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 29TH NOVEMBER 2018

LECTURE ROOMS 1 & 2,
THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
11-1	To receive apologies for absence	Chair of the Trust Board	Verbal
11-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
11-3	Minutes of the Part 1 meeting of 25th October 2018	Chair of the Trust Board	1
11-4	To note progress with previous actions	Chair of the Trust Board	2
11-5	Safety moment	Chief Nurse / Medical Director	Verbal
11-6	Report from the Chair of the Trust Board	Chair of the Trust Board	3
11-7	Report from the Chief Executive	Chief Executive	4
11-8	Integrated Performance Report for October 2018	Chief Executive	
	▪ Effectiveness / Responsiveness	Chief Operating Officer	
	▪ Safe / Effectiveness / Caring (incl. planned and actual ward staffing for October 2018)	Chief Nurse	
	▪ Safe / Effectiveness (incl. mortality and an update on the traceability of blood components following an MHRA visit)	Medical Director	5
	▪ Safe (infection control) (incl. SSI update)	Dir. of Infection Prev. and Control	
	▪ Well-Led (finance)	Chief Finance Officer	
	▪ Well-Led (workforce)	Director of Workforce	
11-9	62-day Cancer waiting time target: capacity needed compared to that currently available	Chief Operating Officer	Verbal
11-10	Detailed review of the Best Care programme (incl. update from the Best Care Programme Board)	Chief Executive / Chief Finance Officer / Programme Director	6 (to follow)
11-11	Review of the Board Assurance Framework 2018/19	Trust Secretary	7
	Quality items		
11-12	Closure report on the Clostridium difficile outbreak	Dir. of Infect. Prev. and Control	8
	Planning and strategy		
11-13	Update on the project to create a single Pathology service for Kent & Medway	Chief Executive	9
11-14	Update on funding of replacement Linear Accelerator (LinAc) programme	Chief Finance Officer	10
	Assurance and policy		
11-15	Emergency Planning update (annual report to Board) (incl. "When tragedy strikes" briefing from NHS Confederation)	Chief Operating Officer / Head of Emerg. Planning & Response	11 (& video)
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
11-16	Quality Committee, 14/11/18	Committee Chair	12
11-17	Trust Management Executive (TME), 21/11/18 (incl. revised Terms of Reference, for information)	Committee Chair	13
11-18	Finance and Performance Committee, 27/11/18 (incl. quarterly progress update on Procurement Transformation Plan; and approval of request for an uncommitted loan facility (in advance of PSF payments))	Committee Chair	14, 15 & 16 (to follow)
11-19	Charitable Funds Committee, 27/11/18	Committee Chair	Verbal
11-20	**To consider any other business**		
11-21	**To receive any questions from members of the public**		
11-22	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	Chair of the Trust Board	Verbal
	Date of next meeting: 20th December 2018, 9.45am, Lecture Rooms 1 & 2, Education Centre, Tunbridge Wells Hospital		

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH OCTOBER 2018, 9.45A.M, AT MAIDSTONE 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)
	Nazeya Hussain	Non-Executive Director	(NH)
	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:	Hannah Ferris	Deputy Director of Finance (Financial Performance)	(HF)
	Neil Griffiths	Associate Non-Executive Director	(NG)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Ruth Paul	Bereavement Support Midwife (for item 10-8)	(RP)
Observing:	Roxanne Potts	Deputy Head of Radiotherapy	(RF)
	Darren Yates	Head of Communications	(DY)
	Pam Croucher	Member of the public/representative from Healthwatch Kent	(PC)
	Caitlin Webb	Local Democracy Reporter (from item 10-7)	(CW)

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

10-1 To receive apologies for absence

Apologies were received from Steve Orpin (SO), Chief Finance Officer, but 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. DH then welcomed AJ to his first Trust Board meeting.

10-2 To declare interests relevant to agenda items

No interests were declared.

10-3 Minutes of the 'Part 1' meeting of 27th September 2018

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

10-4 To note progress with previous actions

The circulated report (Attachment 2) was noted.

10-5 Safety moment

COB confirmed that the focus for October was the implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI) across the Trust on 01/11/18. COB added that the initiative had been launched following the deaths of several patients who had choked after eating foods of incorrect consistency. COB added that the step was a significant change, but the Trust was ready.

10-6 Report from the Chair of the Trust Board

DH referred to Attachment 3 and highlighted the following points:

- A Consultant Gastroenterologist had been appointed
- DH was very pleased that the Trust had exited the Financial Special Measures (FSM) regime
- DH had been invited, at short notice, to attend an engagement event in relation to the development of the NHS 10 year plan. The event had made it clear that integrated care would be very important to the plan, and also highlighted that plan would be detailed in relation to the first 5 years, but be more aspirational for the 5 years after that. It was also apparent that it was intended to hold fewer funds centrally, and in that context, the funds allocated to the Provider Sustainability Fund (PSF) would in future be allocated to the urgent and emergency care tariff. Control totals would also cease to be set for future years. The delegates were encouraged to seek more advanced local solutions, including Aligned Incentives Contracts (AICs), which the Trust already had. The Secretary of State for Health and Social Care also acknowledged that workforce was a constraining factor, which led to the decision to make Health Education England (HEE) accountable to NHS Improvement (NHSI), and HEE's workforce strategy would be absorbed into the 10 year plan. The Secretary of State also took the opportunity to promote the use of technology, but the point was made that the capital funding situation needed to be resolved before real progress could be made in that area. Finally, there was recognition that some enabling legislation may be required to ensure integrated care developed as intended, as the Health and Social Care Act 2012 included several constraints to such development.

10-7 Report from the Chief Executive

MS referred to Attachment 4 and highlighted the following points:

- The Inquest into the death of Timothy Mason had been a very affecting situation for the family and staff, and PM and COB's teams should be commended for the support they had provided. It was important that the Trust considered the lessons from the case
- The entire Trust Board should be proud of its contribution to the Trust's exit from FSM. The key issue was to now ensure that the financial position strengthened, whilst motivating staff to maintain good housekeeping, particularly in the context of the significant financial over-expenditure seen at other local NHS organisations. The potential delivery of over £12m of PSF monies also needed to be highlighted.
- A neighbouring room in the Academic Centre was the location for a celebration of Black History Month and MS had attended for the first presentation, which was given by the Trust's former Associate Director of Procurement, who now worked for NHS England. The Trust had also held an LGBT+ community conference the previous week, and both events illustrated the importance of considering what diversity meant to the Board. It may be appropriate to discuss this at one of the 'Away Day' sessions.

PM then referred back to the case of Timothy Mason and noted that the Trust performed quite well on the Sepsis metrics that were monitored by West Kent Clinical Commissioning Group (CCG). PM continued that the individual clinicians involved in the case had acted in the way he would expect, and want, them to, and when PM had spoken with one of those clinicians, they had already carried out the steps that PM would have advised be talen. PM continued that SM had met with Mr Mason's family and they had acted in a very dignified way and wanted to help the Trust learn. PM stated that he was therefore keen to engage with the family and would meet with them at a mutually convenient time. PM suggested that the Trust Board may find it beneficial for the family to be invited to one of the 'patient experience' items at a future Board meeting.

SDu acknowledged the tragedy of the case, but asked what would be done differently if a patient attended the Trust's hospitals today with the same symptoms. PM noted that the presentation of flu-like symptoms was common, but stated that the most important step was to ensure that a senior doctor reviewed patients with abnormal physiological status before they were discharged, and such reviews would now be mandated, if certain conditions were met.

