estate • Grounds and gardens • Utilities • Fire detection systems and alarms
Kent and East Sussex Weald Hospital Limited (KESWHL)	KESWHL is a Special Purpose Vehicle that was formed to enter into a Private Finance Initiative (PFI') concession contract with the Trust to design, build, finance and operate Tunbridge Wells Hospital. The contract was signed in March 2008 and will run until 2042. KESWHL has no direct employees but sub-contracts to Interserve FM Limited for the provision of certain services at Tunbridge Wells Hospital (see above)
Undertakings	The activities carried out by the Trust in order to fulfil its function.

3.0 Duties

Person/Group	Duties
Trust Board	• Ensure that all relevant statutory instruments are complied with and that appropriate arrangements are in place for resourcing an managing risk • Receive a Health and Safety Annual Report • Discuss and modify the Key Performance Indicators (KPIs), targets and programme outlined in the Health and Safety Annual Report as required • Delegate the monitoring and implementation of the programme to the Executive Lead and the Health and Safety Committee • Ratify the Health and Safety Policy and Procedure, thereby demonstrating top level commitment to health and safety within the Trust
Chief Executive	• Has overall accountability for the management of health and safety within the Trust • Ensure that effective policies and procedures are developed and implemented and that the performance of these is monitored and evaluated against statutory obligations and Trust objectives.
Trust Management Executive (TME)	• Oversee the work of the Health and Safety Committee • Receive reports from the Health and Safety Committee • Assist in the management of health and safety risks that cannot be managed at directorate level, including accepting risk on behalf of the Trust • Make recommendations to the Trust Board, as required
Health and Safety Committee	• Act as the Trust's health and safety committee as required under the HSWA 1974. • Act as the key committee for health and safety issues that are not covered by other specialist committees • Make recommendations to the Trust Board and/or the Chief Executive and/or the Trust Management Executive (TME) on matters relating to the health and safety of the Trust's employees or those affected by the Trust's activities • Monitor the annual health and safety KPIs and targets • Implement the annual health and safety programme • Manage and monitor a health and safety action plan • Manage and monitor the implementation of this Policy and Procedure and other key health and safety-related policies, procedures and documentation • Provide reports to the TME • Seek assurance from directorates that they are managing their health and safety risks • Audit and monitor directorate risk assessments and risk

Person/Group	Duties
	assessment programmes • Monitor the outcomes from workplace audits • Monitor suitable health and safety statistics to detect trends and plan programmes to reduce adverse incidents and harm to staff and patients For Terms of Reference of the Health and Safety Committee see **Appendix 7**
Chief Operating Officer	• Responsible for the day-to-day organisation and implementation of health and safety • Chair the Health and Safety Committee and report to the TME on relevant matters. • Ensure that sufficient resources are available so that all staff are provided with appropriate and effective information, instruction, supervision, training and where necessary supervision to enable them to fulfil their health and safety responsibilities within the workplace. • Ensure the Trust has suitable and sufficient arrangements in place for the management of health and safety including the appointment of sufficient Competent Persons to assist the Trust in complying with legal requirements
Director of Workforce	• Responsible for ensuring the provision of Occupational Health Services • Ensure processes are in place to check the competence of potential new employees, including the checking of qualifications and registration • Ensure records of accredited staff representatives from unions and staff side organisations are maintained • Encourage the election and development of staff representatives • Ensure that job descriptions contain health and safety responsibilities, both statutory and job specific, and that these job descriptions are reviewed and amended as required.
Director, Estates and Facilities Management	• Responsible for compliance with relevant health and safety statutory requirements with regards to the buildings, traffic routes, environment and infrastructure. This also includes responsibility for the management of contractors. • Responsible for the Facilities functions within the Trust including security and the management of violence and aggression on all Trust premises. • To be (on behalf of the Chief Finance Officer) the “Trust Representative” and be responsible for the co-ordination of the Project Agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL) to ensure an environment that is safe for the Tunbridge

Person/Group	Duties
	Wells Hospital at Pembury. • The "Trust Representative" will coordinate the two organisation's health and safety arrangements as a member of the "Programme Liaison Committee" and the Trust "Health and Safety Committee".
Directors / Clinical Directors	• Responsible for the overall management of health and safety within their Directorate. • Ensure systems are in place and resources available to allow staff at all levels to participate in managing health and safety effectively. • Review Directorate health and safety performance • Ensure work-related risks faced by staff and others within their directorate are suitably assessed. • Ensure effective arrangements are in place for planning, implementing, monitoring and reviewing preventative and protective measures. • Ensure staff within the Directorate are provided with understandable and relevant information on the risks they face and the preventative and protective control measures in place that effectively manage those identified risks. • Ensure that all wards/departments within have a suitable number of Competent Persons to manage health and safety and risk including undertaking risk assessments, adverse incident reporting and investigation, workplace health and safety inspections and providing reports to Directorate meetings and other relevant committees
Directorate Risk Leads	• The Risk Lead will have delegated responsibility for health, safety and welfare on behalf of their senior managers and directors • Develop and implement individual policies in line with the Trust's health and safety objectives to ensure compliance within all workplaces under their control • Monitor and report on Directorate health and safety performance to relevant committees • Ensure health and safety training is relevant and appropriate to the roles and responsibilities of staff within the Directorate and monitor compliance • Ensure risk assessments within the Directorate are carried out according to the Risk Assessment Policy and Procedure • Ensure health and safety-related recommendations for remedial action are undertaken as soon as is practicable • Attend the Health and Safety Committee or nominate an appropriate and suitably briefed deputy For a directory of local staff and managers see **Appendix 4**.
Departmental /	• Responsible for the day-to-day implementation of Trust

Person/Group	Duties
Ward Managers	policy and are empowered to take all reasonable measures to ensure that all workplaces and work practices within their areas of responsibility are safe, healthy and meet legal requirements • In conjunction with local risk assessor(s), design and implement safe systems of work for any tasks that pose a significant risk to health and safety • Consult with staff as appropriate prior to incorporating local written policies and procedures. • Ensure all staff receive training in the use of appropriate control measures prior to undertaking the task. • Ensure identified staff attend Occupational Health for health surveillance as required. • Ensure each individual's health and safety responsibilities, both statutory and job specific, are contained in their written job description and that these are reviewed and amended as required. • Ensure that all staff are appraised annually and that the appraisal includes a review of compliance with health and safety policy and practice. • Allow any accredited staff representatives from unions and staff side organisations sufficient time to develop and carry out their function. • Ensure that appropriate health and safety signage and equipment within the local work environment is in place, appropriate and within date. • Ensure all staff are provided with suitable and sufficient information, instruction, supervision and training on health and safety issues relevant to their workplace as identified by risk assessment. • Ensure all adverse incidents are reported, investigated and action taken to reduce/ eliminate recurrence in accordance with the "Incident Management Policy and Procedure". • Ensure all equipment, plant and machinery is regularly serviced, maintained and records kept. • Report defects and faults in buildings, grounds, equipment and machinery. • Ensure remedial action is carried out effectively and in accordance with Trust guidelines. • Report defects and faults in electrical / mechanical medical equipment to local EME department telephone number 01622 223151 for all sites. • Ensure that systematic and documented safety inspections of the workplace and work practices take place at least every three months • Ensure re-assessments are carried out following any

Person/Group	Duties
	significant changes. • Have a suitable number of Competent Persons to undertake workplace health and safety audits, providing reports to Directorate Meetings, via the Directorate Risk Lead. • If they manage teams or individuals who are unable to use or access computers; managers must provide Trust wide communications in an appropriate format. • Consult and/or meet with staff, their representatives and other relevant parties for the discussion and resolution of local risk issues. • Where a manager engages the services of non-Trust personnel to undertake business on behalf of the Trust, both on and away from Trust premises, they shall consult with those persons before work begins to ensure that risks to all persons are identified, assessed and controlled. • Ensure that staff, contractors and other visitors are given an appropriate health and safety induction according to relevant Trust policy and procedure.
Competent Persons	• Promote and provide advice and guidance on health, safety and risk management • Undertake Trust wide risk assessments in key areas of hazard and risk. From these they will develop policies and procedures, including safe systems of work. • Monitor performance and provide reports to managers and committees • Identify new legislation and guidance and review related policies and procedures • Serve on Trust committees and advise on risk issues • Act as key contact with enforcing officers from regulatory bodies
Risk and Compliance Manager and Head of Fire, Safety and Compliance	• Give advice and support all staff in the management of health and safety • Ensure that all key staff and managers have access to sufficient health and safety information and training to undertake their duties • Ensure health and safety training delivered as part of the statutory and mandatory programme is relevant and appropriate to the roles and responsibilities of staff • Carry out risk management performance audits against KPIs
Occupational Health Department	• Provide health assessment, personal and environmental monitoring and health surveillance where required by statute, risk assessment and organisational need
Learning and Development	• Responsible for the planned delivery of induction training • Responsible for the training needs analysis and the

Person/Group	Duties
Department	planned delivery of mandatory and statutory update training
All staff	• Take care of their own health and safety and that of other employees, patients, visitors and non-employees who may be affected by their acts or omissions. • Comply with all health and safety regulations and notices issued by an enforcement agency. • To co-operate with the Trust so far as is necessary to enable compliance with all health and safety regulations and notices issued by an enforcement agency. • Comply with safe systems of work and recognised procedures as identified by risk assessment. • Not interfere with, misuse or intentionally disregard the appropriate use of any equipment, item or notice provided by the Trust in the interest of health and safety. • Bring to the attention of their managers any shortcomings they are aware of in respect of health and safety policies, procedures, practice, guidelines, safe systems of work, training and supervision. • Report any adverse incident of which they are aware to their line manager or person in charge of the workplace at the time of the incident and complete an incident report form in accordance with the Incident Management Policy and Procedure. • Participate fully in any training programme identified by their manager. • Report any health issue that may inhibit the individual's ability to carry out the full range of duties in a safe manner. These requirements also apply to contractors working for and within the Trust. Employees of KESWHL and Interserve FM are also expected comply with Trust policy, procedures and safe systems of work.

4.0 Training/competency requirements

The provision of information, instruction, training and supervision is a general duty of employers under HSWA 1974.

It is a requirement that employees, including volunteers, receive appropriate health and safety training which is refreshed periodically and in line with new and changing risk.

Training for those who use and/or supervise the use of work equipment is required under Provision and Use of Work Equipment Regulations (PUWER) 1998 (PUWER). This also includes non-employees if they need to use Trust equipment.

Corporate and local induction is an important means of safeguarding the health and safety of those whose lack of familiarity with the workplace may place at greater risk. For more information see the Induction Policy and Procedure.

Statutory and mandatory training includes a general health and safety session. This is carried out online or face to face, with a requirement to be completed at least every 3 years. For more information see the Statutory and Mandatory Training Policy and Procedure.

Line managers must ensure that time be made available for statutory health and safety (including online training) to take place during normal working hours.

Competent Persons must have the specialist skills, knowledge and qualifications to undertake their duties in relation to health and safety. In order to maintain their skills, knowledge and expertise, which may be a requirement for external bodies assessment of competence, the Trust will support their Continuing Personal Development with regards to Health and Safety.

5.0 Procedure

5.1 Communication and consultation

5.1.1 Staff consultation processes

The Trust will consult with staff on health and safety matters directly through the communications department, through employee representatives and Directorate Risk Leads on the Trust's Health and Safety Committee. The Trust has also established appropriate management and staff consultative structures including the Joint Consultative Forum.

5.1.2 Staff safety representatives

The Trust acknowledges the roles of both Union accredited and locally elected staff safety representatives and shall encourage their active participation in both the organisation and implementation of health and safety within the Trust. All recognised Trades Unions and Professional Organisations who are signed up to the Trust Partnership Agreement have a right to a place on the Health and Safety Committee as do persons who are elected from a work group who are not represented by a Trades Union or Professional Organisation.

The Trust encourages the election and development of staff representatives and ensures that staff representatives have sufficient time for their function.

Representatives will feedback issues discussed at Health and Safety Committee to their members and to the Staff Side Chair for further discussion at the Joint Consultative Forum.

5.1.3 Direct communication

As well as communication through the Union Safety Representatives (staff-side), the Trust also consults with staff directly on health and safety matters. This direct communication includes:

- Email to all staff through the Communication Department
- Cascade of information through line managers via local management meetings
- The Chief Executive's update to all staff
- The Clinical Governance newsletter to all staff

- Through the Trust's intranet site
- Committee minutes and reports
- Mandatory update training
- Internal safety alerts issued by the Quality Governance Directorate
- Posters including the statutory health and safety poster

For staff unable to use or access computers, their managers will ensure access to communications in an appropriate format.

5.2 Hazard identification and risk assessment

The process is described in detail in the Risk Assessment Policy and Procedure.

5.2.1 Local hazard identification and risk assessment

Risk assessments should be reviewed according to the Risk Assessment Policy and Procedure which includes an annual review of the "hazard profile checklist" for that area. This checklist lists reasonably foreseeable hazards for the general hospital environment as well as scope to expand to include other, more specific, hazards.

Managers will ensure that local health and safety inspections are undertaken at least quarterly, during which they may identify further hazards.

Adverse incident reporting and management will also identify unforeseen hazards.

Depending on the level of risk and associated Trust wide policy, procedure or risk assessment, managers will:

- Where a hazard is trivial or not applicable record this in the hazard profile checklist
- Record the way lower risk activities and processes are managed in the hazard profile checklist
- Complete formal risk assessments for significant hazards

The manager will share all the documentation with all relevant staff who will sign to confirm they have read and understood.

5.2.2 Trust wide hazard identification and risk assessment

The Trust's Competent Persons will identify hazards within their area of expertise. They undertake specialised risk assessments for these hazards. The results of these assessments will be incorporated into policies, procedures and safe systems of work that are implemented Trust wide. Significant assessments are added to the Risk Register as closed risks (archived but accessible to staff via the Risk and Compliance Manager or relevant Directorate Risk Lead). Some assessments will be appended to policies and procedures.

The Trust's Competent Persons view all adverse incidents in their areas of expertise. They sit on Trust committees so are able to identify or indicate hazards around the Trust.

Where policies, procedures or assessments exist they are hyperlinked to the hazard profile checklist to assist local managers.

5.3 Adverse incident reporting

All adverse incidents will be reported and managed in accordance with the Trust's Incident Management Policy and Procedure.

5.4 Policy and procedure

The Trust's "undertakings" are complex and offer many risks. There are a large number of risk assessments carried out at all levels of the Trust. These result in many 'safe systems of work' ranging from local rules and method statements through to Trust wide policies, procedures and guidance documents. Some policies and procedures are specifically required by the Department of Health and Social Care and its enforcing agencies and bodies. See **Appendix 5** for more information on these documents.

This policy is supported by a framework of specific policies and procedures. These each undergo consultation and peer review before approval through specialist committees. Many of the Trust's health and safety arrangements are encompassed within these documents. The relevant documents are listed in the "Associated documents" section.

5.5 Health and safety assistance

The Trust employs Competent Persons to assist it in complying with the requirements of any relevant statutory provisions, and for the provision of advice, guidance, instruction and training. The names of the staff in these roles at present are given in **Appendix 6**.

For an outline of a number of the key Competent Persons and their role in Trust risk management arrangements see the Risk Management Policy and Procedure.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- This policy will be ratified by the Board. It will also be agreed and accepted by Trade Unions, professional bodies, other staff representative groups and signed by the chair of the Joint Consultative Forum.
- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will upload it to the Trust Policy database on the intranet, under “Policies & guidelines”.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under “Policies & guidelines”. Notification of the posting is included on the intranet “News Feed” and in the Chief Executive’s newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy should be read in conjunction with other associated health, safety and risk management policies. This policy will form the basis of health, safety and risk management training provided for all staff at all levels.
- The implementation of this policy will be driven by that of the Risk Management Policy and Procedure, which defines the organisation and arrangements for managing all risk including health and safety.

2.0 Monitoring compliance with this document

- The Trust Board, through its review of the Health and Safety Annual Report, the Health and Safety Committee and Trust Management Executive will monitor the implementation of this policy
- Health and safety KPIs are also reported on and monitored at directorate meetings, the Trust Clinical Governance Committee and the Quality Committee
- Health and Safety KPIs are set through the Risk Management Policy and Procedure, other Trust policies and by key committees. These KPIs will be monitored to measure the Trust’s performance and be used as part of the directorate review process to assess compliance.
- The Risk and Compliance Manager and Trust Health and Safety Manager carry out risk management performance audits against KPIs. Each department and directorate will be compared as part of a benchmarking exercise across the Trust. The Trust will be compared with national figures from similar Trusts taken from HSE databases. Performance will be reported to the Health and Safety Committee. This will be part of a process of continuous improvement.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years.

This policy will be reviewed and revised periodically to incorporate new or revised statutory requirements and changes in the needs and objectives of the Trust and its services.

4.0 Archiving

The Trust approved document management database on the intranet, under “‘Policies & guidelines”, retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2

CONSULTATION ON: Health and Safety Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Risk and Compliance Manager, rob.parsons@nhs.net

By date: 24/05/18

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff must be included in all consultations:				
Corporate Governance Assistant	02/05/18	21/05/18	Y	Y
Counter Fraud Specialist Manager (Tiaa)	21/05/28			
Energy and Sustainability Manager	02/05/18			
Chief Pharmacist and Formulary Pharmacist	02/05/18			
Staff-Side Chairs	02/05/18			
Complaints & PALS Manager	02/05/18			
Emergency Planning Team	02/05/18			
Head of Staff Engagement and Equality	02/05/18			
All individuals listed on the front page	02/05/18			
All members of the approving committee. Health and Safety Committee	02/05/18			
Members of the Executive Team	02/05/18			
Trust Secretary	02/05/18			
Directorate Risk Leads	02/05/18	08/05/18	Y	Y
Clinical Directors	02/05/18			
The following staff have given consent for their names to be included in this policy and its appendices: Rob Parsons, Mark Vince, Wendy Bates, Tanisha Okoli, Mark Knight, Christian Lippiatt, Lesley Smith, Jo Hand, Stu Meades, Anne Woolridge, Jeanette Batten				

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Health and Safety Policy and Procedure
What are the aims of the policy?	To ensure the health and safety of employees and others
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Respond
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	Yes. This policy and associated control measures Health and safety signage and notices may not be understood
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Minimal and justifiable. Measures are in place to assist those for whom English is not a first language.
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

Maidstone and Tunbridge Wells NHS Trust

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Directory of local health and safety staff and managers	RWF-OWP-APP678	This policy
5	Trust risk documentation	RWF-OWP-APP3	This policy
6	Key contacts	RWF-OWP-APP4	This policy
7	Terms of Reference of the Health and Safety Committee	RWF-OWP-APP725	This policy
8	Trust Committee structure chart	RWF-OWP-APP2	Standing Orders [RWF-OPPCS-NC-TM23]

General and Risk Leads

Datix Sub Specialties	Division	Directorate	Director	Deputy Director, Associate Director, General Manager etc.	Datix Specialty	Directorate Risk Lead	Risk Register Administrators
Car Parking & Grounds	Corporate Services	Estates and Facilities	Jeanette Batten	Darren Bulley (Associate Director) Kev Pearson (Associate Director)	Estates & Facilities	**Mark Vince**	Lisa Briggs Mark Vince
Catering							
Domestics							
Laundry							
Maintenance							
New Hospital Build							
Non-Patient Transport							
Patient Transport							
Portering							
Postal Services							
Projects							
Security							
Financial Services		Finance	Steve Orpin	Hannah Ferris (Deputy Director) Stuart Doyle (Deputy Director)	Finance	**Stuart Doyle**	K Lawrence Stuart Doyle
Financial Management							
Contracts and Income							
Counter Fraud							
External Audit							
Internal Audit							
PMO							
Purchasing/supplies/procurement							
Materials Management							
Business Intelligence						**James Jarvis**	
Clinical coding							
Information Team							
Chaplaincy		Workforce	Simon Hart		Workforce	**Ruth Bailey**	Ruth Bailey S Watson
Education and Training							
Human Resources							
Library							
Occupational Health							
Payroll							
Communications		Corporate Development		Kevin Rowan (Trust Secretary)	Corporate (CORP)	**Rob Parsons**	Rob Parsons
Corporate							
Media Interest							
Reconfiguration							
Nursing		Nursing	Claire O'Brien	John Kennedy (Deputy Chief Nurse) Gemma Craig (Assistant Deputy Chief Nurse)	Nursing		
PALS							
Patient Affairs							
Patient Experience							
Professional Standards							
Voluntary Services					Voluntary Services		
Clinical Audit		Governance and Quality	Peter Maskell	Paul Sigston (Deputy Medical Director) Sharon Beesley (Deputy Medical Director) Sarah Flint (Deputy Medical Director) Wendy Glazier (Associate Director)	Governance and Quality		
Customer Services							
Risk							
Governance							
Legal Services							
Patient Safety Team							
PALS							
R&D							
External Trusts					External Agencies		
Dermatology							
PCT/CCG							
Social Services							
Information Governance		MTW Health Informatics	Michael Beckett		IM&T	**Michael Beckett**	Michael Beckett
Information Technology							
Switchboard							
Emergency Planning		Operations Management	Angela Gallagher		(CORP)	**John Weeks**	
Outpatients					Outpatients	**Kelly Cushman**	Kelly Cushman
Private Patients					Private Patients	**Alan Dando**	Alan Dando