Patient experience

10-8 A patient's experience of the Trust's services

DH welcomed RP to the meeting. RP then gave a presentation highlighting the following points:

- The Fraser family had given RP permission to report their story to the Board
- At her 12-week scan, Mrs Fraser's baby son, Joseph, was noted to have increased nuchal, so the screening midwives were involved
- A condition called Trisomy 18 (Edwards' syndrome) was subsequently diagnosed, but the family decided to continue with the pregnancy, as they did not feel that they should determine when their baby should die
- The Fetal medicine service at Tunbridge Wells Hospital (TWH) was involved. Mrs Fraser was reviewed at 15 weeks and a pregnancy plan was made. The Trust's Bereavement Midwife was involved on a palliative care basis
- There was communication with the community services to ensure continuity of care and understanding of the prognosis. Mrs Fraser was seen as required by community midwives
- A meeting was held with senior paediatricians at 31 weeks. The parents' wishes were explored and the care plan agreed
- There was a visit to the Neonatal Unit and the palliative care team from the Evelina London Children's Hospital was involved
- Over the time, there had been a change in the parent's perspective, in the sense that they were waiting for Joseph's death. The parents initially hoped that the experience would be 'over' early on, but they later longed for Joseph to be born alive. Both parents reflected and were also very concerned for their sons
- Discussions were held regarding the time to be spent with Joseph, the funeral, post-mortem etc. The parents were also shown the bereavement suite, which would be available for their use following Joseph's birth
- An induction delivery was planned and the Consultant on-call was made aware (as this was not the same Consultant that had met with Mrs Fraser). The Bereavement Midwife continued to be involved however, for continuity
- Joseph was delivered stillborn and after the delivery the family was able to spend time with Joseph in the bereavement suite
- The parents were keen to ensure that something positive arose from Joseph's death, so Great Ormond Street Hospital were contacted and they were able to use Joseph's body for research
- Mrs Fraser had stated that "The care we received was second to none. It made an incredibly difficult experience more bearable. In the midst of all the uncertainty, anguish and sadness we have experienced over the past months, from the time Joseph was diagnosed with Edwards syndrome to today, we have been greatly blessed".

PM thanked RP for the story, noting that he was personally quite affected, and stated that it was clear that significant support was given to the Fraser family and the speed at which the Trust had reacted, and the continuity of care that had been provided, had been very good. PM continued that it appeared as if exemplary care had been provided, but asked whether the support given to staff was part of RP's role. RP replied that she spent much time, in an informal way, supporting staff, but more formal staff support was being considered via the Trust's Clinical Ethicist. RP elaborated that she would always visit the delivery suite if there was a couple experiencing pregnancy loss, and speak to the Midwives involved to establish how they had felt providing care.

MS stated that the parents should be contacted to thank them for giving permission to relay their story, and confirmed he would do this.

Action: Contact the family referred to in the "Patient experience" item at the Trust Board on 25/10/18 to thank them for giving permission to relay their story (Chief Executive, October 2018 onwards)

MS then asked whether RP was able to work with the department to communicate some of the lessons learned. RP noted that sharing stories such as the Fraser's was beneficial in illustrating the importance of being flexible when offering care. MS commented that it appeared that many of the issues that went well were not suited to being included in a written protocol, so sharing the experience was the correct approach.

COB then remarked that the Trust was very fortunate to have RP and emphasised the importance of building relationships with the family. COB added that the story had been shared with the Care Quality Commission when they inspected the Trust in 2017 and they confirmed this had been valuable.

DH concluded by noting that he was also the Chair of the Board of Trustees of Demelza, so asked whether hospice care would always be accessed via the Evelina London Children's Hospital, rather directly. RP replied that she had always accessed such facilities via a Neonatal Unit.

DH thanked RP for attending.

10-9 Integrated Performance Report for September 2018

MS referred to Attachment 5 and invited each relevant Member of the Executive Team to address the specific areas of performance within their remit.

Effectiveness / Responsiveness

AG highlighted the following points:

- Quarter 1 of the A&E 4-hour waiting time target trajectory had been delivered. Reduction in Length of Stay (LOS) had been important in the context of maintaining non-elective patient flow
- Delayed Transfers of Care (DTOCs) had been managed to remain below 5%, although there had been a rise in September. The system needed to work together to improve and there was more to be done, although patient flow had improved much in the last few years
- Performance on the 62-day Cancer waiting time target remained in recovery. Performance for August was 67.7%. The focus was on improving the diagnostic phase of the pathway i.e. increasing capacity for initial outpatients and subsequent diagnostics (MRI, CT and Endoscopy). This had been done, and since the Trust had been in its recent period of intense recovery, the data to the end of August showed that the median time from referral to diagnosis had been reduced by circa 40%, as result of the intense efforts made to reduce the interval between diagnosis and treatment
- Page 6 of 42 showed the trajectory that had been shown to the Trust Board in September 2018 and discussions were continuing with the Intensive Support Team (IST) before finalising the trajectory. Some ‘green shoots’ of recovery were being seen, but there was a workforce issue in relation to the future sustainably
- The November 2018 Board meeting should be able to be shown an updated trajectory that extended beyond April 2019

SDu noted that the 62-day Cancer waiting time target performance had been discussed at the Finance and Performance Committee meeting on 23/10/18 but asked what assurance could be given regarding the completion of the demand and capacity work from the IST, given the importance of that to future sustainability. AG confirmed the work required urgency and AG and MS had a telephone call booked with the IST on 29/10/18 to establish the status. AG added that it had already been recognised that the Trust had insufficient internal capacity to deal with the demand, so work was also taking place to see what streamlining could be undertaken within the pathways, working with the Trust Lead Cancer Clinician. AG added that she however unable to guarantee a plan that would not require change after the first Quarter. MS proposed that for the next Trust Board meeting, AG present details of the sustainable capacity required for each tumour site, and how this compared to current capacity. SDu welcomed this. AG noted that the Trust’s treatment capacity was likely to be sufficient as treatment was still being delivered within 31 days, but the key issue was to ensure a swift diagnosis, particularly in the large volume specialities. AG added that there would therefore need to be a large increase in diagnostic capacity in the future.

Action: Submit a report to the November 2018 Trust Board comparing the level of capacity needed to meet the 62-day Cancer waiting time target on a sustainable basis with the level of capacity that was currently available (Chief Operating Officer, November 2018)

PM then reported on the harm reviews that had been undertaken on the Cancer patients that had waited over 104 days for treatment, and noted that of the 74 cases reviewed, 1 case of serious harm had been found, which related to a patient with lung cancer that needed 3 pre-operative

treatments at 3 different institutions. PM continued that the serious harm related to the fact that the patient's stage had changed from 1a to 1b, but the treatment for both stages was the same. PM added that the harm for the other patients that had been reviewed was related to the continuation of their symptoms.

EPM asked whether the impact from patient feedback of the Trust's poor Cancer performance was known. PM replied that the latest Cancer patient survey showed that Trust performed very well, but this related to general satisfaction and not to the specific issue of waiting time. AG added that there had not been an associated increase in complaints.

MC asked whether the patients that had waited longer had been notified that they had experienced a delay i.e. that they had not been treated by the 62-day target. PM replied that patients experiencing harm had been notified of this, under the Trust's duty of candour, but other patients were not currently routinely notified. DH pointed out that the target was a percentage, so even if the 85% target was being met, there would still be 15% of patients who would be treated after 62-days. The point was acknowledged. AG highlighted that individual patients were also likely to be notified of the steps within their own pathway. PM noted that a new Standard Operating Procedure (SOP) had resulted from the harm reviews and therefore proposed that he ask the Trust Lead Cancer Clinician to advise on the matter. DH agreed with PM's proposal.

Action: Ask the Trust Lead Cancer Clinician to advise on whether the Trust should routinely notify Cancer patients that had not received a first definitive treatment within the 62-day target (Medical Director, October 2018 onwards)

AG then continued, and highlighted the following points:

- One of the key issues affecting the Referral to Treatment (RTT) target performance was the duplicate pathways that had been created following the implementation of the Allscripts Patient Administration System (PAS), but progress was being made to reduce the duplicates
- Non-elective activity plans had been affected by workforce issues and increased non-elective activity. For Ophthalmology, work undertaken on productivity and efficiency had led to a deliberate reduction in capacity and this needed to be reinstated. It would however be difficult for the Trust to deliver its planned levels of elective activity without outsourcing

DH referred to the duplicate pathways section on page 9 of Attachment 5 and asked for confirmation that the 2300 patients that still had 2 pathways had these legitimately. AG confirmed this was the case, noting that the number was similar to the number of legitimate pathways that were in place before the duplicate problems had arisen.

NG asked if there was a continuing team of validators working at the Trust. AG confirmed there was a small number of such validators but it had been recognised that this was insufficient as additional validators were likely to be required once the RTT module of the PAS was implemented. DH asked whether a firm date for the implementation of that module would be known by the next Board meeting. AG replied that April 2019 was the likely date, as she wanted the RTT module to be in place for at least 6 months before the implementation of the Electronic Patient Record (EPR).

Safe / Effectiveness (incl. mortality)

COB referred to Attachment 5 and highlighted the following points:

- The falls that had occurred in September were at a similar level to those in August. Four falls were reported as Serious Incidents (SIs). The NHSI Falls Collaborative work had now been completed and this had been quite successful, particularly on Ward 2. The focus would therefore now be on sustaining this and extending the successes to other Wards
- The pressure ulcer rate remained stable but 3 SIs had been reported in month. Some of the cases involved patients who had been admitted with skin damage but the cases were being reviewed. The use of incontinence pads was also being reviewed
- There had been increase in incidents involving patients with dementia, including rise in aggression against staff from patients exhibiting challenging behaviour. The need to ensure staff were properly supported was recognised
- The Friends and Family Test (FFT) response rate had improved significantly. The iPad data collection was being implemented, but there remained a reliance on the paper-based system

- The progress with the complaints responses had not been as good as COB would like and the response rate was now at 54% for 25- or 60-day responses. Work to address the issue was however continuing, including the development of an SOP that could be applied across all areas. The access to healthcare records would also now be audited as this had been raised as an inhibiting factor. Discussions would also be held with the Project Management Office (PMO) to see if some improvement methodology could be applied. The 75% target rate was not expended to be achieved for next month either, but COB felt that the situation was improving
- There had been 17 SIs reported in the month

SDu stated that she was interested in the steps being taken to prevent complaints arising, noting that the presentation given under item 10-8 was a textbook example of how to achieve this. COB noted that complaints were not always negative and the Trust's rate of complaints was at the level expected. SDu clarified that her query related to the process of preventing an initial concern from leading to a more formal complaint. COB acknowledged the point and noted that engagement had taken place with other organisations to consider whether the Trust's process was appropriate.

COB then referred to the "Safe staffing" section of Attachment 5 and noted that the next series of detailed safe staffing reviews would soon commence. COB added that the methodology used in those reviews would be informed by a "Developing Workforce Safeguards" event that SH and COB would attend in November. DH noted that he would also be attending that event.

PM then referred to Attachment 5 and reported that the Summary Hospital-level Mortality Indicator (SHMI) continued to reduce, but the Hospital Standardised Mortality Ratio (HSMR) had plateaued. PM also stated that he would ask the Mortality Review Group to investigate weekend mortality in more detail.

Safe (infection control)

SM then referred to Attachment 5 and highlighted the following points:
- The Trust had 7 cases of Clostridium difficile in September, and there was a higher rate compared to the previous year, which led to an outbreak being declared
- Outbreak meetings had been held at TWH and MH and there had been very good engagement. The Facilities department had reacted very well to the significant challenges they had been given, which included cleaning sluices and ensuring that deep cleaning at TWH was up to date

DH referred to the deep cleaning process and asked how long a Ward was unavailable for use when fogging was used. SM replied that this used to be 4 hours but new equipment meant that this was now completed in 2 hours.

SM then reported that the outbreak was expected to be closed down at the end of the month and a full closure report would be submitted to the next Trust Board meeting.

Well-Led (finance)

HF then referred to Attachment 5 and highlighted the following points:
- The plan had been achieved for September but not via the methods intended and some contingency monies had to be used
- The Trust had a £3.6m deficit for the year to date, which was in accordance with the plan but included slippage on the Cost Improvement Programme (CIP) and over-expenditure on budgets
- There were £17.8m of risks to delivery of the plan, although the plan was still forecast to be delivered. Actions to mitigate such risks were being developed and all Divisions had been asked to construct additional plans
- The cash position was also in accordance with the plan, but the non-delivery of the PSF would challenge this. The PSF funding for Quarter 2 would however be received as the relevant targets had been met
- The financial position had been discussed in detail at the Finance and Performance Committee meeting on 23/10/18

DH asked whether the costs associated with the winter plan were included in the forecast. HF noted that £2.9m had been included in the forecast for the winter plan, but AG had stated that she did not believe this was sufficient, so further discussions were required.

DH emphasised that there was a major incentive to achieve the control total as this would lead to significant PSF monies being received. The point was acknowledged.

Well-led (workforce)

SH then referred to Attachment 5 and reported the following issues:
- Sickness absence for August was still low but it was appropriate for that time of the year
- The influenza vaccination campaign had commenced and although the target was 85% for front-line staff, 24% of such staff had already been vaccinated. An increased number of peer vaccinators had been appointed and this had been very successful. The process had involved an element of peer competition, which had also helped. The campaign was an important part of the winter plan

DH commented that some Trusts had tweeted that they had already achieved a 50% vaccination rate, but he understood that the Trust had received its vaccine 2 weeks after others. SH then continued, and highlighted the following points:
- The staff turnover rate remained in accordance with the plan
- Work continued on the development of new roles and Apprenticeships, and the trainee Nurse Associates who had presented at the September 2018 Board meeting had now had their contracts confirmed
- Mandatory training was slightly below the target in month, but this was partly related to the implementation of a new Learning Management System as well as the inclusion of the Workshop Raising Awareness of Prevent (WRAP) training in the data
- The appraisals rate was below the target. Some Divisions were not compliant and this would be discussed in the Divisional Performance Reviews (DPRs)

DH referred to the latter point and noted that he needed to appraise the Non-Executive Directors, so asked that an action be recorded for him regarding this.

Action: Ensure that all Non-Executive Directors received an appraisal (Chair of the Trust Board, October 2018 onwards)

10-10 Update from the Best Care Programme Board

MS referred to Attachment 6 and proposed that a more detailed discussion be held at the next Trust Board meeting in relation to the key critical paths, lessons learned etc. of the Best Care programme, to distil the key points thus far. DH agreed.

Action: Schedule a detailed review of the Best Care programme for discussion at the November 2018 Trust Board meeting (Trust Secretary, October 2018 onwards)

Quality Items

10-11 Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)

SM referred to Attachment 7 and highlighted the following points:
- It had again been a really busy year, with many challenges but some successes, including the Trust being in the best performing quartile nationally for Clostridium difficile and having zero cases of MRSA bacteraemia
- There had been much change within the Infection Prevention and Control Team over the past year. Sarah Fielder had been appointed to a regional post, which was the second time one of the Team had achieved such a promotion. However, this kept the Trust's external links strong
- The "What the Board need to know..." section constituted the Trust Board's annual refresher training in Infection Prevention and Control
- The Trust had a solid culture for infection prevention and SM believed that the Trust had one of the cleanest hospitals, which was an important point given the Trust's FSM status. The Trust had also been innovative with the use of new methods, such as ultraviolet (UV) cleaning

- The Trust was compliant with the Hygiene Code and declared such compliance annually. The Statement of Compliance was available on the Trust's website
- National priorities included antimicrobial stewardship and the Trust took this very seriously. The associated Commissioning for Quality and Innovation (CQUIN) target had been achieved, which had been challenging, given the increased acuity of patients
- 'Gram negative sepsis' would be the new term used for gram negative bacteraemia, and the number of cases had stabilised rather than reduced, so more work was required
- The major challenge for 2018/19 was to implement the National Early Warning Score (NEWS) 2 by the end of the year, and the Trust was currently on track to do this
- The one area that left a cause for concern was surgical site infection (SSI), as there was limited resource to investigate this. The Trust undertook the required mandatory surveillance of SSIs in hips and knees, but 1 case of infection per quarter led to a Trust being above the national average. The Trust had also not yet fully implemented the associated NICE guidance, as it had not yet identified an effective way of warming surgical patients (noting the previous incident that had taken place with the 'hot dog' warming blanket)
- The Trust continued to work with partner organisations and the Infection Prevention and Control Team had been asked to peer review other teams, which enabled cross-learning

DH noted that PM was chairing the EPR Programme Board but stated that he wanted assurance that infection control issues would be incorporated. PM pointed out that SM would be the Deputy Chair of the EPR Programme Board, and added that the Programme Board was provided with advice from the Clinical Advisory Group, which was chaired by the Trust's Chief Clinical Information Officer (CCIO).