Datix Sub Specialties	Division	Directorate	Director	Deputy Director, Associate Director, General Manager etc.	Datix Specialty	Directorate Risk Lead	Risk Register Administrators
A&E	Urgent Care	Acute and Emergency	Akbar Soorma	Nick Sinclair (General Manager)	A&E	**Gemma Viner**	Gemma Viner Dr DJ Brown
Blood Borne Diseases		Specialist Medicine and Therapies	Laurence Maiden	Darren Palmer (General Manager)	Specialist Medicine	**Sharon Page**	Sharon Page Mary Rogers
Cardiology							
Diabetics							
Elderly Care							
Endocrinology							
Gastroenterology							
General Medicine							
Neurology							
Rehabilitation							
Respiratory							
Rheumatology							
Stroke services							
Diatetics				Amanda Allen (Head of Therapies)	Therapies	**Amanda Allen**	Amanda Allen Helen Furminger
Occupational Trerapy							
Physiotherapy							
Chiropody							
Speech & language							
Breast Care	Planned Care	General Surgery Urology and Gynae Oncology	Daniel Lawes	Lisa Brereton	Surgery	**Sally Batley**	Sally Batley
Colorectal							
General Surgery							
Neuro Surgery							
Vascular Surgery							
Day Surgery					Surgical Aids		
Surgical Aids					Gynae Oncology		
Gynae Oncology					Urology		
Urology					Planned Care	**Di Peach**	
Choose and book							
Medical Records							
Planned Care							
Audiology		Head and Neck	Carole Jones	Claire Hubert (General Manager)	Head and Neck	**Val Gallagher**	Val Gallagher Helen Rogers
Ear nose and throat							
Maxillo Facial							
Opthalmology							
Orthoptics		Trauma and Orthopaedics	James Nicholl	Andrew Lindsey (General Manager)	T&O	**Kelly Cushman**	Kelly Cushman
Trauma							
Orthopaedics		Critical Care	Greg Lawton	Daniel Gaughan (General Manager)	Theatres	**Jacqui Slingsby**	Jacqui Slingsby Sabreena Stanton
Anaesthetics							
Chronic pain							
Endoscopy							
High dependancy unit							
Intensive care							
Outreach							
Theatres							
Chemotherapy		Cancer, Haematology and Radiology	Henry Taylor	David Fitzgerald (General Manager)	Oncology	**Charlotte Wadey**	Charlotte Wadey Hayley Corke
General Oncology							
Haemotology Service							
Medical Physics							
Nuclear medicine							
Palliative care							
Radiotherapy				Neil Bedford (General Manager)	Radiology	**Mike Tatlow**	Mike Tatlow
CT scanning							
MRI							
Ultrasound imaging							
X-ray							
Blood Transfusion		Pathology and Pharmacy	Sara Mumford	Mark Holland (General Manager)	Pathology	**Helen Dasley**	Helen Dasley Paula Warrington
Biochemistry							
Cytology							
Haematology laboratory							
Histopathology							
Microbiology							
Mortuary							
Pharmacy				Mildred Johnson (C	Pharmacy	**Mildred Johnson**	Mildred Johnson Katy Rogers
Infection Control					Infection Control	**Lesley Smith**	
Midwifery / Obstetrics					Obstetrics		

Datix Sub Specialties	Division	Directorate	Director	Deputy Director, Associate Director, General Manager etc.	Datix Specialty	Directorate Risk Lead	Risk Register Administrators
Gynaecology	**Women's Children's and Sexual Health**	Women's and Sexual Health	Sarah Flint	Fiona Martin (General Manager)	Gynaecology	**Jenny Cleary**	Jenny Cleary Rachel Thomas
Genito-urinary (GUM)					Sexual Health		Rita Joseph
Paediatrics		Children's Services			Paediatrics	**Jackie Tyler**	Jackie Tyler
NNU							

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Martyn	Abbott	Zone Manager (M)	Soft Facilities Management	Estates and Facilities
Alice	Abed	Physiotherapist	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Janine	Absalom	Ward Manager	Maidstone Birth Centre	Women's and Sexual Health
Marion	Adams	Senior Midwife	Bank Staff- Nursing & Midwifery Registered	
Jeetendra	Adhikari	Zone Supervisor (TW)	Soft Facilities Management	Estates and Facilities
Noella	Aers	Senior Midwife	Midwifery Services (TW)	Women's and Sexual Health
Iryna	Afafsa	Zone Manager (M)	Soft Facilities Management	Estates and Facilities
Susan	Akehurst	Radiographer	Nuclear Medicine (TW)	Cancer, Haematology and Radiology
Monika	Alger	Medical Education Officer	Maidstone and Tunbridge Wells NHS Trust	
Edzil	Alicaya	Staff Nurse	Ward 11 (TW)	Surgery, Urology and Gynae Oncology
Julia	Allcock	Lead Nurse	Theatre Staff (M)	Critical Care
Elizabeth	Allen	Clinical Lead	Occupational Therapy (TW)	Specialist Medicine and Therapies
Mark	Allison	Inventory Specialist	Procurement Department	Finance
Catarina	Alves Nina Ramos Cunha	Ward Manager	Ward 21 (TW)	Specialist Medicine and Therapies
Diana Cristina	Amaral Costa	Sister/Charge Nurse	Intensive Care (M)	Critical Care
Kaye	Asbury	Senior Practitioner	Theatre Staff (M)	Critical Care
Mary	Attwood	Quality Technical Manager	Soft Facilities Management	Estates and Facilities
Julia	Azille	Senior Diabetes Nurse Specialist	Diabetes Centre (M)	Specialist Medicine and Therapies
Susan	Backhouse	Consultant Nurse	Maidstone and Tunbridge Wells NHS Trust	
Harkiret	Bahra	Advanced Specialist Optometrist	Head Optician (EEM)	Head and Neck
Coralle	Baillie	Senior Sister/Charge Nurse	Discharge Liaison (TW)	
Rasana	Bajracharya	Consultant Obstetrics & Gynaecology	Obs & Gynae Medical Staff (TW)	Women's and Sexual Health
Matthew	Baker	Lead Practitioner	Theatre Staff (M)	Critical Care
Lynne	Balderstone	Deputy Transfusion Practitioner	Haematology (TW)	Pathology and Pharmacy
Julie	Banwell	Administrator	COPD Respiratory Nurses	Specialist Medicine and Therapies
Caryn	Barker	Sister/Charge Nurse	Ophthalmology Out Patients (MED)	Head and Neck
Ma	Barnett	Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Merlyn	Barrion	Sister/Charge Nurse	Ophthal Outpatients (M)	Head and Neck
Rosamund	Barwell	Ward Manager	Ward 20 (TW)	Specialist Medicine and Therapies
Caroline	Bates	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Lesley	Baxter	Assistant General Manager	Surgery Directorate Management (M)	Surgery, Urology and Gynae Oncology
Karen	Beeching	Sister/Charge Nurse	Ward 10 (TW)	Surgery, Urology and Gynae Oncology
Stuart	Belton	Booking Clerk	Clinical Admin Unit - Head and Neck	Head and Neck
Louie	Beltran	Supervisor	Estate Maintenance (M)	Estates and Facilities
Glynis	Bennett	Staff Nurse	Main Out Patients (TW)	
Elizabeth	Benny	Staff Nurse	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Frances	Best	Senior Clinical Support Worker	Culpepper Ward (M)	Specialist Medicine and Therapies
Kanthi	Bibulewitharana	Staff Nurse	Eye Day Care (M)	Head and Neck
Maria	Blanco-Criado	Head of Pharmacy - Cancer and Technica	Oncology Pharmacy (M)	Cancer, Haematology and Radiology
Andrea	Blurton	Sister/Charge Nurse	Charles Dickens Ward (M)	Cancer, Haematology and Radiology
Wendy	Bonnert	Biomedical Scientist	Haematology (M)	Pathology and Pharmacy
Marian	Bourner	Ward Manager	MOU (M)	Trauma and Orthopaedics
Deborah	Bowles	Administrator	Maidstone and Tunbridge Wells NHS Trust	
Mark	Bradley	Sister/Charge Nurse	Intensive Care (TW)	Critical Care
Rebecca	Brett	Junior Sister / Charge Nurse	Children Services Management	Children's Services
Sonia	Bridger	Sister/Charge Nurse	Medical Imaging (M)	Cancer, Haematology and Radiology
Margaret	Bridges	Staff Nurse	Occupational Health	Workforce
Clare	Brito	Clinical Trials Research Assistant	Bank Staff - Additional Clinical Support	
Joe	Brooks	Team Leader	Clinical Admin Unit - Head and Neck	Head and Neck
Caroline	Brooks	Sister/Charge Nurse	Diabetes Centre (M)	Specialist Medicine and Therapies
Sarah	Brunger	Specialist Orthoptist	Head Orthoptist (EEM)	Head and Neck
Jasmin	Budhai	Staff Nurse	Urology Investigation Unit (M)	Surgery, Urology and Gynae Oncology
Hilary	Bulmer	Ward Manager	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
Christina	Bunch	Staff Nurse	Main Out Patients (M)	
Megan	Burch	Clinical Lead	Maidstone and Tunbridge Wells NHS Trust	
Helen	Burn	Head of Pharmacy with SCR and Unlock	Pharmacy (M)	Pathology and Pharmacy
Caroline	Bush	Sister/Charge Nurse	Main Out Patients (M)	
Katharine	Butcher	Biomedical Scientist	Cytology	Pathology and Pharmacy
Caroline	Butler	Senior Sister/Charge Nurse	Diabetes Centre (TW)	Specialist Medicine and Therapies
Joanne	Byfleet	Procurement Services Officer	Procurement Department	Finance
Debra	Byrne	Physiotherapist	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Lorraine	Carpenter	PA / Medical Secretary	Clinical Admin Unit - Head and Neck	Head and Neck
Elaine	Cassem	Junior Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Bobby	Castillo	Junior Sister/Charge Nurse	Accident & Emergency (TW)	Acute and Emergency
Louise	Castro	Integrated Sexual health Nurse	GU Medical Staff	Women's and Sexual Health
Katy	Cawkwell	Bank Staff Nurse Band 5	Maidstone and Tunbridge Wells NHS Trust	
Matthew	Chandler	Sister/Charge Nurse	Ward 21 (TW)	Specialist Medicine and Therapies
Peter	Chaseley	Inventory Specialist	Procurement Department	Finance
Mereen	Cherian	Optometrist Technician	Maidstone and Tunbridge Wells NHS Trust	
Lorraine	Chivers	Senior Clinical Support Worker	Bank Staff - Additional Clinical Support	
Janice	Christie	Unit Manager	Haematology Day Unit (TW)	Cancer, Haematology and Radiology
Marie-Therese	Church	Midwife - Senior Sister/Charge Nurse	Maidstone Birth Centre	Women's and Sexual Health
Anne	Clark	Staff Nurse	Eye Unit (TW)	Head and Neck
Kathryn	Clarke	Specilaist Nurse	Maidstone and Tunbridge Wells NHS Trust	
Lorraine	Clarke	Risk and Health and Safety Coordinator	Maidstone and Tunbridge Wells NHS Trust	
Angela	Clarke	Senior Midwife	Midwifery Services (TW)	Women's and Sexual Health
Elisabeth	Cocks	Clerical Officer	Director of Nursing and Quality	
Sarah	Collins	Staff Nurse	Ward 21 (TW)	Specialist Medicine and Therapies
Elaine	Collins	Specialist Nurse Practitioner	Womens Services Management	Women's and Sexual Health
Angela	Collison	HR Business Partner	Business Partner Team	Workforce
Sarah	Constant-Taylor	Staff Nurse	Short Stay Surgery Unit (M)	Surgery, Urology and Gynae Oncology
Sonia	Cook	Staff Nurse	Main Out Patients (TW)	
Tina	Cooper	Practice Development Nurse	Medicine Management (TW)	
Graham	Cooper	IT Technitian Team Leader	Service Desk	MTW Informatics
Julie	Coppin	Senior Midwife	Womens Services Management	Women's and Sexual Health
Rosemarie	Cottenden	Deputy Manager	Health Records All Sites	
Lucy	Coutts	Biomedical Scientist	Haematology (M)	Pathology and Pharmacy

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Claire	Cox	Team Leader	Maidstone and Tunbridge Wells NHS Trust	
Andrea	Cox	Simulation Facilitator	Post Graduate Centre (TW)	
Sheila	Craft	Senior Sister/Charge Nurse	Eye Day Care (M)	Head and Neck
Sally	Craven	Senior Sister/Charge Nurse	Endoscopy Out Patients (TW)	Critical Care
Peter	Crawley	Senior Technician	Medical Physics Health Physics	Cancer, Haematology and Radiology
Kenneth	Crossley	Mortuary Technician	Mortuary (M)	Pathology and Pharmacy
Stephen	Crouch	Systems and Catalouge Manager	Procurement Department	Finance
Graham	Crust	Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Kelly	Cushman	Modern Matron	Directorate Admin T&O	Trauma and Orthopaedic
Jane	Dalton	Medical Laboratory Scientist	Haematology (M)	Pathology and Pharmacy
Alan	Dando	Modern Matron	Medicine Management (TW)	
Helen	Dasley	Quality Manager	General Pathology No Site	Pathology and Pharmacy
Joanna	Davies	Integrated Sexual health Nurse	GU Medical Staff	Women's and Sexual Health
Ceri	Davies	Radiographer	Medical Imaging (TW)	Cancer, Haematology and Radiology
Royston	Davis	Bank Admin & Clerical Officer Band 7	Bank Staff - Admin & Clerical	
Claire	Davison	FOI Assistant	Information Governance (5)	MTW Informatics
Vanessa	Davis-Smith	Bereavement Lead	Administration (M)	Corporate
Peter	Deal	Biomedical Scientist Advanced	Histopathology	Pathology and Pharmacy
Susan	Deal	Site Coordinator	Maidstone and Tunbridge Wells NHS Trust	
Susan	Dennison	Data Quality Manager	Clinical Coding Dept	MTW Informatics
Gurinder	Dhami	Staff Nurse	Maidstone and Tunbridge Wells NHS Trust	
Heather	Dias	Superintendent Radiotherapist	Therapeutic Radiography (M)	Cancer, Haematology and Radiology
Mary	Digman	Senior Sister/Charge Nurse	Endoscopy Out Patients (M)	Critical Care
Karen	Dixon	Ward Manager	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Nadia	Donald	Hearing Therapist	Audiology	Head and Neck
Erin	Donovan	Radiation Physics Trainee Clinical Scientis	Medical Physics Health Physics	Cancer, Haematology and Radiology
Gillian	Dorrington	Staff Nurse	Discharge Lounge (TW)	Critical Care
Ingrid	Dubrow	Patient Safety Administrator	Patient Safety Team	Clinical Governance
Kevin	Duffett	Zone Manager (M)	Soft Facilities Management	Estates and Facilities
Jane	Duffy	Clinical Manager	Occupational Therapy (M)	Specialist Medicine and Therapies
Louise	Dunkley	Acting Health Records Manager	Health Records All Sites	
Hannah	Durling	Medical Education Administrator	Maidstone and Tunbridge Wells NHS Trust	
Carrie	Dyett	Sister / Charge Nurse	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Teresa	Elliott	Senior Sister/Charge Nurse	Ophthal Outpatients (M)	Head and Neck
Kirsty	Ellis	Ward Manager	Short Stay Surgery Unit (M)	Surgery, Urology and Gynae Oncology
Andrew	Esling	Manager	Head & Neck Directorate Mgt	Head and Neck
Emma	Farmer	Sister / Charge Nurse	Edith Cavell (M)	Specialist Medicine and Therapies
Robert	Farnes	Sister/Charge Nurse	Catheter Laboratory (TW)	Specialist Medicine and Therapies
Debbie	Fassam	Team Leader	Maidstone and Tunbridge Wells NHS Trust	
Rachel	Field	Sister / Charge Nurse	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
Gemma	Fifield	Radiographer	Medical Imaging (M)	Cancer, Haematology and Radiology
Karen	Finn	Manager	Telephone Switchboard (M)	MTW Informatics
Jacqueline	Fisher	Staff Nurse	Discharge Lounge (M)	Critical Care
Ann	Foreman	Site Manager for Systems & Services	Library Services	Workforce
Gregory	Forsyth	Maintenance	Estate Maintenance (M)	Estates and Facilities
Suzanne	Foster	Senior Staff Nurse	Maidstone and Tunbridge Wells NHS Trust	
Alan	Foster	Supervisor	Portering (M)	Estates and Facilities
Lucy	Franks	Clinical Nurse Specialist - Acute Pain	Chronic Pain (TW)	Critical Care
Ana	Freitas	Ward Manager	Ward 21 (TW)	Specialist Medicine and Therapies
Lynsey	Frroku	Clinical Lead	Occupational Therapy (TW)	Specialist Medicine and Therapies
Helen	Furminger	PA to Head of Acute Therapy Services	Therapy Administration	Specialist Medicine and Therapies
Valerie	Gallagher	Lead Nurse	Head & Neck Directorate Mgt	Head and Neck
Catherine	Galloway	Senior Radiographer	CT Scans (Med Imaging) (TW)	Cancer, Haematology and Radiology
Stephen	Gaskin	Chief Pharmacy Technician	Pharmacy (M)	Pathology and Pharmacy
Hayley	Geere	Clinical Nurse Specialist	Oncology Clinical Nurse Specialists	Cancer, Haematology and Radiology
Ancy	George	Staff Nurse	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
Gaynor	Gibbons	Modern Matron	Medicine Management (TW)	
Tracy	Gilmore	Senior Midwife	Bank Staff- Nursing & Midwifery Registered	
Bernis	Glady	Senior Physiotherapist	TADS Team	Specialist Medicine and Therapies
Julius	Gnanamoney	Clinical Specialist	Therapeutic Radiography (M)	Cancer, Haematology and Radiology
Sandra	Goad	Sister/Charge Nurse	Endoscopy Out Patients (TW)	Critical Care
Elizabeth	Gonzalez	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Mary Ellen	Gordon	Ward Manager	Bank Staff- Nursing & Midwifery Registered	
Joanne	Gould	Biomedical Scientist Advanced	Clinical Biochemistry (TW)	Pathology and Pharmacy
Andreia	Graca	Lung Function Technician	Chest Unit Technicians (TW)	
Martin	Grant	Supervisor	Estate Maintenance (M)	Estates and Facilities
Carol	Graves	Junior Sister / Charge Nurse	Urology Investigation Unit (M)	Surgery, Urology and Gynae Oncology
Fiona	Green	Practitioner	Bank Staff- Nursing & Midwifery Registered	
Sara	Greene	Staff Nurse - ENT Outpatients	ENT Outpatients (TW)	Head and Neck
Sarah	Greenslade	Extended Scope Practitioner Physiotherap	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Gillian	Grundy	Clinical Specialist	Maidstone and Tunbridge Wells NHS Trust	
Linda	Gulliver	Head of Performance	Facilities Management	Estates and Facilities
Mansiri	Gurung	Ward Manager	Mercer Ward (M)	
Diane	Gyford	Radiographer	Maidstone and Tunbridge Wells NHS Trust	
Leon	Hadlow	Maintenance	Estate Maintenance (M)	Estates and Facilities
Rebecca	Haines	E-Resources Librarian	Library Services	Workforce
Kate	Hallewell	Modern Matron	Medicine Management (TW)	
Ruta	Halter	Nurse Specialist	GU Medical Staff	Women's and Sexual Health
Joanne	Hand	General Manager (Security)	Facilities Management	Estates and Facilities
Helen	Harman	PA / Medical Secretary	Clinical Admin Unit - Head and Neck	Head and Neck
Julie	Harper	Senior Clinical Support Worker	Eye Unit (TW)	Head and Neck
Sally	Harper	Bank Dietitian Band 7	Maidstone and Tunbridge Wells NHS Trust	
Sheena	Harris	Medical Education Officer	Maidstone and Tunbridge Wells NHS Trust	
Stacy	Harrison	Staff Nurse	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Sara	Harrison	Clinical Support Worker	Ophthal Outpatients (M)	Head and Neck
Aziza	Hashimi	Biomedical Scientist Specialist	Clinical Biochemistry (M)	Pathology and Pharmacy
Moira	Hatton	Biomedical Scientist Basic	Haematology (M)	Pathology and Pharmacy

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Sharon	Hayes	Junior Sister	MOU (M)	Trauma and Orthopaedics
Steven	Hazelton	Senior Radiographer	Medical Imaging (M)	Cancer, Haematology and Radiology
Samantha	Hazlewood	Deputy Medical Education Manager	Maidstone and Tunbridge Wells NHS Trust	
Laura	Henderson	Snr Physiotherapist Clin Lead	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Philip	Hepburn	Biomedical Scientist Advanced	Clinical Biochemistry (M)	Pathology and Pharmacy
Steven	Herring	Senior Radiographer	Medical Imaging (M)	Cancer, Haematology and Radiology
Alan	Hewett	Travel Co-ordinator	Estates & Facilities	Corporate
Brian	Higgins	Technical Officer	Estate Maintenance (M)	Estates and Facilities
Wendy	Higgins	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Lucinda	Hill	Assistant General Manager	Anaesthetics Medical Staff (M)	Critical Care
Andrew	Hills	Porter	Portering (M)	Estates and Facilities
Justina	Hissett	Sister/Charge Nurse	Medical Imaging (M)	Cancer, Haematology and Radiology
Derek	Hitchcock	Porter	Maidstone and Tunbridge Wells NHS Trust	
Mathew	Hitchcock	Zone Manager (M)	Soft Facilities Management	Estates and Facilities
Shelley	Hitchman	Ward Manager	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Julie	Hobson	Secretarial Manager (Radiology)	Medical Imaging (M)	Cancer, Haematology and Radiology
Andrew	Holland	Lead Clinical Site Manager	Clinical Site Managers (TW)	
Allen	Hollands	Porter	Portering (TW)	Estates and Facilities
Catherine	Honey	Junior Sister/Charge Nurse	Acute Medical Unit (M)	Acute and Emergency
Jan	Hopper	Lead Theatre Nurse	Theatre Staff (TW)	Critical Care
Irene	Hoyal	Senior Pharmacy Technician	Pharmacy (M)	Pathology and Pharmacy
Claire	Hubert	Manager	Head & Neck Directorate Mgt	Head and Neck
Laura	Hughes	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Kim	Hutchins	Snr Physiotherapist Clin Lead	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Mark	Jackman	Project Officer	Maidstone and Tunbridge Wells NHS Trust	
Anita	Jackson	Team Leader	Maidstone and Tunbridge Wells NHS Trust	
Alison	Jankowski	Clinical Manager	TADS Team	Specialist Medicine and Therapies
Tracy	Jardine	Head of Healthcare Information	Trust Information Services	
Matthew	Jarvis	Radiographer	Medical Imaging (TW)	Cancer, Haematology and Radiology
Maria	Jarvis-Putter	Physiotherapist	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Rosalind	Jeapes	Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Hannah	Jenkins	Sister/Charge Nurse	Catheter Laboratory (TW)	Specialist Medicine and Therapies
Susan	Jeyes	Sister/Charge Nurse	Eye Day Care (M)	Head and Neck
Gareth	Johnson	Sister / Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Sharon	Jones	Radiographer	Mobile Breast Screening	Cancer, Haematology and Radiology
Deborah	Jones	Technician	Nuclear Medicine (TW)	Cancer, Haematology and Radiology
Anthea	Jones	Senior Pharmacy Technician with SCR	Pharmacy (M)	Pathology and Pharmacy
Jain	Jose	Staff Nurse	Edith Cavell (M)	Specialist Medicine and Therapies
Abraham	Joseph	Radiotherapy Plan Manager (K&C)	Therapeutic Radiography (CAN)	Cancer, Haematology and Radiology
Christopher	Judson	Pharmacist Advanced	Pharmacy Administration (TW)	Pathology and Pharmacy
Aminata	Kamara	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Tracey	Karlsson	Head of Employee Services	Recruitment	Workforce
Andrew	Kemp	Physiotherapist	Maidstone and Tunbridge Wells NHS Trust	
Lynne	Kettle	Radiographer	Mobile Breast Screening	Cancer, Haematology and Radiology
Sania	Khan	Deputy Head of Department	Audiology	Head and Neck
Wendy	Kichenside	Ward Clerk	Acute Medical Unit (M)	Acute and Emergency
Olivia	Kirk	Biomedical Scientist	Histopathology	Pathology and Pharmacy
Juby	Kurian	Staff Nurse	Catheter Laboratory (M)	Specialist Medicine and Therapies
Geraldine	Lagman-Yambao	Junior Sister/Charge Nurse	Acute Medical Unit (TW)	Acute and Emergency
Janet	Lamzed	Senior Clinical Support Worker	Main Out Patients (TW)	
Cheryl	Latter	Bank Senior Sister/Charge Nurse Band 7	Bank Staff- Nursing & Midwifery Registered	
Pollyanna	Law	Sister/Charge Nurse	Ward 33 (Gynae) (TW)	Women's and Sexual Health
Colin	Lawler	Biomedical Scientist	Haematology (TW)	Pathology and Pharmacy
Carol	Lawley	Staff Nurse	Endoscopy Out Patients (TW)	Critical Care
Barry	Leaf	General Manager	Estate Maintenance (M)	Estates and Facilities
Joanne	Lee Yow	Sister/Charge Nurse	Main Out Patients (TW)	
Sharon	Leeming	Biomedical Scientist Advanced	Maidstone and Tunbridge Wells NHS Trust	
Julie	Leeper	Chief Pharmacy Technician	Oncology Pharmacy (M)	Cancer, Haematology and Radiology
Karen	Leeson	Senior Midwife	Crowborough Birth Centre (CBC)	Women's and Sexual Health
Julia	Legg	Senior Practitioner	Theatre Staff (TW)	Critical Care
Matthew	Lewis	Clinical Support Worker	Maidstone and Tunbridge Wells NHS Trust	
Sabita	Limbu	Inventory Team Leader	Procurement Department	Finance
Kevin	Lock	Driver	Transport	Estates and Facilities
Parween	Lootfun	Ward Manager	Catheter Laboratory (M)	Specialist Medicine and Therapies
Brian	Louden	Biomedical Scientist Advanced	Microbiology (M)	Pathology and Pharmacy
Emma	Loughrey	Ward Manager	Ward 30 (TW)	Trauma & Orthopaedics
Ruth	Lowdell	Senior Sister/Charge Nurse	Medical Imaging (M)	Cancer, Haematology and Radiology
Eric	Lucas	Sister/Charge Nurse	Accident & Emergency (M)	Acute and Emergency
Gail	Lucas	Senior Sister/Charge Nurse	Intensive Care (M)	Critical Care
Felicity	Lusted	Lead Physiotherapist	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Daniel	Lyons	Theatre Clinical Co-ordinator	Theatre Staff (TW)	Critical Care
Jackielyn	Maddatu Suyo	Junior Sister/Charge Nurse	Acute Medical Unit (TW)	Acute and Emergency
Hala	Mahfoud	Locum Consultant	Locums	
Karen	Mair	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Sakheleni	Makena	Ward Manager	Ward 22 (TW)	Specialist Medicine and Therapies
Farzana	Mali	Planning Manager	Radiotherapy Physics (CAN)	Cancer, Haematology and Radiology
Karen	Mangan	Elective Flow Co-ordinator	Surgery Directorate Management (M)	Surgery, Urology and Gynae Oncology
Mely	Manuel	Sister / Charge Nurse	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
Pippa	Marks		Agency	
Maria	Maroufidou	Staff nurse	Acute Medical Unit (M)	Acute and Emergency
Hugo Luis	Marques De Sousa	Sister/Charge Nurse	Surgical Assessment Unit (TW)	Surgery, Urology and Gynae Oncology
Catarina	Marques Oliveira	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Katharine	Martin	Radiographer	CT Scans (Med Imaging) (TW)	Cancer, Haematology and Radiology
Caroline	Mason	Lead Nurse	ENT Specialist Nurses	Head and Neck
Louise	Mason	Admin Assistant	Maidstone and Tunbridge Wells NHS Trust	
Susan	Mattison	Bank Staff Nurse Band 5	Bank Staff- Nursing & Midwifery Registered	
Emma	May	Clinical Skills Sister	ENT Specialist Nurses	Head and Neck

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Iain	McCracken	Systems Operations Centre Team Manage	Maidstone and Tunbridge Wells NHS Trust	
Ann	McGowan	Sister/Charge Nurse	Stroke Unit (M)	Specialist Medicine and Therapies
Hilary	McGuigan	Pharmacist Advanced with SCR	Pharmacy Administration (TW)	Pathology and Pharmacy
William	McKee	Senior Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Nicole	McLay	Clinical Support Worker	ENT Services Eemu	Head and Neck
Amanda	McLoughlin	Sister/Charge Nurse	Lord North Ward (M)	Cancer, Haematology and Radiology
Mary	McQuillan	Sister/Charge Nurse	Intensive Care (TW)	Critical Care
Marianne	Meech	Adviser	Occupational Health	Workforce
Diane	Mercer	Senior Booking Clerk	Clinical Admin Unit - Trauma & Orthopaedic	Trauma and Orthopaedic
Matthew	Miles	Senior Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Paul	Mills	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Nicola	Mitra	Assistant Chaplain	Chaplains	Corporate
Kirstie	Moody	Chief Pharmacy Technician	Pharmacy Administration (TW)	Pathology and Pharmacy
Julia	Moore	Senior Midwife	Community Midwifery Services (M)	Women's and Sexual Health
Louise	Moore	Phlebotomy Manager	Haematology (TW)	Pathology and Pharmacy
Jocelyn	Moore	Ward Mgr Ward DSU	Surgical Assessment Unit (TW)	Surgery, Urology and Gynae Oncology
Claire	Morris	Lead for Inpat Therapy Services	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Lorraine	Moxom	Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Elizabeth	Mukiwa-Mlambo	Intervention Recovery Manager	Catheter Laboratory (TW)	Specialist Medicine and Therapies
Wendy	Munn	Sister/Charge Nurse	Hedgehog Ward (TW)	Children's Services
John	Munro	Clinical Specialist	Physiotherapy Outpats (TW)	Specialist Medicine and Therapies
Lucy	Murray	Senior Radiographer	Medical Imaging (M)	Cancer, Haematology and Radiology
Dhanya	Nair	Staff Nurse	Short Stay Surgical Unit (TW)	Surgery, Urology and Gynae Oncology
Bahram	Nedjati Gilani	Radiographer	Maidstone and Tunbridge Wells NHS Trust	
Jennifer	Needham	Senior Oncology Pharmacist	Oncology Pharmacy (M)	Cancer, Haematology and Radiology
Wendy	Needham	Specialist Nurse	Rheumatology Outpatient (M)	Specialist Medicine and Therapies
Anthony	Nnadi	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Margaret	O'Donoghue	Dietitian	Dietetics	Specialist Medicine and Therapies
Omowunmi	Ogunnoiki	Consultant Obstetrics & Gynaecology	Obs & Gynae Medical Staff (TW)	Women's and Sexual Health
Bosede	Okufi	Staff Nurse	Ophthalmology Out Patients (MED)	Head and Neck
Michael	Oldfield-Marsh	Programme Manager	Programme Management Team (5)	
Patricia	Oliver	Midwife	Midwifery Services (TW)	Women's and Sexual Health
Elizabeth	Olorunfemi	Procurement Services Officer	Procurement Department	Finance
Linda	Omisore	Associate Project Consultant	Maidstone and Tunbridge Wells NHS Trust	
Lucy	O'Neill	HR Business Partner	Business Partner Team	Workforce
Erutase	Oputu	Pharmaceutical Manager	Pharmacy Administration (TW)	Pathology and Pharmacy
Deborah	O'Reilly	Advanced Orthoptist	Head Orthoptist (EEM)	Head and Neck
Brendan	O'Reilly	Deputy Lead Sonographer	Ultrasound (M)	
Peter	Packard	General Manager	Estate Maintenance (M)	Estates and Facilities
Ian	Pamphlett	Chief Pharmacy Technician	Pharmacy KOC R&D	Pathology and Pharmacy
Sukhvinder	Panesar	Cheif Pharmacy Technician with SCR	Pharmacy (M)	Pathology and Pharmacy
Ruth	Parker	Advanced Orthoptist	Head Orthoptist (EEM)	Head and Neck
Catherine	Payton	Lead Sonographer	Ultrasound (M)	
Craig	Pearce	IM&T Specialist (Networks)	Maidstone and Tunbridge Wells NHS Trust	
David	Pearce	Senior I Radiographer	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Rebecca	Pearson	Sister/Charge Nurse	Bank Staff- Nursing & Midwifery Registered	
Lee	Pearson	Porter	Portering (M)	Estates and Facilities
Stephanie	Pearson	PMO Co-Ordinator	Programme Management Team	
Joanne	Penman	Dep Radiotherapy Mgr (M)	Maidstone and Tunbridge Wells NHS Trust	
Graham	Pennock	Regulatory Manager- Health and Safety	Estate Maintenance (M)	Estates and Facilities
Audrey	Perkins	Sister/Charge Nurse	Bank Staff- Nursing & Midwifery Registered	
Alison	Pettipiere	Bank Nurse Practitioner	Bank Staff- Nursing & Midwifery Registered	
Krzysztof	Piaseczny	Zone Supervisor (TW)	Soft Facilities Management	Estates and Facilities
Lea	Pilongo	Staff Nurse	Eye Day Care (M)	Head and Neck
Katy	Piper	PA / Medical Secretary	Clinical Admin Unit - Womens & Children	
Sara	Pizzy	Ward Manager	Main Out Patients (M)	
Wayne	Plumridge	Customer Support IT Team Leader	Maidstone and Tunbridge Wells NHS Trust	
Pavel	Polinski	Zone Supervisor (TW)	Soft Facilities Management	Estates and Facilities
Evertje	Pont	Staff Nurse	Main Out Patients (TW)	
Roxanne	Potts	Principal Clinical Scientist	Radiotherapy Physics (CAN)	Cancer, Haematology and Radiology
Teresa	Prentice	Supervisor	Domestic Services (M)	Estates & Facilities
Yolanda	Price	Biomedical Scientist	Clinical Biochemistry (M)	Pathology and Pharmacy
Gillian	Prior	Category Byer	Procurement Department	Finance
Diane	Provost	Biomedical Scientist Advanced	Histopathology	Pathology and Pharmacy
Susan	Prowse	Sister/Charge Nurse	Ophthal Outpatients (M)	Head and Neck
Rebecca	Pullen	Senior Physiotherapist	TADS Team	Specialist Medicine and Therapies
Tina	Purland	Senior Practitioner	Theatre Staff (TW)	Critical Care
Lisa	Purnell	Staff Nurse	Bank Staff- Nursing & Midwifery Registered	
Gladys	Quisido	Ward Manager	Ward 11 (TW)	Surgery, Urology and Gynae Oncology
Rana	Rahman	Clinical Specialist	Ultrasound Ante Natal (TW)	
Krishnabahadur	Rai	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Anil	Rai	Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Nicola	Ramsden	Decontamination Supervisor	TSSU / HSDU (M)	
Gillian	Reader	Senior Pharmacy Technician	Oncology Pharmacy (M)	Cancer, Haematology and Radiology
Clare	Redfearn	Speciality Registrar (H) Obstetrics & Gyna	Maidstone and Tunbridge Wells NHS Trust	
Robert	Reilly	Biomedical Scientist Advanced	Haematology (TW)	Pathology and Pharmacy
Anna	Renju	Sister / Charge Nurse	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Kristian	Rennie	Biomedical Scientist	Haematology (M)	Pathology and Pharmacy
Julie	Reynolds	Sister/Charge Nurse	Hedgehog Ward (TW)	Children's Services
Lindsey	Reynolds	Matron	Intensive Care (TW)	Critical Care
Paul	Rhodes	Quality Technical Manager	Soft Facilities Management	Estates and Facilities
Christine	Richards	Manager	Oncology Management (M)	Cancer, Haematology and Radiology
Janice	Rickard	Senior Midwife	Midwifery Services (TW)	Women's and Sexual Health
Amanda	Riley	Senior I Radiotherapist	Therapeutic Radiography (CAN)	Cancer, Haematology and Radiology
Nina	Robinson	Assistant Practitioner	Chartwell Private Patient Unit (M)	Cancer, Haematology and Radiology
Claudia Maria	Rodrigues Dos Santos	Staff Nurse	Occupational Health	Workforce
Helen	Rogers	Head of Orthoptics and Optometry	Head Orthoptist (EEM)	Head and Neck

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Katy	Rogers	Principal Pharmacist	Pharmacy (M)	Pathology and Pharmacy
Chloe	Ronaldson	Senior Midwife	Crowborough Birth Centre (CBC)	Women's and Sexual Health
Janet	Rose	PA to Director of Workforce	Chief Executive	
Catherine	Rose	Ward Manager	Hedgehog Ward (TW)	Children's Services
Helen	Ross	Staff Nurse	Short Stay Surgical Unit (TW)	Surgery, Urology and Gynae Oncology
Kerry	Rothwell	Senior HR Adviser	Business Partner Team	Workforce
Lucy	Rushton	Respiratory Nurse Practitioner	COPD Respiratory Nurses	Specialist Medicine and Therapies
Nyadzai	Ruzayi	Ward Manager	Short Stay Surgical Unit (TW)	Surgery, Urology and Gynae Oncology
Kamaldeep	Sahota	Snr Oncology Clin Pharmacist	Maidstone and Tunbridge Wells NHS Trust	
Jean	Salcedo	Sister/Charge Nurse	Ward 33 (Gynae) (TW)	Women's and Sexual Health
Philippa	Salmon	Physiotherapist	Physiotherapy Outpats (TW)	Specialist Medicine and Therapies
Martin	Sands	Physiotherapist	Maidstone and Tunbridge Wells NHS Trust	
Christopher	Sands	Chief Pharmacy Technician	Pharmacy Administration (TW)	Pathology and Pharmacy
Jane	Sansom	Senior Sister/Charge Nurse	Intensive Care (TW)	Critical Care
Paula	Savage	Staff Nurse	Endoscopy Out Patients (TW)	Critical Care
Angela	Savage	Complaints Case Manager	PALS and Complaints	Clinical Governance
Trudie	Scarlett	Clinical Skills Sister	ENT Specialist Nurses	Head and Neck
Hannah	Schofield	Sister/Charge Nurse	Children's Comm Nursing Team	Children's Services
Danielle	Scott	Deputy Team Leader	Head Orthoptist (EEM)	Head and Neck
Nichola	Scrimgeour	Discharge Co-ordinator (Nursing)	Bank Staff- Nursing & Midwifery Registered	
Robert	Scutt	Computer Scientist	Medical Physics Computing	Cancer, Haematology and Radiology
Jennifer	Sebastian Pillai	Physics Technician	Maidstone and Tunbridge Wells NHS Trust	
Claire	Sedden	Emergency Nurse Practitioner	Emergency Nurse Practitioner	Acute & Emergency Medicine
Miranda	Selby-Shakespeare	Staff Nurse	Ophthalmology Out Patients (MED)	Head and Neck
Matthew	Selfe	Customer Support IT Manager (Field)	Maidstone and Tunbridge Wells NHS Trust	
Sarah	Shipton	Clinical Lead	Occupational Therapy (TW)	Specialist Medicine and Therapies
Victoria	Simons	Clinical Site Manager	Clinical Site Managers (TW)	
Lynne	Simper	Staff Nurse	Maidstone and Tunbridge Wells NHS Trust	
Augustina	Simpson	Sister/Charge Nurse	Endoscopy Out Patients (M)	Critical Care
Elizabeth	Sinacola	Service Manager	Maidstone and Tunbridge Wells NHS Trust	
Sivasubramaniam	Sivappriyan	Consultant Diabetics	Diabetics Med Staff (M)	Specialist Medicine and Therapies
Gail	Slaytor	Staff Nurse	Ophthalmology Out Patients (MED)	Head and Neck
Tracey	Smith	Emergency Nurse Practitioner	Bank Staff- Nursing & Midwifery Registered	
Caroline	Smith	Sister/Charge Nurse	Bank Staff- Nursing & Midwifery Registered	
Elizabeth	Smith	Sister/Charge Nurse	Eye Day Care (M)	Head and Neck
Danielle	Smith	Admin Assistant	MTW Laundry Services	Estates and Facilities
Myrrinete	Socobos	Sister / Charge Nurse	Bank Staff- Nursing & Midwifery Registered/Bank Staff- Nursing & Midwifery Registered	
Noreen	Speller	General Manager	Directorate Admin T&O	Trauma and Orthopaedic
Ian	Spencer	Zone Supervisor (TW)	Soft Facilities Management	Estates and Facilities
Kevin	Spice	Chief Audiologist	Audiology	Head and Neck
Christopher	Spokes	Diagnostic Radiographer (M)	Medical Imaging (M)	Cancer, Haematology and Radiology
Michelle	Stairmand	Complaints Lead	PALS and Complaints	Clinical Governance
Natalie	Stanley	Radiotherapy Plan Manager (K&C)	Maidstone and Tunbridge Wells NHS Trust	
Sabreena	Stanton	Theatre Clinical Co-ordinator	Theatre Staff (TW)	Critical Care
Frances	Staples	Pre-Assessment Practitioner	Pre-Assessment Nursing (M)	
Anne-Marie	Stevens	Voluntary Services Co-ordinator	Administration (M)	Corporate
Elizabeth	Stroud	Sister/Charge Nurse	Pre-Assessment Nursing (M)	
Erna	Stuart-Black	Ward Manager	Coronary Care Unit (TW)	Specialist Medicine and Therapies
Alison	Suitters	Physiotherapist	Physiotherapy Outpats (M)	Specialist Medicine and Therapies
Helen	Summers	Senior Sister/Charge Nurse	Critical Care Outreach Scheme	Critical Care
Sherril	Swain	Bank Staff Nurse Band 5	Bank Staff- Nursing & Midwifery Registered	
Cherry	Taylor	Deputy Medical Education Manager	Maidstone and Tunbridge Wells NHS Trust	
Andrea	Teasdale	Modern Matron	Womens Services Management	Women's and Sexual Health
Tara	Thomas	Clinical Co-Ordinator	Bank Staff- Nursing & Midwifery Registered	
Margaret	Thompson	Sister/Charge Nurse	Oncology Out Patients (M)	Cancer, Haematology and Radiology
Louise	Todd	Ward Manager	Ward 10 (TW)	Surgery, Urology and Gynae Oncology
Leah	Towner	Discharge Manager	Discharge Lounge (TW)	Critical Care
Joy	Trenchard	Sister/Charge Nurse	Medical Imaging (M)	Cancer, Haematology and Radiology
Simon	Trevers	Principal Engineer	Medical Physics Engineering	Cancer, Haematology and Radiology
Julie	Trevers	Radiographer	Mobile Breast Screening	Cancer, Haematology and Radiology
Sarah	Trollope	Sister/Charge Nurse	Chartwell Private Patient Unit (M)	Cancer, Haematology and Radiology
Maria	Turner	Clinical Lead	Occupational Therapy (M)	Specialist Medicine and Therapies
Karen	Tyler	Senior Pharmacy Technician	Oncology Pharmacy (M)	Cancer, Haematology and Radiology
Corrie	Tyrie	Junior Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Nadia	Varela Pavoeiro	Staff Nurse	Intensive Care (M)	Critical Care
Rachael	Vass	Resuscitation Triage Co-Ordinator	Emergency Care Training	
Helen	Vaughan	Therapist	Speech & Language Therapy	Specialist Medicine and Therapies
Nicola	Vidad	Deputy Lead Phlebotomist	Haematology (TW)	Pathology and Pharmacy
Robert	Vidler	Supervisor	Portering (TW)	Estates and Facilities
Remedios	Villanueva	Staff Nurse	Ward 11 (TW)	Surgery, Urology and Gynae Oncology
Mark	Vince	Head of Fire, Safety & Compliance	Estate Maintenance (M)	Estates and Facilities
Elinor	Vinecombe	Head of Treatment and Planning	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Charlotte	Wadey	Lead Nurse	Oncology Management (M)	Cancer, Haematology and Radiology
Lynne	Wadhams	PA / Medical Secretary	Medical Imaging (M)	Cancer, Haematology and Radiology
Elizabeth	Wallis	Emergency Nurse Practitioner	Maidstone and Tunbridge Wells NHS Trust	
Steven	Walters	Senior Radiographer	Medical Imaging (M)	Cancer, Haematology and Radiology
Carmel	Walters	Senior Oncology Clin Pharmacisy with SCI	Pharmacy KOC R&D	Pathology and Pharmacy
Neil	Walton	Data Quality Analyst	Application Management	MTW Informatics
Eleanor	Warner	Clinical Nurse Specialist	Gastroenterology Specialist Nursing	
Fiona	Warr	Staff Nurse	Ward 21 (TW)	Specialist Medicine and Therapies
Annabelle	Waterman	Medical Education Officer	Post Graduate Centre (TW)	
Monika	Wawrzynczyk	Zone Manager (TW)	Soft Facilities Management	Estates and Facilities
Penelope	Webster	Physiotherapist	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Kevin	Weeden	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Sarah	Weeds	Biomedical Scientist	Cytology	Pathology and Pharmacy
Steven	Weeks	Lead Practitioner	Theatre Staff (M)	Critical Care
Cheryl	Weller	Specialist Nurse	Chest Unit (M)	