MS then asked SM to elaborate on the work being undertaken in relation to SSI. SM stated that one of the Orthopaedic surgeons was leading a lookback of such infections from the last several years, and a full action plan was in place. MS stated that it would be useful to understand what interventions were required to have a positive impact. SM acknowledged the point but clarified that only one aspect of the aforementioned NICE guidance on SSI had not been implemented.

Planning and Strategy

10-12 Update on 2017/18 Winter and Operational Resilience Plan

AG referred to Attachment 8 and gave a presentation which highlighted the following points:

- The objectives for the winter plan for 2018/19 were to manage all aspects of patient flow safely; to avoid prolonged periods of over-crowding in the Emergency Department (ED); to avoid 12-hour trolley breaches; to avoid 30 and 60 minute Ambulance handover delays; to deliver the plan within the agreed budget; to ensure plans were in place to manage the expected activity scenarios and likely impact of bed capacity; to deliver the agreed plan of elective activity; and to adopt and implement evidence-based best practice to reduce non-elective admissions
- The plan had already delivered a number of changes, including Frailty & Ambulatory Emergency Care (AEC) Units at both TWH and Maidstone Hospital (MH)
- The key actions to be taken included transferring beds from surgery to medicine

DH asked how the surgical Nurses had reacted to the transfer to medical beds. AG noted that it had been accepted that it was better to do this in advance and this would be the third year the Trust had undertaken such a transfer. COB added that it was important to ensure that the Nursing teams knew the medical teams and work had been done on that aspect.

SDu asked whether any analysis had been carried out to determine whether outlier patients experienced a higher LOS than other patients. AG noted this had not been done specifically but explained that lessons had been learned from the previous year. SDu asked whether a Key Performance Indicator (KPI) would therefore be monitored that year. AG explained that this would be incorporated within the LOS KPIs. AG then continued, and highlighted the following points:

- 2 Multi Agency Discharge Events (MADEs) would be held
- A new Virtual Ward service would be introduced which would be operated by Kent Community Health NHS Foundation Trust

- A range of supplementary actions would also be taken, including having increased Nursing and Medical cover within the ED
- Capacity and demand analysis and modelling showed that there would be an increase of 2.3% in Type 1 patients over the winter compared to the previous winter. The modelling also showed that with the new GP streaming service in place, 200 to 250 patients would be streamed per week, which was circa twice as many as last year.
- Emergency admissions were expected to be in accordance with the ED attendance increase (i.e. 2.3%) whilst DTOCs were expected to be maintained at current levels

DH asked whether the assumed 2.3% increase in emergency admissions was a prudent assumption. AG confirmed that was the level that had been advised, but a worst case increase of 6% had also been considered, as this had been experienced in the past.

NG asked whether the impact of winter on the A&E 4-hour waiting time and RTT targets had been modelled. AG confirmed this had been incorporated into the trajectory for the former target.

EPM asked whether the aforementioned £2.9m funding for the winter plan included the aspects that were outstanding i.e. the proposed extended hours in the Frailty and AEC Units. AG confirmed these aspects were not included. MS pointed out that a Frailty service had not been in place at all during the previous winter.

AG then continued, and highlighted the following points:
- Significant operational details had been developed and a 59-page operational plan was available to Trust Board Members on request, as this would be completed w/c 29/10/18
- The key issues to manage / mitigate included an even greater increase in non-elective admissions (the worst case scenario plan was for an increase above 6%); a failure to increase external capacity; snow appearing before Christmas; Norovirus that affected more than one Ward at any time; any increase in staff sickness above expected levels, and the Kent & Medway Stroke review decision (including the state of the Stroke service at Medway NHS Foundation Trust)

SDu asked what the implications were of not meeting the 60-minute ambulance handover target. It was confirmed that there was no contractual penalty as the Trust operated under an AIC, so the matter was solely a performance issue.

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

10-13 Workforce Committee, 27/09/18 (incl. Annual Report from DME on work schedule reviews relating to education and training; Work Race Equality Standard (WRES) report for 2018; and Freedom to Speak Up update)

NH referred to Attachment 9 and highlighted that Christian Lippiatt, Occupational Health Manager, had been appointed as the new Freedom to Speak Up Guardian, and Appendix 1 contained further details. NH also noted that Workforce Race Equality Scheme data had been reviewed and this was shown in Appendix 2.

10-14 Quality Committee, 15/10/18

The circulated report was noted.

10-15 Trust Management Executive (TME), 17/10/18

The circulated report was noted.

10-16 Finance and Performance Committee, 23/10/18

The circulated report was noted.

10-17 Charitable Funds Committee, 23/10/18

DH reported that the Committee had not in fact met on 23/10/18 and the meeting had been rescheduled for 27/11/18.

10-18 To consider any other business

KR asked that the Trust Board delegate the authority to the 'Part 2' Board meeting being held later that day to make decisions regarding the Trust's properties at Springwood Road and 32 High Street Pembury. The requested authority was duly delegated.

10-19 To receive any questions from members of the public

PC referred back to the comments made by PM under item 10-7 and asked if a senior review was available if a junior doctor was working during the night. PM confirmed that such a review was available.

10-20 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 – November 2018

Maidstone and Tunbridge Wells NHS Trust

11-4 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]
9-4 (Sept 18)	Ensure that Non-Executive Directors were provided with details of the individuals appointed to the key posts within the new clinical management structure, once finalised	Trust Secretary	November 2018	The details of the appointments to the Chiefs of Service were forwarded to the Non-Executive Directors by email on 21/11/18. The details of the other appointments will be provided once they have been confirmed
10-9c (Oct 18)	Ensure that all Non-Executive Directors received an appraisal	Chair of the Trust Board	October 2018 onwards	The appraisals are being arranged and one will have taken place prior to the November 2018 Board meeting

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-8 (Oct 18)	Contact the family referred to in the "Patient experience" item at the Trust Board on 25/10/18 to thank them for giving permission to relay their story	Chief Executive	November 2018	A letter was sent to family on 21/11/18
10-9a (Oct 18)	Submit a report to the November 2018 Trust Board comparing the level of capacity needed to meet the 62-day Cancer waiting time target on a sustainable basis with the level of capacity that was currently available	Chief Operating Officer	November 2018	The item has been scheduled for a verbal report at the Trust Board meeting on 29th November 2018
10-9b (Oct 18)	Ask the Trust Lead Cancer Clinician to advise on whether the Trust should routinely notify Cancer patients that had not received a first definitive treatment within the 62-day target	Medical Director	November 2018	The Trust Lead Clinician has advised that it is not usual practice amongst other Trusts contacted (the Royal Marsden, Imperial, Frimley Park, Guildford and Newcastle) to routinely inform patients that their treatment has been 'delayed' if they breach 62 days. The Trust Lead Clinician has advised that any approach adopted would need to reflect the

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				significant difference between groups that breach i.e. patients who chose to delay decision making about their pathway; patients who were treated just outside 62 days because of hospital treatment capacity issues; patients who wait significant amounts of time due to either complex diagnostics or management of their significant comorbidities. It is therefore felt that there are more pressing priorities currently and these will be prioritised in the first instance. Clarification will be sought from NHSI Medical Director but no action on this issue is planned in the short term
10-10 (Oct 18)	Schedule a detailed review of the Best Care programme for discussion at the November 2018 Trust Board meeting	Trust Secretary	October 2018	A review has been scheduled for the November 2018 Trust Board meeting

Actions not yet due (and still 'open')

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

Trust Board meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-6 Report from the Chair of the Trust Board — Chair of the Trust Board

Since the last Board, I have chaired the interviews for the new Chief of Service appointments and I congratulate the successful candidates. These are key roles for the success of the Clinically-Led organisation and I am sure we have appointed well qualified leaders.

Miles and I also met with the NHSI representatives who observed our September Board, and we will discuss the feedback at our Board 'Away Day' in December.