Risk Assessors				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Ellen	Wescomb	Associate Physicist	Radiotherapy Physics (CAN)	Cancer, Haematology and Radiology
Christopher	West	Practitioner	Maidstone and Tunbridge Wells NHS Trust	
Michael	Weston	Advanced Orthoptist	Head Orthoptist (EEM)	Head and Neck
Elizabeth	Wheeler	Senior Technician	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Susan	White	Superintendent	MRI (TW)	Cancer, Haematology and Radiology
Kimberley	Whitehouse	Sen II Radiotherapist	Maidstone and Tunbridge Wells NHS Trust	
Kathleen	Whybrow	Associate Emergency Nurse Practitioner	Emergency Nurse Practitioner	Acute & Emergency Medicine
Lynda	Wickenden	Sister/Charge Nurse	Ward 33 (Gynae) (TW)	Women's and Sexual Health
Michelle	Wickens	Ward Manager	Hedgehog Ward (TW)	Children's Services
Belinda	Wienrich	Specialist Practitioner	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Adam	Wilder	Medical Education Administrator	Post Graduate Centre (TW)	
Ian	Wilkins	Supervisor	Portering (TW)	Estates and Facilities
Frances	Williams	Clinical Lead	Occupational Therapy (M)	Specialist Medicine and Therapies
David	Williams	Physiotherapist	Physiotherapy Outpats (TW)	Specialist Medicine and Therapies
Agnes	Williams	Sister/Charge Nurse	Short Stay Surgery Unit (M)	Surgery, Urology and Gynae Oncology
Susan	Willington	Theatre System Lead	Theatres Administration	Critical Care
Daniel	Winson	Senior Sister/Charge Nurse	Intensive Care (M)	Critical Care
Karen	Withell	Biomedical Scientist Advanced	Microbiology (M)	Pathology and Pharmacy
Charlotte	Witt	Biomedical Scientist	Haematology (TW)	Pathology and Pharmacy
Pauline	Wood	Senior I Radiographer	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Jenevre	Woodrow	Clinical Nurse Specialist - Acute Pain	Chronic Pain (TW)	Critical Care
Oliva	Woodward	Staff Nurse	Main Out Patients (M)	
Wayne	Wright	Gen Transport Team Ldr (M)	Transport	Estates and Facilities
Kynn	Wynn	Specialty Doctor Anaesthetics	Anaesthetics Medical Staff (M)	Critical Care
Soni	Xavier	Staff Nurse	Urology Investigation Unit (M)	Surgery, Urology and Gynae Oncology
Diane	Young	Senior Audiologist	Audiology	Head and Neck

Incident Investigators				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Alice	Abed	Physiotherapist	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Janine	Absalom	Ward Manager	Maidstone Birth Centre	Women's and Sexual Health
Nicole	Adams	Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	Acute and Emergency
Iryna	Afafsa	Zone Manager (M)	Soft Facilities Management	Estates and Facilities
Susan	Akehurst	Radiographer	Nuclear Medicine (TW)	Cancer, Haematology and Radiology
Paulinah	Akinmejiwa	Site Practitioner	Maidstone and Tunbridge Wells NHS Trust	
Julia	Allcock	Lead Nurse	Theatre Staff (M)	Critical Care
Sara	Amess	Ultrasonographer	Ultrasound (M)	
Rachel	Anderson	Junior Sister/Charge Nurse	Acute Medical Unit (M)	Acute and Emergency
Krishnan	Balasubramanian	Consultant Paediatrics	Paediatrics Medical Staff (TW)	
Paul	Bolton	Head of Information (Operational)	Business Intelligence	Finance
Wendy	Bonnert	Biomedical Scientist	Haematology (M)	Pathology and Pharmacy
Natalie	Boxer	Ward Manager	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Rebecca	Brett	Junior Sister / Charge Nurse	Children Services Management	Children's Services
Jasmin	Budhai	Staff Nurse	Urology Investigation Unit (M)	Surgery, Urology and Gynae Oncology
Hilary	Bulmer	Ward Manager	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
Megan	Burch	Clinical Lead	Maidstone and Tunbridge Wells NHS Trust	
Helen	Burn	Bank Staff		
Ilona	Cassar	Senior Sister/Charge Nurse	Intensive Care (TW)	Critical Care
Nancy	Clements Smith	Cardiac Specialist Nurse	Bank Staff- Nursing & Midwifery Registered	
Julie	Coppin	Senior Midwife	Womens Services Management	Women's and Sexual Health
Alison	Crayford	Facilitator	ITU Audit (TW)	Critical Care
Stephen	Crouch	Systems and Catalouge Manager	Procurement Department	Finance
Linda	Curtin	Staff Nurse	Ward 12 (TW)	
Caroline	Dadson	Sister / Charge Nurse	Whitehead Ward (Gynae) (M)	Women's and Sexual Health
Jane	Dalton	Medical Laboratory Scientist	Haematology (M)	Pathology and Pharmacy
Helen	Dasley	Pathology Quality Manager	Pathology	Pathology and Pharmacy
Johanna	de Lange	Lead Physicist (Radiotherapy Canterbury)	Maidstone and Tunbridge Wells NHS Trust	Cancer, Haematology and Radiology
Peter	Deal	Laboratory Manager	Mortuary	Pathology and Pharmacy
Paul	Denham	Laboratory Manager	Histopathology	Pathology and Pharmacy
Gurinder	Dhami	Staff Nurse	Maidstone and Tunbridge Wells NHS Trust	
Karen	Dixon	Ward Manager	Cornwallis (New Surgery) (M)	Surgery, Urology and Gynae Oncology
Gillian	Donald	Laboratory Manager	Molecular Pathology	Pathology and Pharmacy
Carole	Dudley	Dementia Nurse Facilitator	Dementia Nursing	
Shaun	Dunmall	Computer Scientist	Medical Physics Computing	Cancer, Haematology and Radiology
Alison	Durrant	Senior Midwife	Midwifery Services (TW)	Women's and Sexual Health
Robert	Farnes	Sister/Charge Nurse	Catheter Laboratory (TW)	Specialist Medicine and Therapies
Rachel	Field	Sister / Charge Nurse	Peale Ward (Surgery) (M)	Surgery, Urology and Gynae Oncology
David	Fish	Consultant Cellular Pathology	Histopathology	Pathology and Pharmacy
Katy	Fleckney	Head of Nuclear Medicine Physics	Medical Physics Health Physics	Cancer, Haematology and Radiology
Gaynor	Gibbons	Modern Matron	Medicine Management (TW)	Specialist Medicine and Therapies
Caroline	Gibson	Incident / Patient Safety Lead	Patient Safety Team	Clinical Governance
Sandra	Goad	Sister/Charge Nurse	Endoscopy Out Patients (TW)	Critical Care
Kiranjit	Grewal	Administrator	Private Patient Unit (TW)	
Rebecca	Griffiths	Site Practitioner	Clinical Site Managers (TW)	
William	Gritt	Zone Supervisor (M)	Maidstone and Tunbridge Wells NHS Trust	
Mansiri	Gurung	Ward Manager	Mercer Ward (M)	Specialist Medicine and Therapies
Wendy	Higgins	Zone Supervisor (M)	Soft Facilities Management	Estates and Facilities
Sandra	Hobden	Service Manager	Microbiology (M)	Pathology and Pharmacy
Rosemary	Hooper	Staff Nurse	Theatre Staff (M)	Critical Care
Kim	Hutchins	Snr Physiotherapist Clin Lead	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Charlotte	Hyde	Sister/Charge Nurse	Accident & Emergency (M)	Acute and Emergency
Jennifer	Ireland	Laboratory Manager	Biochemistry	Pathology and Pharmacy
Alison	Jankowski	Clinical Manager	TADS Team	Specialist Medicine and Therapies
Nicholas	Jenkins	Head of Radiotherapy Physics	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Anthea	Jones	Senior Pharmacy Technician with SCR	Pharmacy (M)	Pathology and Pharmacy
Julie	Kelloway	Site Practitioner	Clinical Site Managers (TW)	
Carol	Kinsella	Manager	Physiotherapy Outpats (TW)	Specialist Medicine and Therapies
Mark	Knight	Head of Health Physics and Imaging Group	Medical Physics Health Physics	Cancer, Haematology and Radiology
Ketkee	Kothadia	Laboratory Manager	Haematology (Xsite)	Pathology and Pharmacy
Kundavaram	Kumar	Consultant Diabetics	Diabetics Med Staff (M)	Specialist Medicine and Therapies
Geraldine	Lagman-Yambao	Junior Sister/Charge Nurse	Acute Medical Unit (TW)	Acute and Emergency
Joanne	Lee Yow	Sister/Charge Nurse	Main Out Patients (TW)	
Felicity	Lusted	Lead Physiotherapist	Physiotherapy Inpats (TW)	Specialist Medicine and Therapies
Christopher	MacQuillin	Junior Sister/Charge Nurse	Acute Medical Unit (TW)	Acute and Emergency
Jackielyn	Maddatu Suyo	Junior Sister/Charge Nurse	Acute Medical Unit (TW)	Acute and Emergency
Laurence	Maiden	Consultant Gastroenterology	Gastroenterology Med Staff (TW)	
Farzana	Mali	Planning Manager	Radiotherapy Physics (CAN)	Cancer, Haematology and Radiology
Karen	Mangan	Elective Flow Co-ordinator	Surgery Directorate Management (M)	Surgery, Urology and Gynae Oncology
Katharine	Martin	Radiographer	CT Scans (Med Imaging) (TW)	Cancer, Haematology and Radiology
Carol	Maynard	Sister/Charge Nurse	Surgical Assessment Unit (TW)	Surgery, Urology and Gynae Oncology
Karen	McDonald	Unit Manager	Haematology Day Unit (TW)	Cancer, Haematology and Radiology
Mary	McQuillan	Sister/Charge Nurse	Intensive Care (TW)	Critical Care
Rebecca	Mitchell	Senior Sister	Bank Staff- Nursing & Midwifery Registered	
Julia	Moat	Ward Manager	SCBU (TW)	Women's and Sexual Health
Daniel	Moore	Modern Matron	Infection Control Nursing	Pathology and Pharmacy
Louise	Moore	Phlebotomy Manager	Phlebotomy	Pathology and Pharmacy
Diane	Morgan-Jones	Manager	Maidstone and Tunbridge Wells NHS Trust	
Claire	Morris	Lead for Inpat Therapy Services	Physiotherapy Inpats (M)	Specialist Medicine and Therapies
Lorraine	Moxom	Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Elizabeth	Murray	Staff Nurse	Whitehead Ward (Gynae) (M)	Women's and Sexual Health
Dhanya	Nair	Staff Nurse	Short Stay Surgical Unit (TW)	
Patricia	Oliver	Midwife	Midwifery Services (TW)	Women's and Sexual Health
Louise	Pack	Senior Sister/Charge Nurse	Clinical Site Managers (M)	
Louise	Paddison	Midwife - Senior Sister/Charge Nurse	Maidstone Birth Centre	Women's and Sexual Health
Arnold	Page	Head of Physics Engineering	Medical Physics Engineering	Cancer, Haematology and Radiology
Teresa	Prentice	Supervisor	Domestic Services (M)	Estates and Facilities
Joanne	Pride	Senior Clinical Coding Analyst	Clinical Coding Dept	
Susan	Prowse	Sister/Charge Nurse	Ophthal Outpatients (M)	
Gladys	Quisido	Ward Manager	Ward 11 (TW)	
Emily	Reed	Discharge Co-ordinatir	Clinical Site Managers (M)	
Robert	Reily	Laboratory Manager	Blood Transfusion (Xsite)	Pathology and Pharmacy
Lindsey	Reynolds	Matron	Intensive Care (TW)	Critical Care
Christine	Richards	Manager	Oncology Management (M)	Cancer, Haematology and Radiology
Katharine	Roberts	Lead Radiographer	CT Scans (Med Imaging) (TW)	Cancer, Haematology and Radiology
Helen	Ross	Staff Nurse	Short Stay Surgical Unit (TW)	Surgery, Urology and Gynae Oncology

Incident Investigators				
First Name	**Last Name**	**Job Title**	**Department**	**Directorate**
Paula	Savage	Staff Nurse	Endoscopy Out Patients (TW)	Critical Care
Sarah	Shipton	Clinical Lead	Occupational Therapy (TW)	Specialist Medicine and Therapies
Victoria	Simons	Clinical Site Manager	Clinical Site Managers (TW)	
Caroline	Smith	Sister/Charge Nurse	Bank Staff- Nursing & Midwifery Registered	
Myrrinete	Socobos	Sister / Charge Nurse	Bank Staff- Nursing & Midwifery Registered/Bank Staff-Nursing & Midwifery Registered	
Natalie	Stanley	Radiotherapy Plan Manager (K&C)	Maidstone and Tunbridge Wells NHS Trust	
Carole	Stone	Manager	Medical Imaging (TW)	Cancer, Haematology and Radiology
Erna	Stuart-Black	Ward Manager	Coronary Care Unit (TW)	Specialist Medicine and Therapies
Sherril	Swain	Bank Staff Nurse Band 5	Bank Staff- Nursing & Midwifery Registered	
Louise	Todd	Ward Manager	Ward 10 (TW)	
Alison	Tumani	Senior Sister/Charge Nurse	Accident & Emergency (M)	Acute and Emergency
Sarah	Turner	Associate Director of Nursing Services	Clinical Operations Management	
Maria	Turner	Clinical Lead	Occupational Therapy (M)	Specialist Medicine and Therapies
Corrie	Tyrie	Junior Sister/Charge Nurse	Maidstone and Tunbridge Wells NHS Trust	
Ann	Wakeling	Senior Sister	Medical Imaging (TW)	Cancer, Haematology and Radiology
Sylvia	Want	Sister/Charge Nurse	Bank Staff- Nursing & Midwifery Registered	
Sarah	Ward	Staff Nurse	Hedgehog Ward (TW)	Children's Services
Fiona	Warr	Staff Nurse	Ward 21 (TW)	Specialist Medicine and Therapies
Melanie	Wates	Wellbeing Advisor	Maidstone and Tunbridge Wells NHS Trust	
Theresa	Welfare	Service Manager	Cellular Pathology	Pathology and Pharmacy
Alison	Wells	Lead Physicist	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Elizabeth	Wheeler	Senior Technician	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Susan	White	Superintendent	MRI (TW)	Cancer, Haematology and Radiology
Teresita	Whiting	Junior Sister/Charge Nurse	Culpepper Ward (M)	
Michelle	Wickens	Ward Manager	Hedgehog Ward (TW)	Children's Services
Amanda	Williams	Manager	Radiotherapy Physics (M)	Cancer, Haematology and Radiology
Lisa	Wolvey	Deputy Head of Employee Services	HR Employee Services	Workforce
Maria	Wright	Senior Midwife	Community Midwifery Services (M)	Women's and Sexual Health

Appendix 5

Trust Risk Documentation

Document	Requirements		Associated Documents
Health and Safety Policy and Procedure	Health and Safety at Work etc Act 1974	Describes Trust arrangements for managing health and safety risk including: • Policy statement of managerial intent • Responsibilities • Health and safety arrangements	Risk Management Policy and Procedure
Risk Management Policy and Procedure	Required by The Department of Health	Describes Trust arrangements for managing risk including: • Definitions • Duties, roles and accountabilities • Trust risk committee structure • Local process for the management of risk, including escalation and reporting • Introduction to risk assessment • Introduction to incident investigation • Monitoring, auditing and assurance	Health and Safety Policy and Procedure
Risk Assessment Policy and Procedure	Required by: • Management of Health and Safety at Work Regulations • Risk Management Policy and Procedure • Health and Safety Policy and Procedure	Describes how risks are assessed in the Trust including: • Hazard identification • Risk assessment (who can be harmed and how they can be harmed) • Evaluating risks (risk scoring) • Recording and sharing risk assessment • Reviewing risk assessments	Health and Safety Policy and Procedure Risk Management Policy and Procedure

Document	Requirements		Associated Documents
		• Appraising a risk assessment	
Incident Management Policy and Procedure	Required by: • NHS England guidance • Risk Management Policy and Procedure • Health and Safety Policy and Procedure	Describes how adverse incidents are managed in the Trust including: • Reporting an incident • Immediate response to an incident. • Incident categorisation • Incident investigation (root cause analysis) • Reporting incidents (internal and external) • Learning from incidents	Health and Safety Policy and Procedure Risk Management Policy and Procedure
Serious Incidents (SI) Policy and Procedure	Required by: • NHS England guidance • Risk Management Policy and Procedure • Health and Safety Policy and Procedure	Describes how SIs are managed in the Trust including: • Reporting incidents (internal and external) • Learning from incidents	
Guidance on Risk Register Administration and Review.	Required by The Department of Health	Risks identified from local risk assessment and adverse incident investigations are placed on a risk register. This allows risks to be managed effectively or escalated through the local management committee structure to Directorate and Board level. Also allows risks to be managed (mitigated or accepted) at the correct level, recorded and shared.	

Maidstone and Tunbridge Wells NHS Trust

Appendix 6

KEY CONTACTS

Risk and Compliance Manager	Rob Parsons	(01622 2)24581
Head of Fire, Safety and Compliance	Mark Vince	07595647781
Legal Services Manager	Wendy Bates	07525918825
Patient Safety Manager	Tanisha Okoli	07834150070
Fire Safety Officer	Mark Vince	07595647781
Manual Handling Coordinator	-	-
Radiation Protection Adviser	Mark Knight	(01622 2)25005
Occupational Health Manager	Christian Lippiatt	(01622 2)24324
Nurse Consultant - Infection Prevention and Control	Lesley Smith	(01622 2)24038
Local Security Management Specialist	Jo Hand	(01622 2)24535
Energy and Sustainability	Jeanette Batten	(01892 6)33910
Dangerous Goods Safety Advisor	Independent Safety Services Ltd	0114 272 2113
Estates Department Help line - Maidstone		(01622) 224777
“InterserveFM” helpline – Tunbridge Wells		(01892 6) 35359
KESWHL project agreement “Trust Representative”	Jeanette Batten	(01892 6)33910
Electro Mechanical Engineering Services (EME) Help line		(01622 2)23151
Police		Via main switchboard
Fire		Via main switchboard

Staff can access the names of their key staff and managers from the risk page of the Trust’s intranet or **Appendix 4** of the Health and Safety Policy and Procedure (RWF-OWP-APP678).

Appendix 7

Maidstone and Tunbridge Wells NHS Trust

Terms Of Reference For The Trust Health and Safety Committee

1 Constitution

The Health and Safety Committee is constituted at the request of the Trust Management Executive (TME) to ensure the implementation and management within the Trust of the operational aspects of health, safety and risk.

The aim of the Trust Health & Safety Committee shall be to promote the closest co-operation and understanding between management and staff in order to secure an acceptable standard of health and safety. To enable the Trust to meet its duties under the Health and Safety at Work etc. Act 1974 and regulations enabled under the Act.

The Trust Health & Safety Committee may make recommendations to the Chief Executive or to the TME on any subject which it considers appropriate to the health and safety of the Trust's employees or to persons who may be affected by the work activities of such employees.

2 Membership

2.1 Management membership.

- Chief Operating Officer (Chair)
- Deputy Chief Nurse (Vice Chair)
- Risk and Compliance Manager
- Trust Health and Safety Advisor
- Head of Fire, Safety and Compliance
- Local Security Management Specialist (LSMS)
- Radiation Protection Advisor (RPA)
- Occupational Health Manager
- Nurse Consultant Infection Prevention

Managers can send a deputy to the meeting. The initials of the deputy will be recorded in the attendance report and be recorded as present.

2.2 'Staff Side' Membership

- Chair of Staff side Committee.
- All recognised 'Staff Side' Union Representatives

Staff side representatives have functions rather than duties under H&S law. Hence, all staff side members have a seat on the committee and will decide themselves who will attend.

2.3 Directorate Risk Leads (one from each Directorate)

- Acute and Emergency
- Cancer, Haematology and Radiology
- Critical Care
- Pathology & Pharmacy
- Head and Neck
- Paediatrics
- Speciality Medicine and Therapies
- Surgery, Urology & Gynae Oncology
- Trauma and Orthopaedics
- Women's and Sexual Health
- Non-clinical Risk Leads where not covered by a Co-opted member, such as Estates and Facilities and Finance

Leads can send a deputy to the meeting. The initials of the deputy will be recorded in the attendance report and be recorded as present.

2.4 Co-opted members as required by the Committee to provide reports and to discuss specific issues.

- Associated Director Quality Governance
- Fire Officer
- Trust Health and Safety Manager
- Emergency Planning Officer (EPO) (Resilience Committee)
- Environmental and Sustainability Manager (Waste Steering Group)
- Central Alerting System Coordinator (CAS)
- Moving and Handling Coordinator
- Electro-Medical Engineering (EME) Services and Technical Services Manager (Medical Devices Committee)
- Chair of Pathology Health and Safety Committee
- Chair of Falls Group
- Directorate Risk Lead for Health Informatics Services (HIS) (or deputy)
- Other Trust Officers and specialists as required

3 Quorum

1 Chair or Vice chair
3 Managers
1 'Staff Side' member or, where due to organisational pressures attendance is not possible, an agreement in principle on the meeting content
4 Directorate Risk leads (or a deputy)

4 Attendance

Attendance level required by Managers – 60%.
Attendance level required by Directorate Representatives – 100% (may send a nominated deputy).
Attendance level required by co-opted members – 25%.

Managers, Leads and Representatives can send a deputy to the meeting. The initials of the deputy will be recorded in the attendance report and be recorded as present.

Managers, Leads and Representatives can deputise for each other. However, an individual cannot deputise for more than one member.

5 Frequency of Meeting

Meetings will be held every 2 months throughout the year.

6 Terms of Reference

- Promote a positive Health and Safety culture throughout the Trust with consistent attitudes, beliefs and behaviours.
- Demonstrate management commitment to Health and Safety.
- Oversee the operational management of risk within the Trust.
- Consider Health and Safety issues raised by Union safety representatives, competent persons, managers, directors etc.
- Ensure effective communication, consultation and cooperation with staff on Health and Safety issues through the committee structure and all other effective means.
- Ensure the Trust meets all its duties under the Health and Safety at Work etc. Act 1974 and regulations enacted under the Act.
- Monitor the local management of Reporting of Injuries, Diseases, Dangerous Occurrence Regulations 2013 (RIDDOR) reportable incidents.
- Monitor Health and Safety reporting, such as the level of accidents and notifiable diseases, to identify levels and trends that enable risk of harm to be minimised.
- Receive and review hazard alerts and monitor Trust compliance under the Central Alerting System (CAS) for Medical Devices Alerts (MDA) and Estate alerts.
- Set and monitor KPIs and targets to measure Directorate performance in the management of Health, Safety and Risk.
- Monitor the management of risks by reviewing Directorate risk management reports.
- Receive reports from site representatives on local issues that have Trust wide implications.
- Ensure that risks are addressed by specialists with appropriate expertise and competencies by receiving reports from Chair or representatives from the specialist committees described in section 7.
- Actively monitor the management of significant Health and Safety risks through the Health and Safety action plan and oversee the annual Health and Safety programme on behalf of the Board.
- Ensure suitable and sufficient numbers of staff are identified and trained to allow Health and Safety to be adequately managed.
- Approve, review and monitor the implementation of relevant risk related policies and procedures.
- Consider recommendations and consultative documents from external agencies such as the Health and Safety Executive (HSE).
- Report to the TME, specialist committees and the Board, on significant Health and Safety issues, as appropriate.

7. Reporting

The committee is a sub-committee of the TME (a sub-committee of the Trust Board). The committee will also report to Directorate committees through the Directorate risk leads.

The following Committees report to the Health and safety Committee through their respective chairs or representatives:

- Security Group (LSMS)
- Resilience Committee (EPO)
- Waste Steering Group (Environmental and Sustainability Manager)
- Water Steering Group
- Pathology Health and Safety Committee
- Kent and East Sussex Weald Hospital Ltd (WESWHL) monthly Liaison Meeting
- Local Health and Safety Committees
- Radiation Protection Committee (RPA)
- Competent Persons Group
- Asbestos Management Group

8. Administration and Duties

The Committee shall be supported by the Executive Assistant to Chief Operating Officer, whose duties will include:

- Agreement with the Chair and the Risk and Compliance Manager an Annual Work Programme setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair and attendees.
- Call for papers from attendees and invitees at least 2 weeks before a meeting.
- Collation and distribution of papers one week before the date of the meeting
- Taking the minutes and the circulation of draft minutes following each meeting.
- Maintaining a record of meeting papers and minutes as a corporate file for the Trust.

9. Review of Terms of Reference and Monitoring Compliance

These terms of reference will be agreed by the Health and Safety Committee and approved by the Trust Management Executive. They will be reviewed annually or sooner if there is a significant change in the arrangements.

At each meeting the attendance record, the annual plan and the policy list will be presented and reviewed. Non-compliance with the terms of reference will be noted and action taken by the chair. The quorum of the committee will be confirmed.

Terms of reference agreed by Health and Safety Committee: 12/04/2018
Terms of reference approved by Trust Management Executive:
Terms of reference to be reviewed: April 2019

Trust Board meeting - September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-18	**Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment**	**Chief Operating Officer**

The enclosed spreadsheet provides information on the organisations compliance and self-assessment against the NHS England Core Standards for Emergency Planning Resilience & Response:

- The Trust has assessed itself against the Core Standards and is fully compliant
- The Trust Board will receive a full formal report in November
- This year's deep dive assessment into Command & Control has revealed that the Trust is partially compliant with one standard relating to Telecoms resilience. This is the same as all NHS Trusts as the required standard has not been published due to a hold up at NHS England.
- A further assessment and peer review by SECAMB into Chemical Biological Radiological and Nuclear Incident Preparedness revealed full compliance.
- The self-assessment with evidence was submitted to the Commissioning Support Unit on behalf of the CCG and they concurred with the Trust's view.

Which Committees have reviewed the information prior to Board submission?
- Resilience Committee

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
The Board are asked to note the results of the Core Standards assessment and deep dive for this year.

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

Summary

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	3	1	0
Command structures	4	4	0	0
Total	8	7	1	0

Overall assessment:

Instructions:
Step 1: Select the type of organisatio
Step 2: Complete the Self-Assessme
Step 3: Complete the Self-Assessme
Step 4: Ambulance providers only: C
Step 5: Click the 'Produce Action Pla

Fully compliant

n from the drop-down at the top of this page
nt RAG in the 'EPRR Core Standards' tab
nt RAG in the 'Deep dive' tab
omplete the Self-Assessment in the 'Interoperable capabilities' tab
n' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.

25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising

37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders

49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Deep dive

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Partially compliant				
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Fully compliant				
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Fully compliant				
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				
Domain: Command structures										
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Fully compliant				
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-19	Summary report from Workforce Committee, 26/07/18	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 26th July 2018.

- **The key matters considered at the meeting were as follows:**
  - The actions from previous meetings were reviewed,
  - The committee noted that Nazeya Hussain would take over as Chair at the September committee meeting
  - The committee reviewed the Workforce performance data for the preceding month. The committee were pleased to note the continued reduction in sickness absence in all parts of the organisation. The committee also noted the ongoing downward trend in turnover from its high in December 2017. Turnover was now only just above the trust target of less than 10%. Mandatory training compliance also remained above target.
  - The committee noted the actions and challenges of the Best Workforce in meeting the financial savings required of it in particular those relating to Medical Agency rate reduction. The committee agreed with the additional actions being taken to reduce agency spend more widely as well as the plans to tackle vacancies.
  - The committee reviewed the recently submitted NHSi Nurse retention plan and welcomed the efforts being made to support new starters and newly qualified nurses to the trust. The committee also highlighted the need to support and encourage those approaching retirement age to consider flexible approaches to retirement to retain key skills and experience within the organisation.
  - The committee reviewed the progress made against the previously agreed Trust Engagement plan noting outstanding actions relating to the appointment of a Freedom to Speak Up Guardian, Leadership behaviours identification and Trust Briefing process. The committee would continue to review progress against the plan on a quarterly basis.
  - The results of the LiA pulse check were noted in particular the low response rate and desire from those who responded to see action against the issues that they had raised. The committee noted the projects that had taken placed and emphasised the importance of regular communication of these achievements to staff. The need for local directorate follow up on the LiA survey was also agreed as being critical to generating confidence in staff that their concerns were being taken seriously.
  - The committee noted the report of the Guardian for Safer Working. The number of exception reports that he had received was consistent with the previous year. The Guardian engaged with junior doctors on a regular basis to hear their concerns and was supported by two senior registrars as deputies to ensure that there was coverage across both sites and in all areas. The primary challenges related to FY1 surgical doctors and this reflected the challenge of maintaining compliant rotas and dealing with gaps in the rotation.
  - The committee noted and welcomed the review of Disciplinary cases completed in 2017/18 that was done in conjunction with the chair of the trust Cultural Diversity Network. Both the assessment of the panel and the % split of cases by gender and ethnicity showed no evidence of discrimination or bias. The committee also noted and welcomed the reduction in tribunal claims made against the trust in the same period.
  - The committee reviewed the update report on the replacement of the Trust Learning Management system, noting that the replacement was on schedule and would deliver a significant improvement in the level of functionality when compared with the existing provision.

- **The issues that need to be drawn to the attention of the Board are as follows:**
- Report of the Guardian for Safer Working

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

WORKFORCE COMMITTEE – July 2018

26/07/18	**GUARDIAN FOR SAFE WORKING REPORT**	**MATT MILNER, GUARDIAN FOR SAFE WORKING**

Summary / Key points

Report covers the period April – June 2018 (Quarter 1)

- Total of 7 Exception reports received in the period.
- Main reasons raise exception reports this quarter are excessive hours, late finish of clinic, in balance of workload to trainee numbers across surgical teams at Tunbridge Wells Hospital and tasks not able to be completed by end of day.
- The Guardian for Safe Working met with FY1s to discuss some of the issues they have been experiencing and to look at improvements which may support trainees.
- Bank usage is £1,291,137.23
- Agency usage is £1,340,536.62

Which Committees have reviewed the information prior to Workforce Committee submission?
None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.) [1]
- Information
- 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

Reporting Period: April – June 18

This report covers the period April – June 2018 in which time a total of 7 exception reports were raised from FY1, FY2 and SPR grade doctors. Medicine, Surgery, ENT and Orthopaedics all raised reports during this period. All reports related to extra hours worked.

Directorate	Exception reports raised
Medicine	1
Surgery	3
ENT	1
T&O	2

Issues raised

The reasons behind the reports being raised included:

- Excessive hours worked for the duty AMU FY1 on a weekend shift. This is a recurring theme and I will discuss this again further with the Rote Co-ordinator for Medicine.
- An in balance of work load to doctor numbers across Surgery teams at Tunbridge Wells Hospital.
- A late clinic finish.
- Tasks not being completed on time before the end of the working day.

There were no reports received relating to supervision.

On the 16th May I met with FY1s at one of their weekly teaching session to hear their views on working as a Surgical FY1 during this year. This meeting allowed open and frank discussion on how working conditions for Surgery FY1s may be improved. My notes from this meeting have been shared with the Medical Director, Director of Workforce, Director of Medical Education, Surgical College tutors and the Surgery General Manager.

The discussions identified that the following improvements should be considered for the coming year:

1) Deanery support in filling vacant slots
2) A review of the surgical departments recruitment drive initiatives
3) Alterations to FY1 rota to give more scope for TCS constraints on working hours
4) Improvements in registrar level support of FY1 doctors (not all registrars at fault)
5) Better engagement from trainees on attending junior doctor's forum to air views
6) Guardian to attend FY1 teaching monthly to get feedback etc.
7) Continued improvement in supervisors responding to exception reports and acting upon them in a timely manner
8) Rotas are adequately staffed to take into account of annual/study leave and teaching opportunities for the trainees to be had.

On the 10th July a visit by the HEE KSS is planned to carry out a risk-based review of General Surgery at the Trust.

Conclusion:

There has been a further reduction in the number of Exception reports raised in this quarter. This is in keeping with the same quarter last year.

Factors likely to have contributed to the reduced reporting are an improved efficiency and effectivity of the trainee doctors, a more informed appreciation of how the departments work and a "feel good factor" for trainees who have been signed off on their rotations for this year.

High level data April – June 2018:

Number of doctors in training on 2016 TCS (total): 248

- No fines were imposed in the period.
- No Diary card exercises were undertaken.
- No work schedule reviews have been undertaken in the period.

a) Exception reports (with regard to working hours)

Exception reports by department: April – June 2018				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	1	1	0
Surgery	0	3	1	2
ENT	0	1	1	0
T&O	0	2	1	1
Total	**0**	**7**	**4**	**3**

Exception reports by grade: April – June 2018				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	4	2	2
F2	0	2	1	1
SPR	0	1	1	0
Total	**0**	**7**	**4**	**3**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	2	2
F2	0	0	1	1
SPR	0	0	1	0
Total	**0**	**0**	**4**	**3**

b) Locum bookings

Staff Bank: April – June 2018

Specialty	Number of shifts worked	Number of hours worked	Cost of Bank Cover £
Accident and Emergency	1032	8294.50	£566,331.27
General Medicine/Acute Medicine	412	3464.75	£232,069.14
Anaesthetics	166	1403.75	£90,368.25
Cardiology	8	80.5	£7,527.42
Cytology	0	0	0
ENT	9	67.5	£2,931.50
General Surgery	228	2022.5	£107,467.83
GUM	0	0	0
Haematology/Oncology	35	231.5	£14,823.50

Specialty	Number of shifts worked	Number of hours worked	Cost of Bank Cover £
Neurology	0	0	0
Obstetrics and Gynaecology	307	2031.5	£109,636.00
Occupational Health	16	120	£14,000.48
Oncology Consultants	6	53	£2,240.00
Ophthalmology	41	434.5	£21,431.84
Paediatrics	151	1025	£75,327.50
Radiology	35	315.33	£35,527.50
Trauma & Orthopaedics	5	223.5	£11,455.00
Urology	0	0	0
Total	**2471**	**19950.17**	**£1,291,137.23**
Grade of Doctor	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover**
F1	68	680.34	£28,384.53
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	896	7085.83	£401,966.93
ST3+, Specialty Doctor (Registrar Level)	1080	8569.75	£540,281.34
Consultant	427	3614.25	£320,504.43
TOTALS	**2471**	**19950.17**	**£1,291,137.23**

Agency April – June 2018

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover
Accident and Emergency	229	1894.17	£68,130.57
General Medicine/Acute Medicine	1868	14131	£589,696.40
Anaesthetics	0	0	0
Cardiology	35	262.5	£19,976.25
ENT	18	151	£4,184.36
General Surgery	648	5874	£220,725.67
GU Medicine	0	0	0
Haem/Oncology	83	622.5	£40,612.05
Histopathology	0	0	0
Obstetrics and Gynaecology	112	1067.5	£58,011.47
Occupational Health	0	0	0
Ophthalmology	135	1050	£37,516.80
Paediatrics	337	2919	£95,261.14
Radiology	60	580	£44,138.00

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover
Rheumatology	0	0	0
Trauma & Orthopaedics	529	4118.5	£138,087.19
Urology	86	752	£24,196.72
Total	**4140**	**33422.17**	**£1,340,536.62**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Agency Cover
F1	136	1020	£20,778.08
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1748	13924	£408,048.24
ST3+, Specialty Doctor (Registrar Level)	1479	12296.17	£443,467.00
Consultant	777	6182	£468,243.30
TOTALS	**4140**	**33422.17**	**£1,340,536.62**

c) Vacancies WTE

Vacancies by month

Specialty	Grade	April 18	May 18	June18	Total gaps (average)	Comments
Accident & Emergency	FY2					
General Medicine	FY1					
General Medicine/Surgery	FY1		5	6	6	Gaps for Aug 18
General Medicine	FY2					
General Medicine	ST1-2					
General Medicine	ST3+					
Geriatric	ST3+					
General Surgery	ST3+	2	2	2	2	
Ophthalmology	FY2					
Ophthalmology	ST1-2	1	1		1	
Ophthalmology	ST3+	1	1	1	1	
Paediatrics	ST3+	2	2	2	2	
Paediatrics	ST4+	4	4	4	4	
Trauma & Orthopaedics	FY2		9	6	6	Gaps for Aug 18

Vacancies by month						
Trauma & Orthopaedics	ST1					
Trauma & Orthopaedics	ST3+	1	1	1	1	
Obstetrics & Gynaecology	ST1					
Obstetrics & Gynaecology	ST3+					
Medical Oncology	ST3+					
Clinical Oncology	ST3+					
				Total Vacancies	**23**	

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-20	Summary report from Quality Committee, 07/08/18 and 12/09/18	Committee Chair (Non-Executive Director)

The Quality Committee has met twice since the last Board meeting, on 7th August (a Quality Committee 'deep dive' meeting) and 12th September (a 'main' meeting).