It has been agreed by the Provider Chairs & CEO Group that I will be one of the two provider Chairs on the STP Governing Body.

I was pleased to help present the awards at the 2018 Staff Awards event at High Rocks on 9th November. Our external speaker, Dr Phil Hammond, was excellent and the whole evening was a great success.

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.

AAC recommended Consultant appointments (dependant on compliance or withdrawal)					
Date of AAC	**Title**	**First name**	**Surname**	**Department**	**Potential/Actual Start date**
16/11/18	Dr	Bacete	Bwogo	Care of the Elderly	TBC
16/11/18	Dr	Frank	Busch	Care of the Elderly	TBC
19/11/18	Miss	Despina	Mavridou	Obs & Gynae	TBC

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 – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-7 Report from the Chief Executive — Chief Executive

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

1. We honoured colleagues from all areas of our hospitals at our annual Staff Stars and Long Service Awards this month.

   Our Staff Stars Awards marked the achievements of over 260 individuals and teams who have really made a difference to patient care, their service and hospital life.

   I was truly inspired by our winners' commitment, innovation and excellence to improve how we provide care to our patients. What really shone through was the enthusiasm and passion from our staff to deliver the very highest standards.

   Our Long Service Awards celebrated the commitment of over 70 of our colleagues who have worked in the NHS for 30 years or more. I was delighted to be able to pay special tribute to our Head of Radiotherapy Services, Christine Richards, MBE, who has been in the NHS for 45 years.

2. Delivering results for our patients was a key theme of the awards ceremony and a subject we continue to focus on with our senior leaders to secure delivery of our financial plan over the coming months.

   MTW reached one of our significant milestones to financial sustainability recently when we left Financial Special Measures. We need to continue our focus to make sure we deliver what we set out to do, by the end of the financial year.

   Securing our financial goals will mean we will be in full control of our destiny, allowing us to drive our development plans forward and meet our aim of becoming Outstanding. We will also earn a bonus of £12 million, which we can invest in our services, benefiting our hospitals, patients and staff. If we don't meet our financial plan for 2018/19, then we give ourselves a bigger mountain to climb next year – and reduce control over how we make improvements and changes in our hospitals, in future.

   We know we've got a challenging few months ahead operationally, with a tough winter predicted and to meet our RTT and cancer waiting time standards. Even with the challenges that lie ahead, achieving our financial goals is doable. Delivering the operational plan for winter will help us meet our financial plan. We've made a series of investments to manage winter.

   In our EDs we have introduced a range of innovative measures and best practice initiatives, including working closely with our community providers to reduce ED attendances by enhancing services to treat more patients at home and increasing the time our assessment units are open to support our older frail patients. We have introduced more GP hours within our ED's this year, which has freed up time for senior clinicians to see the sickest patients more quickly.

   We're also looking at how we can better stream patients when they arrive in ED to ensure they get the right care, in the right place, at the right time.

   A new element this year sees MTW working in partnership with Kent Community Health NHS Foundation Trust to allow patients, with the support of community nursing teams, to continue their care at home, once their acute hospital care is complete.

   We continue to proactively address our performance against the RTT standard to shorten planned care waiting times and improve our patient experience.

   We have introduced a number of new roles, such as physician's associates, doctor's assistants and nurse endoscopists to support the service and ensure patients are seen and treated in a

timely manner. We have created straight to test triage clinics, virtual clinics and introduced a central admissions lounge for elective patients.

We are also improving our patient experience by changing specific pathways to better meet our patient needs. By way of example, our clinicians have introduced an innovative muscular skeletal pathway that triages patients before the need for a consultant appointment, providing faster access to the care they need.

We are also focused on improving theatre and outpatient efficiency as well as adding theatre sessions and outpatient clinics at weekends.

In our cancer services, we have increased the number of outpatient clinics, endoscopy sessions and radiology, CT and MRI slots, as well as sped 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.

3. Earlier this year colleagues throughout MTW helped shape our vision to develop a more clinically-led organisation. Our shared aim is for everyone at MTW to feel part of and, have a genuine stake in, all that we do to improve our patient and staff experience.

   We have taken some important steps towards becoming a more clinically-led organisation with the appointment of Chiefs of Service for our five new Divisions. These appointments put us on track to launch our new Divisional and Directorate management structures in December.

   Our new Chiefs of Service are:
   - Medicine & Emergency Care – Dr Laurence Maiden, Consultant Gastroenterologist
   - Women's Children's & Sexual Health Services – Miss Sarah Flint, Consultant in Obstetrics and Gynaecology
   - Surgery – Dr Greg Lawton, Consultant in Anaesthesia and Intensive Care
   - Cancer Services – Dr Sharon Beesley, Consultant Clinical Oncologist
   - Diagnostic & Clinical Support Services – Dr Paul Sigston, Consultant in Anaesthesia and Intensive Care

   Our Chiefs will head up their Division and carry overall responsibility for the leadership and management within their area. They are supported by a Divisional Director of Operations (DDO) and Divisional Director of Nursing and Quality (DDNQ) and have Clinical Directors (CDs) for each Directorate.

   We are giving our Divisions, Directorates and clinical services clearer authority, responsibilities and expectations as well as clearer incentives for success and more dedicated support from our corporate departments. To assist this, we are investing in leadership development, talent management, and implementing a Quality, Service Improvement and Redesign (QSIR) faculty to support colleagues in making the changes they want to see.

   As part of our drive to be more clinically led, over 130 leaders came together this month at our first Leadership Forum. One of our key priorities at MTW is to improve staff engagement. It's important that our leaders make time to talk and communicate with their teams. We are launching a team brief to support this approach, and we are rolling out a shop floor commitment where leaders will engage with our people on the frontline.

4. We were delighted to welcome the Executive Director of Education and Quality and National Medical Director for Health Education England, Professor Wendy Reid, to MTW. Professor Reid shared insights on the future of medical training with our clinicians. She described taking a more flexible, individual and inclusive approach to value and retain healthcare professionals. We were also fortunate to welcome Professor Graeme Dewhurst, Postgraduate Dean for Health Education Kent, Surrey and Sussex, and Professor Chris Holland, Foundation Dean of the Kent and Medway Medical School.

5. The Breast Cancer Kent charity has worked in partnership with MTW's breast unit teams to produce an app to help patients recently diagnosed with breast cancer with their understanding of investigations and treatment at our breast units and Kent Oncology Centre. This has the potential to help transform the way we deliver complex information to patients and is another great example of how we can improve our patient experience and, own information systems, by working in association with our much-valued partners.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-8	**Integrated Performance Report, October 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for October 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 October 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]