1. The key matters considered at meeting on 7th August were as follows:

- The **progress with actions** from previous meetings was noted. The Medical Director reported that the issues raised at the June 2018 Quality Committee 'deep dive' into improvements in Paediatrics, relating to staffing issues, had been raised at the Executive Team Meeting earlier that day. The Committee agreed that consideration should be given as to whether any of the existing projects within the Best Workforce workstream might be usefully applied to support the Paediatrics Directorate in re-designing its workload to assist with some of the issues raised
- A **review of the work being taken regarding patient falls** was presented, for which the Falls Prevention Practitioner attended. The report included the following information:
  - The objective for the 2018/19 Board Assurance Framework had been held at 6 per 1000 Occupied Bed Days as more work was needed before this could realistically be reduced
  - Falls prevention work was focused on improving patient safety culture & not exclusively on reducing the falls rate. The falls rate at Tunbridge Wells Hospital (TWH) was comparatively higher than for Maidstone Hospital (MH), which was mainly due to caseload
  - Data for the year to June reflected sound performance against the threshold, but the falls rate had increased in July due to the presence of patients with complex care needs
  - Monthly data for patient falls Serious Incidents (SI) from 2016 to date was noted
  - The actions in place for falls reduction and prevention for 2018/19 were noted, including falls prevention audits on wards; staff training; monitoring of performance against the national median for key indicators from the National Audit of Inpatient Falls (NAIF); and engagement of all Trust personnel in falls prevention
  - The Trust's involvement in the NHSI Falls Prevention Collaborative, designed to provide a framework to address the key indicators requiring improvement was reported
  - Ward 32 and Ward 2 at TWH had been selected as the two pilot wards for this work
  - The focus for the first key indicator had been identified as standardising practice in measuring and documenting Lying and Standing Blood Pressure (LSBP). There was discussion about how appropriate this was as a focus area, given variable staff insight about how to measure LSBP and the potential for the measure to be diluted if inappropriately implemented across the board. The need for guidelines to be intelligently applied according to resource, rather than indiscriminately enforced was noted
  - The NHSI regional lead for the project would visit the Trust and assess progress against the framework at the end of the event
- The second main item reviewed was a **Review of fluid balance and nutrition**, presented by the ICU Matron and Deputy Chief Nurse. The presentation included the following information:
  - Confirmation that fluid balance was a consideration in wider Acute Kidney Injury (AKI) discussions within the Trust
  - An 2017 audit of fluid balance and urine dipstick compliance had shown poor compliance with the identified standards, with key deficiencies in respect of: poor recording/adding up of data on fluid balance charts; fluid balance charts often being started for hydration rather than fluid balance information; poor performance against the requisite 6 hourly review by a registered nurse; poor performance for AKI patients having a urine dipstick within 24 hours; and a discrepancy in Nervecentre urine output data against paper records
  - All wards had been given a copy of their audit results and had individualised plans to address key points; A re-audit by Pye Oliver in 2018 showed significant improvement
  - A hydration chart had been formulated and trialled on wards, but had been withdrawn due to negative staff response
  - All AKI 3 (and, where possible, AKI 2) patients were now reviewed 3 times daily
  - There was discussion about the potential tempering effect of mandating uniform

measurement of fluid balance and parallels were drawn with the discussions outlined above about LSBP; the wider challenge within the Trust to ensure that documentation was appropriately and consistently completed was considered. Work was ongoing to address this issue, primarily focussed on the reasons for non- of compliance and identification of what key information needed to be documented
    - The key elements of the fluid balance workstream were reported as: Education of staff in the importance of fluid balance; use of the Sepsis Group to publicise and disseminate the results of the fluid balance chart audit results and actions; inclusion of fluid balance as a Take Five Talk Five focus topic; & liaison with the Infection Prevention and Control team on its current review of "hydration stations" and reduction in catheter related infections
    - It was agreed that further consideration should be given as to how the issues raised about quality of documentation for fluid balance might be effectively addressed in liaison with Ward Managers & how/if this might be included in the wider work being undertaken about quality of documentation within the Trust. It was also agreed that an update on this work should be scheduled for consideration at a future Quality Committee 'deep dive' meeting
    - Good progress had been made with the AKI Electronic Discharge Notification audit which aimed to ensure AKI issues flagged in hospital were communicated to GPs
- On **nutrition**, the Deputy Chief Nurse reported that:
    - An annual audit was conducted on the use of the Malnutrition Universal Screening Tool (MUST); the Trust's performance in the 2016 audit was very poor and significant improvement had been noted in the preliminary results for the 2018 audit. Recommendations against the latest MUST audit were due by August / September 2018
    - The role of Catering and the Patient-led Assessment of the Care Environment (PLACE) Action Group in patient food provision was noted
    - Following a Never Event in 2017 involving a misplaced feeding tube, there had been very positive staff engagement, policies had been revised and confidence in compliance in the updated framework was high
    - The Trust aimed to achieve compliance with the recently introduced International Dysphagia Diet Standardisation Initiative framework, which established standard terminology to describe texture modification for food & drink, by the end of October 2018
    - Action plan development in response to the 2018 MUST Audit would include involvement with the NHSI Allied Health Professionals (AHP) Supporting Patient Flow Collaborative
    - The Nutrition Steering Group was due to be re-established in October / November 2018
    - Further involvement in an NHSI Dietetic Collaborative was being considered, and it was thought likely that involvement with this would be positive. There was wider discussion about the role of and need for such collaboratives in fundamental areas of professional practice (such as those discussed at that Deep Dive meeting) and it was proposed that the number of 'process issues' raised in the meeting prompted questions about whether the Trust was getting the best out of its staff. One of the Non-Executive Director members of the Committee undertook to observe any particular workstreams related to this as part of her role as a member of the Best Care Programme Board

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

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

- It was agreed to highlight the action being taken to support the Paediatrics Directorate (as detailed above in section 1) within the Quality Committee's report to the Trust Board, so that a verbal update might be given at the Trust Board meeting in September 2018

4. The key matters considered at the 'main' meeting on 12th September were as follows:

- The Deputy Medical Director for Urgent Care attended to report on an **investigation of the circumstances affecting the recent pattern of inpatient admissions**. It was noted that the data showed that the readmission rate was similar at TWH and MH; readmissions were not higher at the major inpatient areas; but the higher proportions of readmissions occurred in the areas with a more rapid turnover of patients i.e. the CDU, AMU and Frailty Units. A higher than expected readmission rate for Tonsillectomies was also highlighted, but it was noted this was under investigation by the Directorate. The Medical Director also confirmed that he expected readmission data to be reviewed at Directorate Clinical Governance meetings.
- The Clinical Director for Trauma and Orthopaedics reported on the **outcomes data from the**

various procedure/sub-specialty and Surgical Site Infection data and it was agreed that a further report, including the data from other Consultants, should be submitted to the 'main' Quality Committee in November 2018

- The reports from the rolling programme of **Directorate-based clinical outcome reports** were reviewed for Critical Care, Head and Neck and Cancer, Haematology and Radiology, and the following points were highlighted:
  - Review of the Critical Care data did not reveal any issues of concern, but the outcomes reports for pain and vascular access should be circulated to Committee members with the meeting minutes as the data was unable to be submitted to the meeting
  - The Clinical Director for Head and Neck highlighted that voluntary outcomes reporting was in place in some specialties and a key factor in this in Ophthalmology was IT restrictions (and specifically that lack of IT capacity prevented efficient use of imaging systems and participation in the National Ophthalmic Database for cataract audit and reporting). It was agreed to ensure that this summary report highlighted the concerns (see below)
  - The current non-compliance with the 62-day Cancer waiting time target was acknowledged, and it was noted that given this, it would be concerning if the outcomes data identified problems. However, the data did not identify any such problems.
- The report of recent **Trust Clinical Governance Committee** meetings was discussed, and each Directorate then highlighted their key issues, the major theme of which was the continuing staff challenges faced by several specialities and Wards
- The summary report from the **Patient Experience Committee**, 05/07/18, was noted
- The Medical Director gave an update on the **review of patients experiencing a long waiting time**. It was noted that the retrospective review was now complete, but it was agreed that the 'main' Quality Committee in November 2018 should receive a report on the process for the prospective review that would now be undertaken
- The Trust Lead Cancer Clinician attended to report on the **clinical harm reviews Cancer of patients who have waited a prolonged period of time**, & it was noted that the West Kent Cancer Improvement Board would randomly select some of the harm reviews for scrutiny, to ensure these were robust. It was also confirmed that the harm reviews would continue
- A **Mortality update** reported the latest position on Hospital Standardised Mortality Ratio (HSMR) (where it was noted that the trend for MH was being investigated), Summary Hospital-level Mortality Indicator (SHMI) and Mortality Reviews undertaken by Directorates (for which compliance had improved and was now regularly over 80%)
- The **workplan being developed in response to the occurrences of Never Events at the Trust** was reviewed, and it was agreed that the 'main' Quality Committee in November 2018 should receive a report on the findings/conclusions from the 3 Never Events Review Panels being held in September and October 2018
- The Associate Director, Quality Governance gave the latest update on **implementation of Quality Accounts priorities 2018/19** and for the "**review of progress with implementing the Quality Strategy**", reported that a launch of the Strategy was scheduled for the autumn
- The latest **Serious Incidents** were reported and the report of the **Quality Committee 'deep dive' meetings** held on 19/06/18 and 07/08/18 was noted

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

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

- It was agreed to ensure that this summary report highlighted the concerns raised by the Clinical Director for Head and Neck regarding the lack of internal IT support/functionality for Ophthalmology IT systems, to enable a response to be given by the Member of the Executive Team that was responsible for IT. Since the meeting, the Chief Finance Officer has arranged for a response to be provided to the issues, and this is enclosed in Appendix 1

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
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: Response to the concerns raised by the Clinical Director for Head and Neck regarding the lack of internal IT support/functionality for Ophthalmology IT systems

Overview
There has been a lack of investment in Information Technology within Ophthalmology services at the Trust over a number of years. As a result, it has been identified that the shortage of IT functionality is impacting the service provided by the department. This paper outlines IT implementations to date and future changes planned within Ophthalmology to support clinicians and improve patient experience.

Governance
IT and Head and Neck departments have setup an Improvement Group with the objective of overseeing the below improvements. This group includes the Clinical Director and the Director of Health Informatics. The group first met at the beginning of August and meets fortnightly to ensure that progress is being maintained.

OpenEyes
OpenEyes is a specialist Ophthalmology Electronic Patient Record (EPR) system which the Trust implemented 5 years ago within the department. The product is currently used within the Trust and the organisation also placed an order at the beginning of September for the additional Cataract module. The Trust has established a project group to manage its implementation.

The Trust is also in collaboration with East Kent Hospitals University NHS Foundation Trust (EKHUFT) to develop a Kent wide Ophthalmology record within a single instance of OpenEyes. A joint funding bid of £600k has been made for its implementation and supporting IT infrastructure. This is expected to be on the Sustainability and Transformation Partnership's (STP's) prioritised list of projects which will be considered for approval by the STP Programme Board on the 1st October, the Business Case can then be submitted to NHS England to release funding. If successful, this will look to implement the full OpenEyes solution across Kent, provide funding for improved IT end-user devices within the MTW Ophthalmology department and look to address improved electronic communications with Optometrists.

ICT Implementation
To ensure that the Trust fully utilises the OCT Triton Camera, additional data storage is required. The new storage solution is now fully implemented at the Trust and as a result, plans with the OCT supplier, Topcon, are underway to migrate the solution. A plan will be in place by the 21st September to complete this work and is being managed via weekly conference calls.

The original delay was caused by a lack of communication around the purchase of the OCT. The teams are working together to ensure this does not happen again with processes around business case approval and regular meetings to review future requirements.

End-User Infrastructure
A review has been completed by IT, with the support of the Ophthalmology department, regarding end-user IT devices. Monitors, PCs and tablet devices are now being rolled out across the service as agreed by the Director of Health Informatics. This work list is being managed directly by the improvement group previously described.

Trust Board meeting - September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-21	Summary report from Audit and Governance Committee, 08/08/18 (incl. the Annual Audit Letter for 2017/18)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 8th August 2018

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

- Progress with actions from previous meetings was noted
- Under the Safety Moment, it was confirmed that the theme for August was Mouth Care and key planned initiatives were noted
- The Board Assurance Framework (BAF) 2017/18, as previously considered by the Trust Board on 26/07/18, and summary of the status of the Trust's Risk Register were noted
- Update on progress with the Internal Audit plan for 2018-19 (incl. progress with actions from previous Internal Audit reviews) was reported
- The list of recent Internal Audit reviews, is shown below (in section 2)
- A Counter Fraud update was reviewed, which included: confirmation that a Bribery Act statement had been drafted and would be cascaded throughout the Trust via the Trust Board; notification of new on-line training packages developed for Trust staff and specialist training on identification documents; confirmation that the latest edition of "Fraud Stop" had been published and disseminated; notification of various fraud alerts issued since 01/04/18, none of which were reported to be of particular risk to the Trust; highlighting of the Crime Pattern Analysis for the sector; and review of the Summary of Reactive Work with updated status of the 7 listed investigations
- It was noted that there was nothing to verbally report by Grant Thornton LLP under the 'Progress and emerging issues report', as no work had yet been undertaken for the year
- The External Audit letter for 2017/18 and the final Audit Findings Report for 2017/18 were received and noted. It was reported that the audit of the Trust's Quality Accounts 2017/18 was now complete and that the Audit Letter would be updated accordingly to reflect this prior to publication (enclosed as Appendix 1)
- The Associate Director of Procurement attended for the review of the latest Single Tender Waivers data
- The Assistant Trust Secretary submitted the latest details of gifts, hospitality and sponsorship declared, which included an update on the process of reconciling information from the Association of the British Pharmaceutical Industry's "Disclosure" database for 2017 with declarations made by Trust staff for the same period
- Details of Payments for compensation under legal obligation and the latest losses & compensations data were received and it was agreed to request that the Chief Nurse considered, as part of the ongoing monitoring of losses, the suggestion that further action should be considered to raise patient awareness of their responsibility for personal effects whilst in hospital
- The Director of Finance provided a verbal summary of the latest financial position
- The Committee agreed that no further action was required on the findings of the Committee evaluation findings, originally discussed at the AGC meeting on 26/02/18, before the next evaluation, which was scheduled for review in February 2019.

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

- "A&E Temporary Staff" (which received a "Limited Assurance" conclusion)
- "Activity and Income Recording including Implementation of SLAM Costing Model" (which received a "Limited Assurance" conclusion)
- "Assurance Framework and Risk Management" (which received a "Reasonable Assurance" conclusion)
- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)

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

- "Non Patient Related Income audit" (1 outstanding action)

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

- N/A

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Grant Thornton

Annual Audit Letter

Year ending 31 March 2018

Maidstone and Tunbridge Wells NHS Trust

July 2018

Contents

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Executive Summary

Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2018.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit and Governance Committee as those charged with governance in our Audit Findings Report on 24 May 2018.

Respective responsibilities

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

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

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

Our work

Materiality	We determined materiality for the audit of the Trust's accounts to be £7.4 million, which is 1.75**%** of the Trust's gross revenue expenditure.
Financial Statements opinion	We gave an unqualified opinion on the Trust's financial statements on 25 May 2018.
NHS Group consolidation template (WGA)	We also reported on the consistency of the accounts consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent.
Use of statutory powers	We referred a matter to the Secretary of State, as required by section 30 of the Local Audit and Accountability Act 2014, on 25 May 2018 because the Trust did not achieve its statutory duty to achieve a cumulative breakeven financial position over a three-year period.

Executive Summary

Value for Money arrangements	We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for the matter identified in respect of the Trust's financial position. This matter related to the fact that the Trust delivered an in-year deficit of £10.9 million, which brought the Trust's cumulative deficit to £58.27 million. This is in breach of the Trust's responsibility to deliver a cumulative breakeven over a three-year period. We therefore qualified our value for money conclusion in our audit report to the Trust on 25 May 2018.
Quality Accounts	We completed a review of the Trust's Quality Account and issued our report on this on 29 June 2018. We concluded that the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance.
Certificate	We certify that we have completed the audit of the accounts of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Code of Audit Practice.

Working with the Trust

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

- An efficient audit – we delivered an efficient audit with you in May, delivering the vast majority of the audit work in the first three weeks, releasing your finance team for other work.
- Sharing our insight – we provided regular Audit and Governance Committee updates covering best practice, including a detailed report on the Trust's Annual Report against its peers. We also shared our thought leadership reports during the course of the year as well.
- Providing training – we provided your teams with training on financial accounts and annual reporting, and key members of the finance team attended our Final Accounts Workshop in March 2018.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
July 2018

Audit of the Accounts

Our audit approach

Materiality

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

We determined materiality for the audit of the Trust's accounts to be **£7.37 million**, which is 1.75% of the Trust's gross revenue expenditure. We used this benchmark as, in our view, users of the Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

We also set a lower level of specific materiality for Cash and Cash Equivalents of **£500,000** to reflect that almost all of the transactions incurred by the Trust during the course of the year impact on the Trust's cash balance.

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

The scope of our audit

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

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

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

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

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

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

Audit of the Accounts

Significant Audit Risks

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

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Improper Revenue Recognition Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. Approximately 87% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We identified the occurrence and accuracy of income from contract variations as a risk requiring special audit consideration.	As part of our audit work we completed the following: • evaluated the Trust's accounting policy for recognition income from patient care activities for appropriateness; • gained an understanding of the Trust's system for accounting for income from patient care activities and evaluated the design of the associated controls; • reviewed the contracts with the Trust's main commissioners; • tested healthcare income from the Trust's main commissioners for the year to contract documentation and invoices billed; • reviewed the year end Agreement of Balances tool and followed up any significant discrepancies in intra-NHS income or receivables with Trust management; • undertook substantive testing of a sample of non-patient care income to supporting documentation.	Our audit work did not identify any issues in respect of revenue recognition.
Management override of internal controls Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. We identified management override of controls as a risk requiring special audit consideration.	As part of our audit work we completed the following: • gained an understanding of the accounting estimates, judgements applied and decisions made by management and considered their reasonableness; • obtained a full listing of journal entries, identified and tested unusual journal entries for appropriateness; and • evaluated the rationale for any changes in accounting policies or significant unusual transactions.	Our audit work did not identify any issues in respect of this area.

Audit of the Accounts

Significant Audit Risks - continued

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

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Valuation of property, plant and equipment The Trust revalues its land and buildings on a quinquennial basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate by management in the accounts. We identified the valuation of land and buildings revaluations and impairments as a risk requiring special audit consideration.	As part of our audit work we completed the following: • reviewed management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • considered the competence, expertise and objectivity of any management experts used; • held discussions with the valuer about the basis on which the valuation is carried out and challenged the key assumptions; • reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding; • completed testing of revaluations made during the year to ensure they were input correctly into the Trust's asset register; • evaluated the assumptions made by management for those assets not revalued during the year and how management satisfied themselves that these are not materially different to current value.	During the course of the audit work in this area, we undertook considerable challenge over the assumptions made by the Valuer, particularly given there was £22.4m of previous impairments which were reversed in-year. We obtained sufficient assurance over the valuation of property, plant and equipment.

Audit of the Accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 25 May 2018, in advance of the national deadline.

Preparation of the accounts

The Trust presented us with draft accounts in accordance with the national deadline, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trust's Audit and Governance Committee on 24 May 2018.

Annual Report, including the Annual Governance Statement

We are also required to review the Trust's Annual Report, including the Annual Governance Statement. These were provided on a timely basis with the draft accounts with supporting evidence. As in previous years, both of these documents were found to be of a high standard, with only very minor amendments identified for the Annual Report.

Other statutory powers

We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 25 May 2018 we reported to the Secretary of State that the Trust agreed a £4.2 million surplus budget with NHS Improvement for 2017/18 and delivered a deficit of £10.9 million for the year ended 31 March 2018.

This contributes to a cumulative deficit. The Trust has breached its statutory duty to achieve a breakeven financial position over a rolling three year period.

Certificate of closure of the audit

We are also required to certify that we have completed the audit of the accounts of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Code of Audit Practice.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

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

Key findings

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

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

As part of our Audit Findings Report agreed with the Trust in May 2018, we agreed one recommendation to address our findings.

Overall Value for Money conclusion

We are satisfied that, in all significant respects, except for the matter we identified in respect of the Trust's Financial Position, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018.

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Financial Position In 2016-17, the Trust delivered a retained deficit position of £10.918m, along with delivering £24.6m of Cost Improvement Programmes (CIPs). However this was significantly less than the £32.1m of CIPs included within the agreed Plan with NHS Improvement. As a result, we issued an 'except for' VfM Conclusion For 2017-18, the Trust was initially forecasting a deficit position of £4.1m (prior to the receipt of any Sustainability and Transformation Funding) and the delivery of £31.7m of CIPs. At Month 8, the Trust was forecasting a deficit position of £17.9m pre-STF, and is on course to deliver £22.9m of CIPs.	As part of our work we updated our understanding of the Trust's financial position, considering any improvements to its financial arrangements; we gained an understanding of the financial plans for the year ahead to evaluate whether or not an 'except for' or an 'adverse' qualification is appropriate.	Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate. The Trust has a cumulative reported deficit of £58.27 million as at 31 March 2018. This increased from last year's cumulative deficit by £10.9 million, the 2017/18 reported deficit. The Trust achieved 71% of its £31.7 million Cost Improvement Programme in 2017/18. The Trust has agreed with NHS Improvement, a deficit financial target of £1.0 million for 2018/19, which equates to a £11.7 million surplus after the inclusion of Provider Sustainability Funding (PSF). Receipt of PSF is conditional on operational and financial performance. Delivery of the financial deficit target will require, in addition to strong budgetary control, the delivery of £24.1 million CIPs, along with a further £10.4 million of non-recurrent savings in year. The Trust has continued to improve its systems to support CIP delivery, but the CIP requirement for 2018/19 is challenging. At the start of the financial year all of the CIPs and non-recurrent schemes have been identified, but there is a degree of risk attached based on its own RAG-Rating. The Trust's future financial plans anticipate returning to in year break even in 2018/19 and cumulative breakeven by 2021/22. The Trust remains in 'Financial Special Measures' after being placed in it in August 2016 by NHS Improvement. However it is clear that progress is being made by the Trust. **Based on the above, we concluded that you did not have proper arrangements in place for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.**
Liquidity Position During the course of the past two years, the Trust has had to rely on considerable external financial support to ensure it has sufficient liquidity to pay their debtors as they fall due. In 2017-18 the Trust envisages needing a further cash injection to manage its position to year end. .	As part of our work we will update our understanding of the Trust's cash position and determine the level of additional cash funding needed in 2018-19 to ensure they have sufficient liquidity to pay their obligations over the next 12 months.	At year end, you held a cash balance of £1.473 million, a very slight increase from the balance held at 31 March 2017. However you had to draw on a further £13.99 million of Working Capital Support loans from the Department of Health in the final three months of the financial year to ensure you had sufficient cash available to pay your obligations as they fell due. However you made great strides over the last few months of the financial year in reducing your Debtors and Creditors to put you in a stronger position ahead of 2018-19. You have prepared a detailed cash flow for the year ahead, and have identified a range of contingencies that can be used to help manage your cash flow over the next year to ensure you are able to repay the borrowing which falls due in 2018-19. **Therefore we have concluded that you have proper arrangements in place to manage your liquidity position over the coming months.**

Quality Accounts

The Quality Account

The Quality Account is an annual report to the public from an NHS Trust about the quality of services it delivers. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with set DH criteria;
- the Quality Account is not consistent with other documents, as specified in the DH guidance; and
- the two indicators in the Quality Account where we have carried out testing are not compiled in line with DH regulations and do not meet expected dimensions of data quality.

Quality Account Indicator testing

We are currently in the process of testing the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile (C.Diff) infections

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Account reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the Department of Health Guidance.
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

Conclusion

As a result of this we issued an unqualified conclusion on the Trust’s Quality Account on 29 June 2018.

A. Reports issued and fees

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

Reports issued

Report	Date issued
Audit Plan	26 February 2018
Audit Findings Report	24 May 2018
Annual Audit Letter	9 July 2018

Fees

	Planned £	Actual fees £	2016/17 fees £
Statutory audit	61,000	61,000	75,069
Charitable fund (to be completed in August)	1,900	1,900	2,500
Total fees	**62,900**	**62,900**	**77,569**

Fees for non-audit services

Service	Fees £
Audit related services	
- Work on the Trust's Quality Accounts	7,500

Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.
- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-22	Summary report from Finance and Performance Committee, 16/08/18 and 30/08/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met twice during August, on 16th and 30th.

1. The key matters considered at the meeting on 16th August were as follows:

- The meeting was an extraordinary meeting, that focused solely on reviewing performance-related issues affecting the key operational targets and the Trust's financial position, with a focus on 62-day Cancer waiting time target performance; Referral to Treatment (RTT) performance; and the A&E 4-hour waiting time target
- A detailed discussion was held on each of the 3 areas. For the Cancer performance, the discussion had shown a desire for assurance and in particular that the actions being taken would address the current, and future, situation. It was agreed that the Chief Operating Officer should provide the Trust Secretary with the detailed action plan providing assurance on the introduction of additional Endoscopy capacity, to enable this to be circulated to Committee members (this was duly done, and the information was circulated later on 16/08)
- For RTT performance, it was agreed that the Chief Operating Officer should arrange for further work to be undertaken to reconcile the "RTT Admitted", "Elective Inpatients" and "Day Cases" data for "Actual" and "Plan" that was reported within the "Activity YTD - April to July" table submitted to the Committee meeting; and the Chief Operating Officer should also arrange for the Trust's 2018/19 Referral to Treatment performance trajectory to be reviewed in the light of the Trust's current circumstances. It was further agreed that the Chief Operating Officer and Chief Executive should consider how the Trust Board could be provided with assurance regarding the Referral to Treatment-related processes used within the Trust's Clinical Administration Units

2. The key matters considered at the meeting on 30th August were as follows:

- A minor amendment to the Terms of Reference was agreed (to add an Associate Non-Executive Director to the membership), and the Board is asked to approve the change (the revised Terms of Reference, with the proposed change 'tracked', are shown in Appendix 1).
- The actions from previous meetings were reviewed, and the intention to discuss the Referral to Treatment (RTT) and 62-day Cancer waiting time target performance at the September meeting was noted.
- Under the "Safety Moment", it was reported that August's theme was mouth care
- The month 4 financial performance was reviewed in detail, including the cash flow position. It was agreed to schedule a "Detailed review of the Trust's cash flow position" item each quarter, from November 2018 onwards.
- The monthly performance item also included a discussion about the risks and mitigation in delivering the full year forecast financial outcome. The key issue was noted to be the risk associated with the Cost Improvement Programme (CIP) programme and one-off items, and the degree of assurance that there are sufficient positive items to offset the likely shortfalls. It was also agreed to ensure that slide 3b ("Year End Forecast") of the monthly financial performance report was included within the financial information submitted to each Trust Board meeting
- The financial aspects of the Best Care programme at month 4 were reviewed, and there was a specific focus on the "key issues/risks" that were red-rated under each Best Care workstream. It was agreed that details of the "…revised timetable…agreed via the working group" in relation to the red-rated risk within the Best Safety workstream that "Job Plans not completed and added to e-job planning system within the agreed timescales" should be provided
- The meeting reviewed the alternatives to achieving the £1.7m of the Cost Improvement Programme that had been planned to be delivered by the establishment of a wholly owned subsidiary, and it was agreed to schedule a further review of the alternatives at the November 2018 Committee meeting
- The standing update on the Lord Carter efficiency review was received, which included

details of the 'Getting It Right First Time' (GIRFT) work that had taken place at the Trust
- The latest quarterly progress update on Procurement Transformation Plan was reviewed, which has been provided in full at Appendix 2 (but refer to the point under section 3)
- An update on the options being considered in relation to the PFI contract at Tunbridge Wells Hospital was considered, and it was confirmed that updates should continue to be received at the Committee every 6 months
- The latest breaches of the external cap on Agency staff pay rate were noted, as was the forward programme, and it was highlighted that the September 2018 meeting would consider the planning arrangements for 2019/20

3. In addition the agreements referred to above, the Committee agreed that:
- The Chief Finance Officer should check whether the "Current" column of the table in section 5 of the "Quarterly progress update on Procurement Transformation Plan" report submitted to the Committee on 30/08/18 should have been RAG rated, and if so, arrange for an amended version to be provided, for submission to the Trust Board on 27/09/18 (30th August). N.B. The report was duly checked and amended to add the RAG rating colours to the actual column for those elements that had a target metric, or where the Trust reports. The others are not rated. The amended report is enclosed in Appendix 2)

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

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.)
1. To approve revised Terms of Reference for the Finance and Performance Committee
2. Information and assurance

Appendix 1: Revised Terms of Reference for the Finance and Performance Committee (for approval)

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

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

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

2. Membership

Membership of the Committee is as follows:

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

Members are expected to attend all relevant meetings.

3. Quorum

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

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

4. Attendance

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

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

5. Frequency of meetings

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

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively
- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- Review and monitor the Trust's Cost Improvement Programme (CIP)
- Obtain assurance that all CIP schemes and Business Cases have been subject to a Quality Impact Assessment (QIA), and to liaise with the Quality Committee, as appropriate, to ensure the robustness of the process
- Monitors the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations")
- Ensure the Trust is actively engaged and addresses all productivity opportunities presented as part of national initiatives

Treasury Management

- Review any significant (in the judgement of the Chief Finance Officer) proposed changes to the Trust's treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review such applications, and make a recommendation to the Trust Board if the value exceeds the Committee's delegated authority)
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- Review the Trust's cash flow and balance sheet, to ensure effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review Business Cases for capital and service development above the threshold set-out in the Reservation of Powers and Scheme of Delegation, and make a recommendation to the Trust Board regarding the approval of such Cases
- Receive assurance on the effectiveness of the Trust's investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

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

Procurement

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

Performance

- To monitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- To escalate performance-related issues to the Trust Board in the event of any concerns

Informatics (including Information Technology)

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

Assurance and Risk

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

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

The Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the Purpose and/or Duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

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

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

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

11. Review of Terms of Reference and monitoring compliance

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

History

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

- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018

Appendix 2: Quarterly progress update on Procurement Transformation Plan

1. INTRODUCTION

1.1 The Procurement Transformation Plan (PTP) was originally approved by the Trust Board on the 19th October 2016. A refreshed PTP has been submitted to NHSI on 11th May 2018 in line with the latest requirements.

1.2 The PTP guidance from NHSI states that "Trusts will be asked to provide regular progress updates on their PTPs to their Trust's board and NHS Improvement. These will take place quarterly."

1.3 In January 2018, NHSI issued new amended procurement model hospital metrics. The metrics are included within the report but with the understanding that new or amended metrics are expected over the year. The model hospital has been updated with some of the new procurement metrics.

2. DETAIL AND BACKGROUND

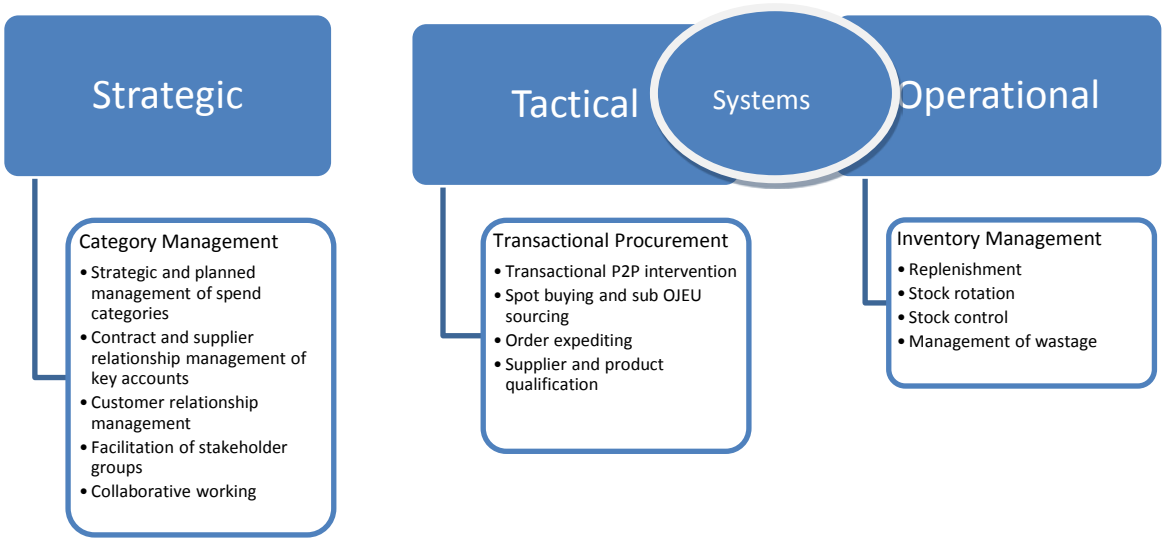
Background

2.1 The original Procurement Transformation Plan was approved by the Trust Board and submitted to NHSI in 2016. Further updates have been provided on a quarterly basis. The report is the updated PTP plan that was submitted to NHSI in May.

3. SUMMARY

3.1 Maidstone and Tunbridge Wells NHS Trust procurement team has been through a three year transformation programme. This programme was implemented as the Trust recognised the importance of the procurement function and the need to invest in this area. The business case for the transformation identified savings of £5million to be delivered in 3 years. The team delivered over £5million in the first two years thereby indicating the success of the transformation programme. The procurement team is now an integral part of every divisional CIP programme and is in attendance at all CIP meetings as well as any new initiatives to ensure procurement are part of the planning to take forward new activity.

3.2 Maidstone and Tunbridge Wells NHS Trust (MTW) procurement team covers three key areas of procurement.



Strategic

3.3 Strategic procurement is a category management procurement function. The team covers all non-pay expenditure except for Pharmacy.

This team is focused on internal stakeholder relationship management; ensuring active and positive engagement throughout the procurement cycle all the way through to contract management stage. The team also covers external supplier management through the splitting of spend into discrete portfolios of categories. This allows a specialist focus on categories to focus on value and total cost of ownership rather than exclusively price down savings initiatives.

Tactical

3.4 This is the more recognisable "purchasing" function managing purchase transactions with suppliers, unplanned sourcing activity and sub-OJEU or "tail" spend not managed through the strategic category management function. The team is also focused on catalogue management to ensure compliance with the Trust policy of No PO No Pay.

Operational

3.5 This function is more recognisable as the inventory management function responsible for the replenishment and distribution of goods throughout the organisation. This team are responsible for the Trust Omnicell inventory management system. They link with supplier change to identify product switches which support the Trust position on quality cost effective products.

Systems

3.6 This sits across the Tactical & Operational teams and covers the technology and manpower resource required to run and maintain the systems needed to drive efficient work practices.

4. NEXT STEPS

4.1 **Strategic** – The Trust 2018/19 CIP target is £4.2million. The team have identified the areas where these savings can be delivered by the end of March 2019, including £2.2million of roll-over savings that commenced in 2017/18. There is also a Kent & Medway STP work programme under the Productivity work-stream which was targeted to deliver £1m full year savings. This programme has been slow to get up to speed and therefore the onus for delivering this number has fallen back on the internal team and is no longer categorised as an STP work stream. A full procurement work programme is monitored by the MTW Best Use of Resources Board, chaired by the Finance Director, on a monthly basis. As at month four, the department is tracking at £86,000 over target.

4.2 **Tactical** – The team have implemented a full P2P system integrated with the finance system Integra2. This has the capacity to provide a full pathway from orders placed on the system, to the receipting of goods, invoicing and payment of the goods. This supports the work within the Trust on electronic purchase orders and catalogue management and we are working with finance to establish e-invoicing where possible with the ultimate aim of implementing a fully electronic PTP process.

4.3 **Operational** – The Trust has implemented an inventory management system, Omnicell within the high cost product areas such as Cardiac Cath Labs, Elective Theatres, Ophthamology and Short Stay Theatres. None of the wards currently have Omnicell deployed, however further areas are being explored for its use including a solution with pharmacy for drug packs to be kept on wards to aid quicker discharge from the wards. This is currently a mixed model of an open system (bar-code scanning) and closed system (automated cabinets).

4.4 **Systems** - The Omnicell system has enabled the Trust to monitor stock levels and identity the maximum and minimum stock levels to be held in each area. It also allows tracking of stock issued to patient level. A review of the way we use this system is being undertaken to ensure we are realising the full benefits of an automated inventory management system. A small restructure of the department may be required to allow for the dedicated and effective management of this system as it is currently extremely resource heavy.

5. TRUST PROCUREMENT PERFORMANCE (RAG rating against updated Carter targets)

MEASURES		PERFORMANCE		COMMENTARY (INCLUDING WHAT HAS BEEN IMPLEMENTED SINCE SUBMISSION OF ORIGINAL PTP AND CONSIDERATION AS TO WHAT SUPPORT IS REQUIRED)
		CARTER TARGET	CURRENT	
1	Monthly cost of clinical and general supplier per 'WAU'	**WAU (£350)**	**£295**	The Trust has seen continual increase in activity year on year. Fixed costs have been stretched to minimise the increase of costs and sustain a low WAU.
2	Total % purchase order lines through a catalogue	**80%**	**97.3%**	The Trust has fully implemented an electronic P2P system integrated with finance. This includes a catalogue which enables end user ordering.
3a	% of invoice value matched to an electronic purchase order	**90%**	**87.2%**	The Trust has a strict no PO no Pay policy. There is also a PO exemption list that is authorised within the Trust SFIs. This includes some services from other NHS organisations.
3b	% by count of invoices matched to an electronically generated purchase order	**90%**	**85.3%**	Same response as 3a
4	% of spend on a contract	**90%**	**Not Reported**	There is a 34% of tail end spend that is under quotation as well as a small portion that is not under contract. The team are reviewing opportunities to aggregate the tail end spend.
5	Inventory Stock Turns	**NA**	**100.1 Days**	This number has come down from the previous quarter, but is still high. This number is high due to one significantly high area within the Trust. This area is under review to understand whether the stock level is correct or is it due to stock not being scanned at use. All other areas in the Trust are less than 50 days of stock held
6	NHS Standards Self-Assessment Score (average total score out of max 3)	**Annex 3 includes the metric breakdown**		Level 1 standard assessment was in December 2017. MTW are awaiting the completion of the process. MTW understandings that a recommendation of level 1 achievement has been made. See comment against People & Organisation in Annex 1.
7	Purchase Price Benchmarking Tool Performance	**NA**	**£366,914**	Previous variance to Median was showing on PPIB as £716,588. These opportunities were reviewed and it is now showing as £366,914. Work is ongoing to reduce further.

6. Procurement Transformation Plan - Summary

1) People & Organisation :

People & Organisation

The team have undergone a transformation programme which structured the teams based on the three areas outlined within the executive summary. One post within the team has now been transformed into an apprenticeship role and recruited to - due to commence in September 2018.

MTW has approached the local Christchurch Canterbury University and is now part of their graduate scheme where purchasing and supplies is one of the areas of study within the university. This is all part of the team succession planning and development as historically the team have struggled to fill posts within category management. We have received a work placement student through this scheme in the summer holiday period for the past 2 years.

Continued development of the team is important and a training matrix has been developed identifying training for each member of the team and how this links to their procurement role. There is also a link to the procurement skills network and sharing learning through peers across the region. Two members of the team are currently studying for their Level 4 CIPS which is being funded by the apprenticeship levy and a further 2 members of staff have expressed an interest in taking this up in the next cycle.

The quarter has seen the departure of the Associate Director of Procurement with this role being filled by the Head of Category Management from 1st July. The HoCM role is therefore vacant and currently out for recruitment, but the post is unlikely to be filled until early December. Authorisation has been given to recruit an interim, but no suitable candidates have been identified or become available so this is presenting some operational challenges.

Annex 2 includes a copy of the current procurement structure.

Next steps – There have been a number of internal changes to the team which is being driven by a clear desire to learn & develop better procurement skills. Whilst attendance on free-to-access procurement day-courses and the availability of the CIPS Level 4 qualification through the Apprenticeship scheme is useful, we will also be starting internal monthly team development sessions to provide practical & bespoke support in areas such as strategy, specification development, key performance indicators, contract writing & management.

Internal movements, long term sickness and resignations have left a shortfall in the Materials Management team which we are having difficulty recruiting to. We are therefore exploring how we might be able to further utilise the Apprenticeship scheme to bring in some school leavers and develop the skills we need internally. A revision of the part-time role into a full time post is also being considered to provide a floating resource between the 2 sites.

An initial review of the Purchase to Pay (P2P) process has identified a number of areas for improvement. Various issues have been identified, one of which is with the inconsistency in the receipting of goods process. The responsibility for this step sits with the Portering staff under Estates and Facilities Management (EFM) which creates a disconnect with the Materials Management team. A high level discussion has been had with EFM on the potential flaws in this process. Analysis as to how this might be better resourced and structured to improve efficiency will be drawn up for discussion. Receipting is a key step in the 3-way matching process for automatic payment of invoices so any lapses in the process can lead to delays and inefficiencies in the payment authorisation process.

Measures Implemented (200 words max)	All staff appraisals identify training needs and KPIs monitored on numbers of staff qualified. Two members of staff undertaking current CIPS training. Category management monitors the savings against monthly targets which have been built into the team's appraisals as objectives. An Apprenticeship post has been recruited to in 2018/19. This post will be trained in Systems, Operations and Category Management with a view to fulfilling the current vacancy in that team. A university graduate has been taken on over the summer for the second year running Learning & Development have been approached to discuss how the Apprenticeship scheme can be used to meet our staffing needs in Materials Management
Impediments and support (200 words max)	The Strategic team require upskilling, or modernising their knowledge base, particularly around commercial awareness & contract management, in order to meet the current challenges. Internal training run by ADoP & HoCM will become a regular fixture once both posts are fully resourced. The Operational & Tactical teams need to develop a more strategic approach to systems so we will continue to identify & learn from best practice organisations nationally. The Procurement team does not have an extensive training budget so identifying ways to access the Apprenticeship funding is key. We will continue to access free of charge PSD training when appropriate and introduce regular bespoke in-house training to support specific development needs.

2) Processes, Policies & Systems :

The Procurement strategy was reviewed in September 2017. The strategy was amended to focus more on the regional STP and align the Trust objectives to support the changes in the national landscape.

The objectives and actions outlined in Annex 1 indicate the priorities for the team outlined within the Strategy.

Processes & Policies

Communication is a key element of the procurement strategy and communications have been issued to the trust on a number of areas. Recent communications include:

- Two Listening into Action (LIA) events focused on procurement to share process and the different ways the Trusts purchases goods and services.
- a reminder of the procurement thresholds within the Trust SFIs,
- product switches within the Trust and the savings this achieved

The redevelopment of the departments Intranet page to make it more user friendly and easier to access categories of information is a key outcome from these communications and this should be completed within the next month.