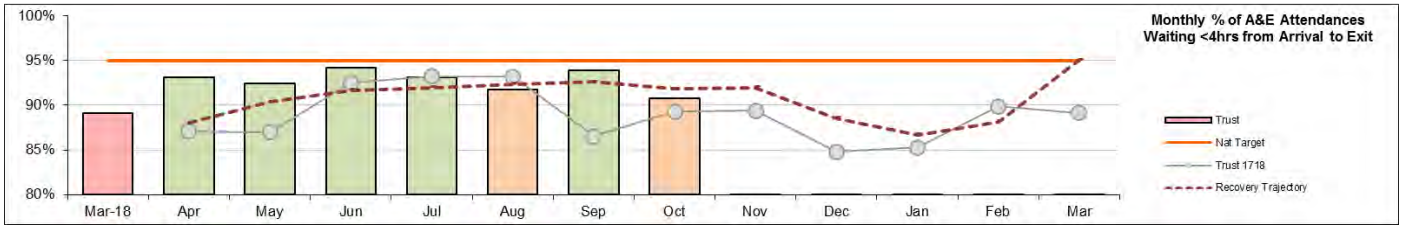
Review and discussion

[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 NOVEMBER-18

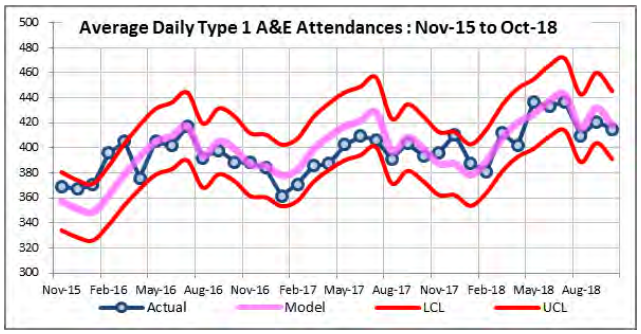
1. 4 Hour Emergency Target

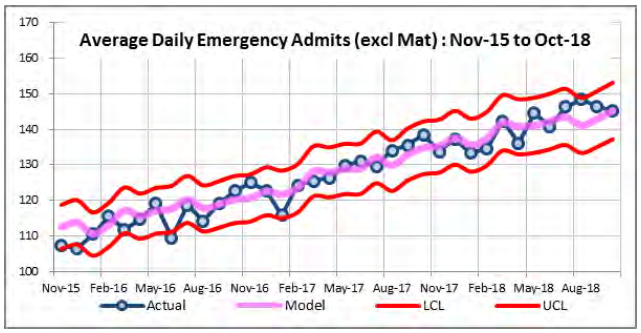
- The Trust was above the recovery trajectory for each month from April to July 2018. Performance dipped slightly below trajectory in August, recovered in September but has dipped again in October to 90.75% (including MIU), against the target of 91.80% (-1.05%).
    - YTD at 31-Oct, the Trust was at 92.79% against a YTD plan of 91.28% and a year-end target of 90.82%.
    - November performance is however is currently challenging at 90.29% against a target of 91.96%.
    - The Trust achieved Q2 with 92.99% against a target of 92.30%.
    - For the year 1718 the Trust scored 89.08%, compared to 87.12% in 1617.



2. ED Attendances & Emergency Admissions

- A&E Attendances continue to increase. Over the last 5 years, annualised growth has averaged 4.4%. This is against a local population increase of around 1.0% per year.
- Total October attendances were 0.5% down on model, but 3.1% up on trajectory at 15,770. This is 4.6% up on last October (like-for-like). YTD attendances are 0.5% up on model, 2.5% up on trajectory and 5.6% up on this time last year. Average weekly attendances were at record levels over the summer.
- Non-Elective Activity (excluding Maternity) was 13.0% above plan in October and 11.3% higher than last October at 4,925 discharges. Over the summer, NE activity has been its highest ever level. 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 10.5% above plan & 13.3% above last year.

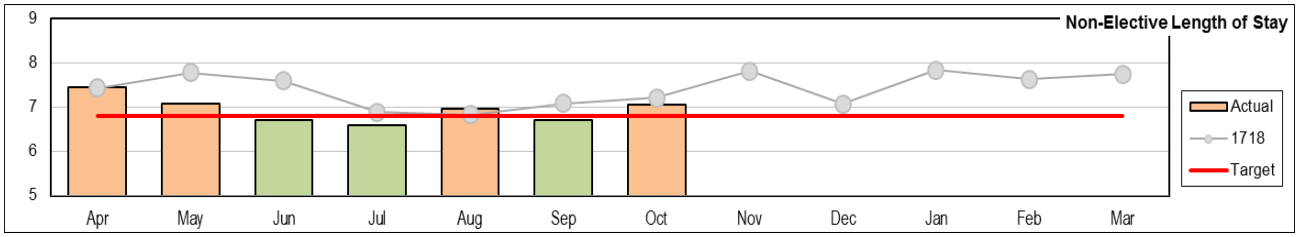




- **Zero LOS admissions**

3. Length of Stay

- Non-Elective LOS was 7.05 days in October, and 6.93 YTD vs 7.41in 1718.



- The average occupied bed-days is up 10 in October to 729, 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 key initiatives are

Managing LOS to the optimal needed, using tools such as

- CUR (clinical utilisation review) to identify reasons for patient delays and implementing targeting actions to address those delays. CUR is being rolled out to every ward, overseen by a CUR project manager and the reports used at the morning site meeting to direct clinical & support staff to the necessary actions needed to remove delays.
- All elderly patients are being assessed against a frailty score to facilitate their appropriate care and interventions on attendance / admission. The intention is to stream all the appropriate patients through the frailty units but the documented frailty score will ensure that patients can still avail of the frailty team when their condition has improved.
- AEC (ambulatory emergency care), ensuring that patients are streamed appropriately to ensure their pathway is relevant to their reason for attendance and their admission avoided where possible and if admitted that their stay is as short as clinically appropriate.
- Hospital at Home (Virtual Ward), working with KCHFT, the Trust is moving forward with implementation of the hospital at home model which will extend the capacity for acute care, but delivered in the patient's usual place of residence. The preparations are in an advanced state to have this service up and running by the beginning of December with all specialties (excluding paediatrics) having potential to access.

Tangible Improvements in patient flow include

- Occupied bed days
- Level of medical outliers
- NEL LOS

4. Delayed Transfers of Care (DTOC)

The percentage of occupied bed-days to DToC fell back from 5.89% in September to 4.52% in October. YTD we are 4.77%

The number of lost bed days due to DTOCs fell by 203 to 940. We ended 1718 on 4.95%, and until September, had been reporting fewer than 5.0% for 10 consecutive months.

On average, 31.8 beds per day have been lost to delays in 1819 compared to 38.8 for the equivalent period last year. We have experienced a greater focus from external partners on the exit routes from the hospital and we have now go a very well established discharge routes visa Pathway 1, 2 & 3 of the Home First initiative.

Both sites have now got a functioning frail elderly unit which has helped to reduce the number of longer stay admissions.

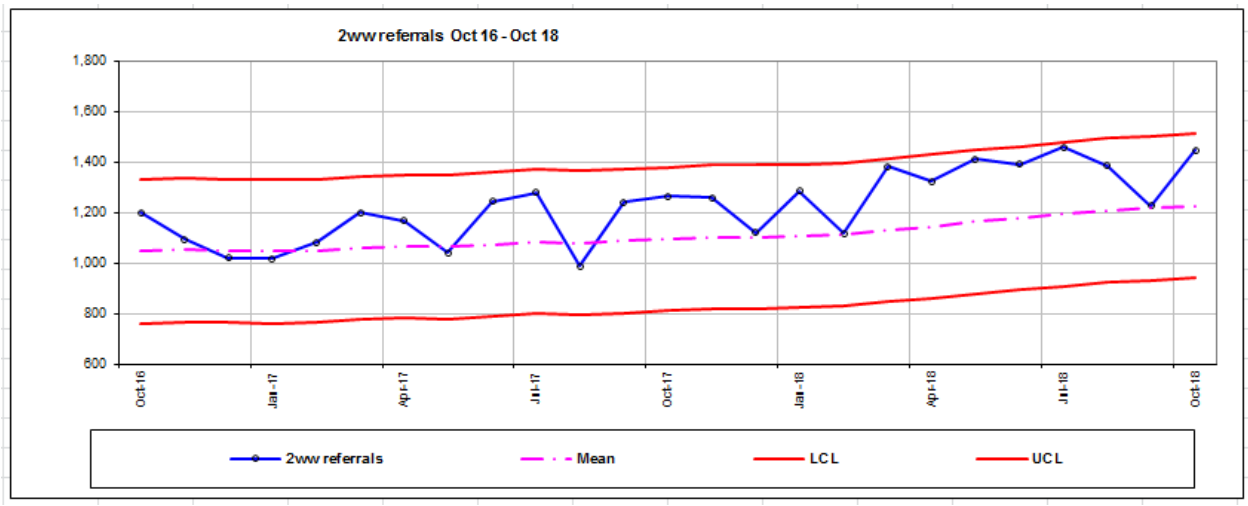
Category	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Rolling 12 Month
A : Awaiting Assessment	6	2	5	2	1	2	5	3	8	17	21	13	**85**
B : Awaiting Public Funding	1	0	1	5	1	2	4	0	0	4	3	0	**21**
C : Awaiting Further Non-Acute NHS Care	10	18	21	9	21	12	20	14	17	22	14	21	**199**
Di : Awaiting Residential Home	19	18	24	18	40	15	23	29	22	9	32	22	**271**
Dii : Awaiting Nursing Home	54	38	37	47	54	53	43	26	34	54	27	35	**502**
E : Awaiting Care Package	36	14	18	20	28	20	31	18	29	24	28	16	**282**
F : Awaiting Community Adaptations	12	4	12	10	7	15	7	6	4	8	10	7	**102**
G : Patient or Family Choice	38	13	11	5	10	3	14	11	9	14	9	17	**154**
H : Disputes	1	0	0	0	0	1	0	0	0	1	1	0	**4**
I : Housing	1	2	3	3	2	6	2	7	5	4	4	4	**43**
Grand Total	**178**	**109**	**132**	**119**	**164**	**129**	**149**	**114**	**128**	**157**	**149**	**135**	**1,663**
Rate	**4.84%**	**3.73%**	**4.27%**	**3.89%**	**4.26%**	**4.56%**	**4.34%**	**4.39%**	**5.03%**	**4.77%**	**5.89%**	**4.52%**	**4.54%**

5. Cancer (see also attached slide pack for latest performance information)

5.1 2-week waits

Endoscopy capacity has been significantly increased from the start of September (as per the graph above) and the majority of patients are now being booked within 2 weeks, having had a wait of up to 6 weeks in June and July. Given the current cancer referral demand, the endoscopy department are required to increase capacity on a permanent basis which involves outsourcing some of this demand to other units, likely to be in the Independent Sector. This is the same for Urology diagnostics, and one –stop breast clinics. The initial output from the IST regarding capacity has identified a shortfall in breast clinics and a likely positive balance for urology outpatients.

In September, the breast service contributed 22.5% of breaches (0.5% reduction compared to last month), Lower GI 36.5% (-1.5% compared to last month) and Upper GI 19.2%.



The number of breaches in Urology has improved significantly in recent months with additional capacity from 2 x locum doctors plus alterations to clinic templates from mid-November. Lower GI breaches have increased due to more patients going through the nurse-led triage for straight to test as this does not stop the clock and the breach has occurred as there has not been sufficient endoscopy or imaging capacity.

Upper GI breaches have increased and contributed 23% of the total breaches. Again, this is due to endoscopy capacity even though this has been significantly increased since the start of September.

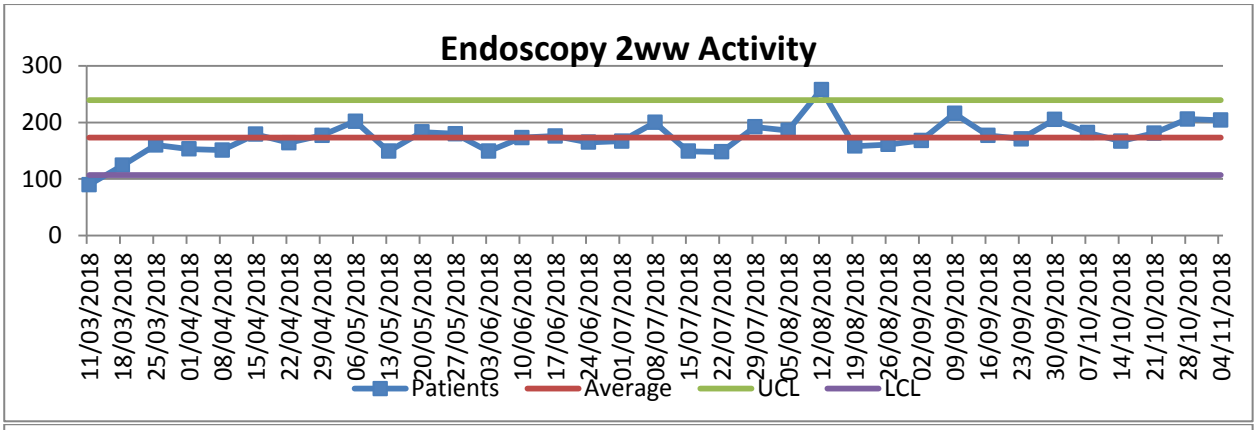
a. Cancer 62 Day First Definitive Treatment

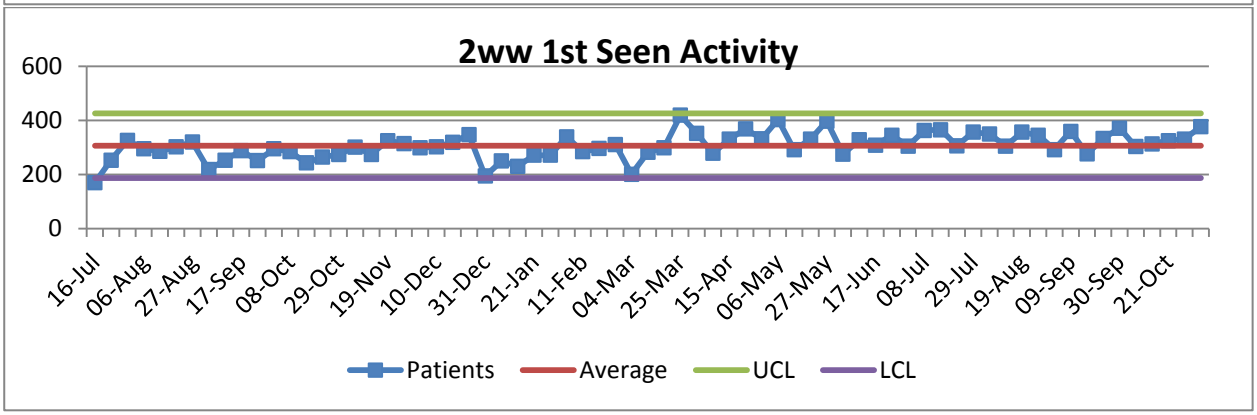
62 day performance for September was 60.1% and 62.2% for 1819 Q2. 1718 finished on 70.4%.

The recovery plan continues to focus 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. In the medium to longer term the focus will remain on establishing more accurate demand and capacity planning for each tumour site particularly for the outpatient and diagnostic phase. Treatment

capacity will be continually reviewed as more patients are diagnosed faster and cross-over with patients being treated in the backlog.

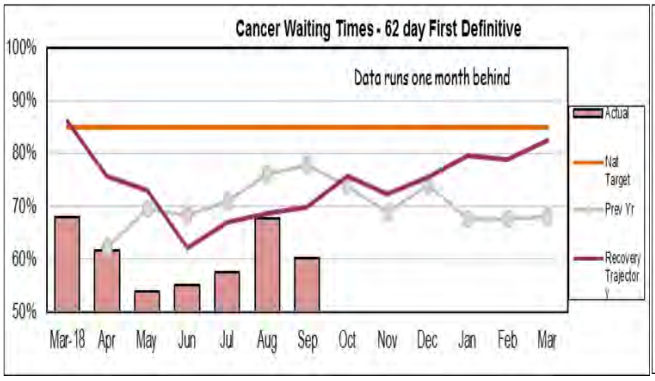
Increases in first seen appointments as well as endoscopy slots to meet the demand for lower and upper GI diagnostic and activity have increased in line with the recovery plan, but is still insufficient to sustain the service in the medium to longer term.

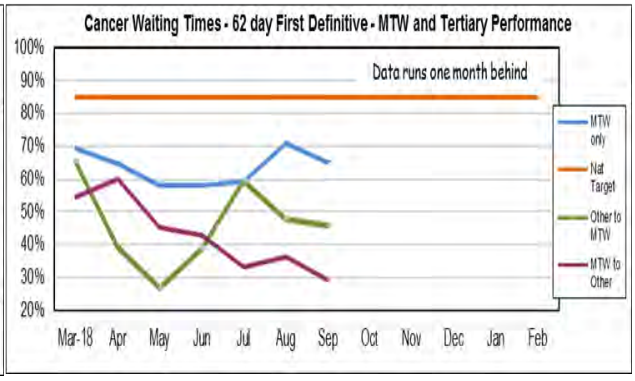




The additional capacity has returned activity delivery back in line with the planned activity for 2018/19. We will continue to work with commissioners to ensure that the revised demand and capacity requirements are reflected in the planning.