Work is underway to improve the way we manage contracts and pricing through the catalogue which will have a direct impact on our ability to police the Trust's no PO no Pay policy. These improvements are focused on ensuring that any request for goods and services has followed the full trust processes and there is a clear audit trail of activity. It also ensures we have more complete usage data which in turn enables us to make better purchasing decisions.

MTW are key members of the Kent STP (along with Medway, Dartford & East Kent). The CIP workstream for the STP is run by Medway and we are active participants in all projects that benefit us. The collaboration has had a number of challenges around resource and skill set, whilst East Kent's transition to a wholly owned subsidiary company has seen them become more distant from the group. The £1M savings target originally attributed to the STP workstreams has had to be brought back in-house.

NHSSC have now been approached to undertake the analysis on behalf of the STP to identify quick wins through commonality of product that could generate better pricing when our volumes are aggregated, or changes in supply route. They will also identify the least contentious areas for product rationalisation across the patch which will be taken to the clinical committees of each Trust. The clinical representation on these committees will be encouraged to attend joint sessions and NHSSC will help to facilitate this.

The Future Operating Model went live in May. As yet, we have seen no impact as there are considerable issues in novating framework contracts across. We are therefore not expecting to see any significant advantages or changes from this restructure until next year. We have been informed that the FOM will be funded through top-slicing of Trust's budgets, but to date no specific detail has been forthcoming on what this might look like.

Systems

The implementation of the Inventory management system (Omnicell) and the integrated procurement and finance system (Integra) has meant the Trust is starting to get real time stock usage information. Work is being developed on how to utilise Omnicell more effectively to provide procedure level data to understand the cost of each patient and procedure variance. This also introduces disciplines that will be essential when Scan4Safety is implemented in the Trust.

Omnicell also allows us to report on our stock rotation efficiency by recording how many days of stock we hold on the shelves at any one time. This is a key metric of the model hospital that identifies areas in which we can remove waste. It is also a strong indicator of how effective our inventory management system is. Real time stock levels allow more accurate management of stock and comparison of usage across the departments.

The three-way match process flow built into Integra [Requisition, Authorise, Receipt] gives us the ability to auto-match our invoices against the orders to ensure we are paying the correct price and for the correct goods. However, this process is not currently functioning to its full capability and is requiring the equivalent of 1 WTE to manually review invoice mismatches. This is therefore scheduled for a full review of the whole Purchase to Pay process which will include the inputs from purchasing (price control), finance (invoice processing) & estates (receipting).

PPIB report is run each month which identifies the opportunities for the Trust. This is reviewed against the Trusts who are performing well in those areas. This validation process allows the buyers to focus on "quick win" opportunities and also opportunities for the category managers to include within their tenders. This work also identifies potential STP opportunities to be taken forward. NHSi will soon be introducing a league table which will measure our performance on PPIB against our peers.

Measures Implemented (200 words max)	The department intranet page is being re-designed to be more category-focused and user friendly A review of the P2P process is to be undertaken from both a systems and staffing perspective The STP has refocused its purpose. NHSSC have been retained to take on the day to day analysis of opportunity whilst the core members will undertake 5 key projects; Orthotics, Radiology Consumables, Topical Negative Pressure Therapy, Enteral Feeds & Patient warming. We will be leading on 2 of these projects. A review of the outputs and processes from Omnicell is underway.
Impediments and support (200 words max)	A full review of the P2P process spans 3 departments. It should be possible to identify the points of the process that require improvement, but it may not be so easy to agree responsibility for resolving the issues. This has been recorded as a project with the Finance Improvement Plan. Obtaining strong clinical engagement across the whole STP to deliver true collaborative working will be challenging. Taking steps to support and attend each other's Clinical Practice Management Committee's will be key to this.

3) Partnerships :

Partnerships - Collaboration

Maidstone and Tunbridge wells NHS Trust is part of the Kent and Medway Sustainability transformation programme (STP) footprint. Part of the STP identifies the need for procurement across the region to work closer together and where possible identify resources that can be shared to achieve best value in the market.

The STP has explored and tested an outsourced and in-house solution for a shared service transactional procurement team, but this has been rejected at this stage.

The STP Heads of Procurement aim to meet every month to discuss opportunities for collaboration and have shared their procurement work plans, and the contacts across the region as well as identifying the skills of each of their staff, to outline what skills are available within the region. This has been instrumental for longer term discussions on how we work more closely together as there is significant skill shortage in procurement and specifically in the South East (SE) there is difficulty in attracting staff out of London.

Projects have been slow to get off the ground due to vacancies within each team refocussing Heads time within individual organisations and competing Trust priorities e.g. EKHUFT's wholly own subsidiary set up.

Next Steps

MFT, MTW, DAG, KMPT & MCH have committed to move projects forward without EKUHT if they are unable to commit whilst NHSSC will identify quick wins across the whole STP.

The Future Operating Model is now live and we are taking steps to collaborate with the new towers on all new projects.

Measures Implemented (200 words max)	The Trust led of an STP tender for Orthopaedics. This was a key success for two of the Trusts and achieved savings in excess of £1million across the two Trusts. This tender has supported joint working and joint contract management meetings with the supplier. The model of this tender will support the STP going forward on how best to work together. The Trust is leading on STP projects for Radiology Consumables and Topical Negative Pressure Therapy and will support on a further 3 projects; Orthotics (KMPT leading), Enteral Feeds (KMPT leading) and Patient Warming (MFT leading)
Impediments and support (200 words max)	The creation of the East Kent wholly owned subsidiary is diluting the impact of STP collaborative projects, but the other members are committed to delivering what they can. The FOM towers are not yet in a position to deliver project support, new frameworks or savings.

7. Risks and issues

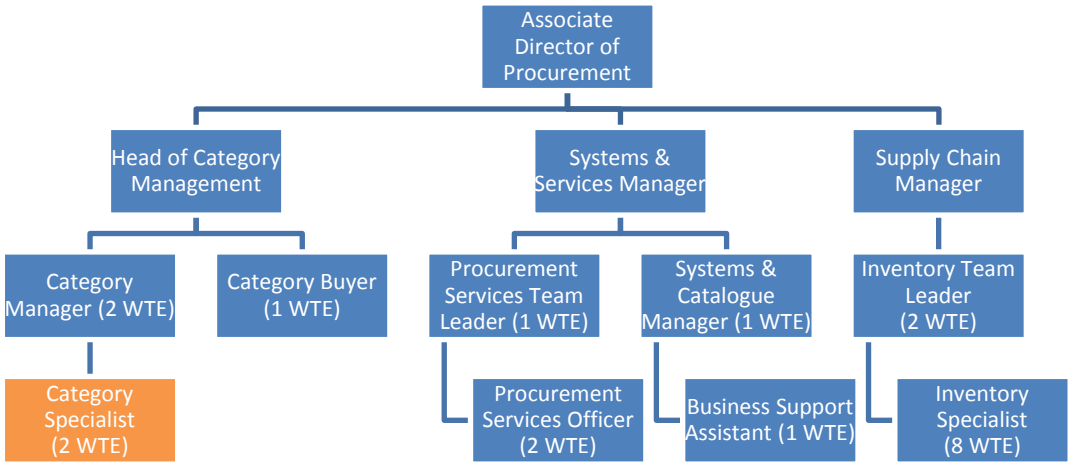
The main risk to the procurement team is the shortage of key procurement skills within the team and the region. To deliver the CIP saving and ensure that the leads identified to support the Trust and the whole STP region, requires staff with good procurement knowledge and the ability to negotiate in the market. Maidstone and Tunbridge Wells is very fortunate to have a Category Management team who are all MCIPS qualified but there is always the risk of losing staff to London where salaries are a lot more attractive.

The vacant Head of Category Management post may impact on the delivery of the work-plan and failure to secure a suitably skilled recruit for this post could have a detrimental effect on the Trust's savings target.

Annex 1 – Procurement action plan

Procurement objective	Action
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified to an appropriate level of CIPS accreditation. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard. There are currently two members of the team training for the CIPS level 4 with a further two planned in September. We are also looking at the possibility of accessing a lesser CIPS qualification through the Apprenticeship scheme to support and develop the Materials Management team.
Procurement workplan	Completion of 2018/19 procurement workplan. This workplan covers tail spend and improvement of the trust position on contract spend.
Procurement Savings	Achievement of agreed 2018/19 £4.2million
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy. Development of the departments Intranet page is being undertaken to improve understanding of the Procurement function & Trust SFI's Increase number of quarterly contract review meetings with key suppliers.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). This is monitored at the Trust finance committee and audit committee to ensure compliance. Improved processes to increase non-clinical spend covered by PO are planned. Improved processes to develop true electronic P2P.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2. This has been achieved, but official accreditation has not yet been received. NHSi have advised that they have have yet to receive a response from the reviewer with regards to our accreditation so have chased again. If they hear nothing within the next week they will review the outputs and evidence they do have, and work with Jacky Bowman as the national lead in assessing how they can conclude the process without having to conduct another formal peer review.
Collaboration	Alignment of procurement work plans across the region
	Market management engagement – 2 supplier events per year.
	Shared learning and collaboration of the FOM across the region
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market

Annex 2 – Current Procurement team structure chart



5. RECOMMENDATION

5.1 It is recommended that the Finance and Performance Committee note and review the information in the report.

Annex 3 – Procurement standards

NHS Procurement & Commercial Standards : Procurement Transformation Plan re-fresh May 2018

Area	Standard			*Level 1 Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)	Level 2 Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)
	If achieved through peer review then insert date to the right			Dec-17	
	If not achieved then input self-assessment scores against each area and insert date of peer review to the right				Apr-18
1. Strategy & Organisation	1.1 - Strategy				2
	1.2 - Executive Commercial Leadership				2
	1.3 - Procurement & Commercial Leadership				2
	1.4 - Internal Engagement				2
	1.5 - External Engagement				2
2. People & Skills	2.1 - People Development & Skills				2
	2.2 - Scope & Influence				2
	2.3 - Resourcing				1
3. Strategic Procurement	3.1 - Category Expertise				1
	3.2 - Contract & Supplier Management				1
	3.3 - Supplier Relationship Management				1
	3.4 - Risk Management				1
	3.5 - Sourcing Process				1
	3.6 - Benchmarking				1
	3.7 - Specifications				1
4. Supply Chain	4.1 - Inventory Management & Stock Control				2
	4.2 - Logistics				2

Area	Standard			*Level 1 Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)	Level 2 Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)
5. Data, Systems and Performance Management	5.1 - Performance Measurement				2
	5.2 - Savings Measurement & Credibility				2
	5.3 - Catalogue Management				2
	5.4 - Procure to Pay (P2P)				2
	5.5 - Cost Assurance				2
	5.6 - Spend Analysis				2
	5.7 - GS1 & Patient Level Costing				1
6. Policies & Procedures	6.1 - Procurement Policy & Guidance				2
	6.2 - Process Compliance				2
	6.3 - Asset Management				1
	6.4 - Corporate Social Responsibility (CSR)				1
	6.5 - SMEs				1
	Overall Average Score			**0.00**	**1.59**

*see statement from NHSi regarding accreditation in Annex 1 above

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-22	Summary report from Finance and Performance Committee, 25/09/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 25th September 2018.

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

- Under the "Safety Moment", it was reported that September's theme was Sepsis
- The month 5 financial performance was reviewed in depth. It was agreed that details of the further savings opportunities being identified by Estates and Facilities should be submitted to the next meeting and that the delivery of the Provider Sustainability Fund should be a key aspect of that meeting. It was also agreed that the monthly report should be adapted to enable monitoring of the plans to implement the Planned Care Prime Provider contract
- The financial aspects of the Best Care programme at month 5 were reviewed, and it was agreed to obtain confirmation as to whether all Cost Improvement Programme schemes were subject to a Quality Impact Assessment (QIA). It was also agreed to schedule an item at the 'main' Quality Committee in Nov. 2018 on the outcome of the current retrospective review of QIAs being led by the Medical Director and Chief Nurse
- The month 5 non-finance related performance was discussed and it was agreed that the outcome of the current Cancer-related demand and capacity analysis should be a key aspect of the next meeting. It was also agreed to that the list of "Assumptions on which trajectory is based" for the revised 62-day Cancer waiting time target trajectory should be RAG-rated, and that the next meeting should review the plan to achieve sustainable delivery of the revised trajectory. It was further agreed that the very latest details of the appointments referred to in the "Immediate Actions – workforce" section of the "Cancer Performance Update" report to the Committee should be reported at the Trust Board meeting on 27/09/18
- The Committee reviewed a report reconciling the Trust total and Referral to Treatment (RTT) reported activity, along with a revised demand and capacity plan for RTT
- The timeline and methodology for the 2019/20 planning process was reviewed in detail and an update on the Lord Carter efficiency review was given. It was agreed to clarify whether the Care Hours Per Patient Day metric only included Ward-based Nursing staff, and if so, that a metric be developed regarding non-Ward-based Nursing staff. It was also agreed to ensure that the development of the Trust's use of Patient Level Costing was incorporated within the implementation plan for the forthcoming Electronic Patient Record
- The relevant aspects of the Board Assurance Framework (BAF) were reviewed and it was confirmed that the latest "How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?" ratings reflected the Committee's understanding of the performance against each objective. It was also agreed that the funding and implementation of the Virtual Ward initiative should be reflected within the "What actions have been taken…" section for the objective "To deliver the trajectory agreed with NHS Improvement for the A&E 4-hour waiting time target"
- A report on progress with the Finance Department Improvement Plan was given, which noted the participation in the national "Future Focused Finance" accreditation scheme
- The standing "breaches of the external cap on Agency staff pay rate" report was noted

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

- The Chief Executive should liaise with the Head of Communications to consider whether the Maternity department's compliance with NHS Resolution's Maternity incentive scheme had been sufficiently recognised by the Trust
- Future versions of the "Year End Forecast Best, Likely and Worst" slide in the monthly financial performance report should be colour-coded, to clearly indicate whether an aspect had improved or worsened

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-23	Summary report from the Patient Experience Committee, 05/09/18	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 5th September 2018.

The key matters considered at the meeting were as follows:

- The Chief Nurse outlined the rationale and format of the CQC engagement event that was taking place in the Trust that day
- An update on actions raised at previous meetings was given, as part of which, it was agreed to:
- Invite the Patient Outcomes and Innovations Manager to attend the PEC meeting in March 2019 to report on progress with updating Patient Information Leaflets
- Consider how technology might be used to support access to Patient Information Leaflets (Associate Director, Quality Governance)
- Confirm with the Critical Care Directorate if training / awareness of use of the emergency buzzer for staff to summon assistance is included in staff induction / training (Chief Nurse)
- An update was given by the Complaints and PALS Manager on the various actions taken and ongoing workstreams to improve telephone response times and the progress made to date
- A presentation was given by the Trust's Learning Disability Hospital Liaison Nurse about her remit and some of the actions that she had taken since her appointment in February 2018, which included: development of the Trust's electronic system for flagging people with learning disabilities (PWLD); development of an electronic referral system via the Trust's clinical system; staff training to improve awareness and understanding of learning disabilities; and promotion of the Trust's hospital passport, designed for PWLD coming into hospital
- The findings from the NHS Inpatient Survey 2017 and Trust action plan to address those areas where the Trust's score had deteriorated since the last survey were considered in detail. The actions taken around improving performance in questions relating to hospital food were noted and it was agreed that provision for more portion control for patient meals at Maidstone Hospital should be added to the Patient-Led Assessments of the Care Environment (PLACE) agenda as an item for further consideration
- An update was given on progress against the Quality Accounts priorities, 2018/19
- A report on the outcome of the latest Quality Assurance Rounds was received and the schedule of planned visits noted. It was agreed to incorporate an appraisal of patient experience of fasting and other parts of the pre-assessment pathway into the Quality Assurance inspection to be undertaken in Theatres in September 2018. The role of the Quality Improvement Committee in the monitoring of the CQC Tracker and in addressing the 17 'should dos' outlined in the CQC's final report was highlighted
- The latest report from the Patient-Led Assessments of the Care Environment (PLACE) Action Group was reviewed and the Trust's consistently good performance against the national average noted. The Chief Nurse undertook, in liaison with the Associate Director for Facilities Management, to review the composition of future PLACE reports to incorporate historic fault data; priority rankings; and progress updates on outstanding actions. It was also agreed that the potential for information and resource sharing with other trusts to more widely inform the PLACE process should be explored
- The Committee noted that no decision had yet been announced about the configuration of Stroke services in Kent & Medway, and concern was raised about the inadequate provision (in terms of road networks) currently allowed for ambulances to travel quickly between Trust sites
- An activity report from Healthwatch Kent was noted
- The usual Communications and Membership update was received
- A presentation was given by the Programme Director (Project Management Office) on the latest activity under the Best Care Programme and it was agreed to schedule a further update for the PEC meeting in March 2019
- A report from the Quality Committee meeting on 04/07/18 was noted

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

- Confirm the Trust's policy for provision of wheelchair assistance/support from the carpark to hospital building for patients attending Maidstone and Tunbridge Wells Hospitals (Chief Nurse)

- Convey to the Associate Director for Facilities Management issues raised about faulty car park signage (incorrectly indicating that there were no spaces) at Maidstone Hospital on the morning of the meeting; a query raised about motorcycle egress from the car parks at Maidstone Hospital; and issues raised about the storage of furniture and equipment in the corridors at both Trust sites (Chief Nurse)
- Consider how i) additional information / direction might be included in letters to patients required to visit the hospital for clinics / admissions during hours when the main receptions are unmanned and ii) how signage might be improved to direct visitors during these times (PALS and Complaints Manager)

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – September 2018

NHS Maidstone and Tunbridge Wells NHS Trust

9-24	**Summary report from the Trust Management Executive (TME), 19/09/18**	**Committee Chair (Chief Executive)**

The TME met on 19th September. **The key matters considered at the meeting were as follows:**

- Revised Terms of Reference were approved (as part of the routine annual review), which removed the duties to "Oversee the management of the highest-rated risks" and "To review and approve requests for replacement Consultant posts", as these tasks were now undertaken by the Executive Team Meeting and Clinical Directors' Committee respectively
- Under the Safety Moment, the Medical Director reported that the month's theme was Sepsis, but also highlighted the need to maintain infection prevention and control standards
- The final proposals for developing a clinically led organisation were reviewed and endorsed. It was however agreed that the associated plans should reflect the need for the Surgery Division to liaise closely with the Acute Medicine & Geriatrics Directorate regarding Orthogeriatric care
- An was given on the Kent & Medway Stroke services consultation, following the announcement of the preferred locations for Hyper Acute Stroke Units (which included Maidstone Hospital)
- The 2018/19 winter plan was discussed in detail and the key elements of the plan were endorsed. It was agreed that the Chief Operating Officer and her team would lead work with Clinical Directors and Executive colleagues to establish operational implementation plans in time for the next TME meeting
- The Chief Finance Officer reported on the business planning process for 2019/20 and noted that updates would be submitted to the TME each month
- The Trust Lead Cancer Clinician reported on the clinical harm review for Cancer patients who have waited a prolonged period of time, and it was noted that there would be further discussion at the next Trust Cancer Committee meeting. It was also agreed that the Deputy Medical Director for Planned Care should develop a proposal regarding the oversight of Cancer patients who were not part of a Cancer access target pathway
- A detailed report of 62-day Cancer waiting time target performance was given & it was agreed to ensure that the 2019/20 plan fully reflected Cancer diagnostic capacity requirements
- The last quarterly update on the implementation of the NHS e-Referral Service (e-RS) and Paper Switch Off in Kent, Surrey & Sussex was received, as was the latest quarterly update on the impact of the Trust's two Frailty Units
- The key aspects of month 5, 2018/19 integrated performance were reported
- The Deputy Director of Infection Prevention and Control (DIPC) reported the latest Infection Prevention and Control issues, which included the response to the Clostridium difficile outbreak
- The 4 clinical Divisions reported on their current key issues, which included Cancer target and Referral to Treatment performance, staffing, and some challenging quality metrics (including an increase in surgical site infections in Paediatrics and Breast Surgery, for which the Deputy DIPC was asked to liaise with the Clinical Director for Paediatrics and Trust Lead Cancer Clinician)
- An update from the Director of Medical Education was briefly reviewed, but it was agreed to schedule the item/report again at the October 2018 TME meeting
- Updates were noted on "Listening into Action", the national 7 day service programme, and the key issues from the Clinical Directors' Committee and Executive Team Meetings
- Reports were noted in relation to national capital funding, the Board Assurance Framework & Trust Risk Register, the Annual General Meeting 2018, progress with the 2018/19 Internal Audit plan, and recently-approved business cases
- Updates were noted on some of the TME's sub-committees (the Trust Clinical Governance Committee, Clinical Operations & Delivery Committee, Health and Safety Committee, MTW Programme Committee and Policy Ratification Committee)

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

2. **The issues that need to be drawn to the attention of the Board are as follows:** None

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