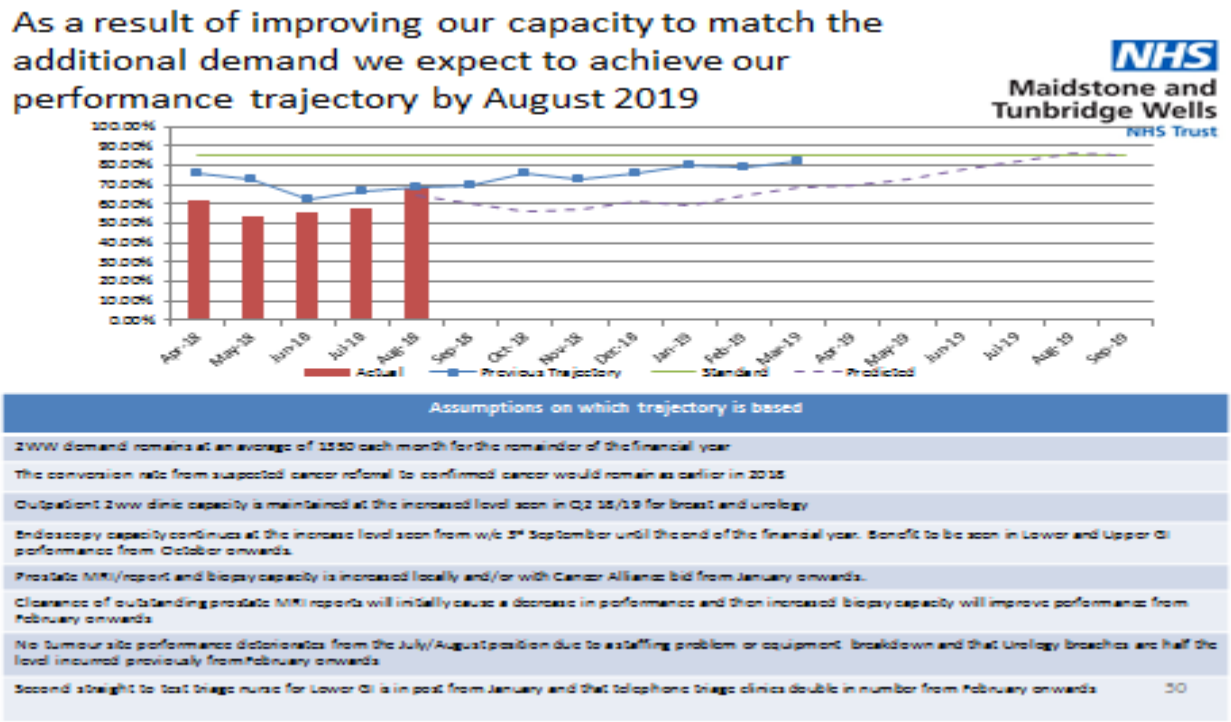
5.3 September 62 day reported performance

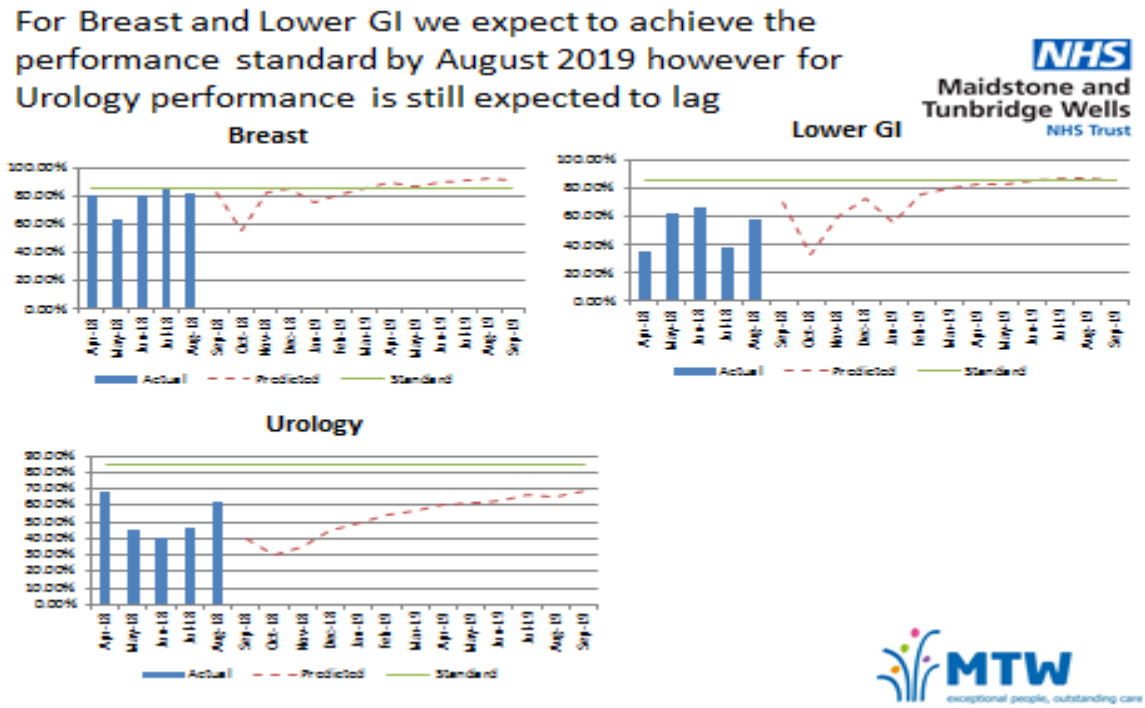




62 Day Performance						
September 2018	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	16.5	3.0	81.8	16	3	81.3
Gynae	11.0	1.0	90.9	7	0	100.0
Haematology	8.5	3.0	64.7	7	2	71.4
Head & Neck	1.5	1.0	33.3	0	0	#DIV/0!
Lower GI	10.0	3.0	70.0	10	3	70.0
Lung	9.5	5.0	47.4	7	3	57.1
Other	2.5	1.0	60.0	2	1	50.0
Upper GI	14.0	5.5	60.7	9	2	77.8
Urology	33.0	20.0	39.4	28	16	42.9
TOTAL	106.5	42.5	60.1	86	30	65.1

The size of the backlog at the end of September was 71 patients (patients waiting over 62 days for treatment with a diagnosis of cancer). For the MTW only patients the backlog was 34. This is a 9 patient decrease compared to August for all patients and 17 patient decrease for MTW only. These reductions is assurance that the current interventions are having an impact and containing the problem but are not sufficient to deliver the sustained change needed to deliver the 62 day target in the next 6 months.





The key limitation in urology is MRI and prostate biopsy capacity (50% deficit currently). To achieve a more rapid recovery further developments are under consideration by the team which inlcude

- Implementation of a 1 stop prostate clinic (discussions are underway – will require a 3 – 6 month implementation)
- Repatriation of EKHUFT prostate biopsies as we currently undertake those. Once funiding (via cancer alliance) has been agreed there is a lead in time of around 3 months to implement, which will include our capacity by around 5 slots per week, leaving a residual deficit of 10 – 15.

5.4 Cancer patient tracking and monitoring

The governance structure around PTL (patient target list) management is being further revised following advice from the Intensive Support Team. The weekly PTL meetings will continue to focus on patient's at 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 multi-specialty oversight meeting has been convened, to review trends in breaches and to help unlock any bottlenecks in pathways. This oversight meeting will also drive the pathway changes necessary to deliver sustainable change in the future.

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.

Specific tumour site action plans are in place and being managed through the specialty teams and a recovery plan and revised trajectory has been developed and submitted. The teams continue to focus on what additional improvements can be made that will bring forward the date for sustainable delivery of this standard. A revised action plan has been developed to capture the initial recommendations from the IST.

Capacity and demand reviews for the modalities in Radiology is underway but is hampered by gaining access data from the radiology information system. Discussions are taking place with East Kent about how this data can be accessed as they have already achieved a better data flow.

The cancer leadership and clinical management team has increased recently to help expedite the pathway & process improvements that are necessary and also to increase the level of performance management support within the division.

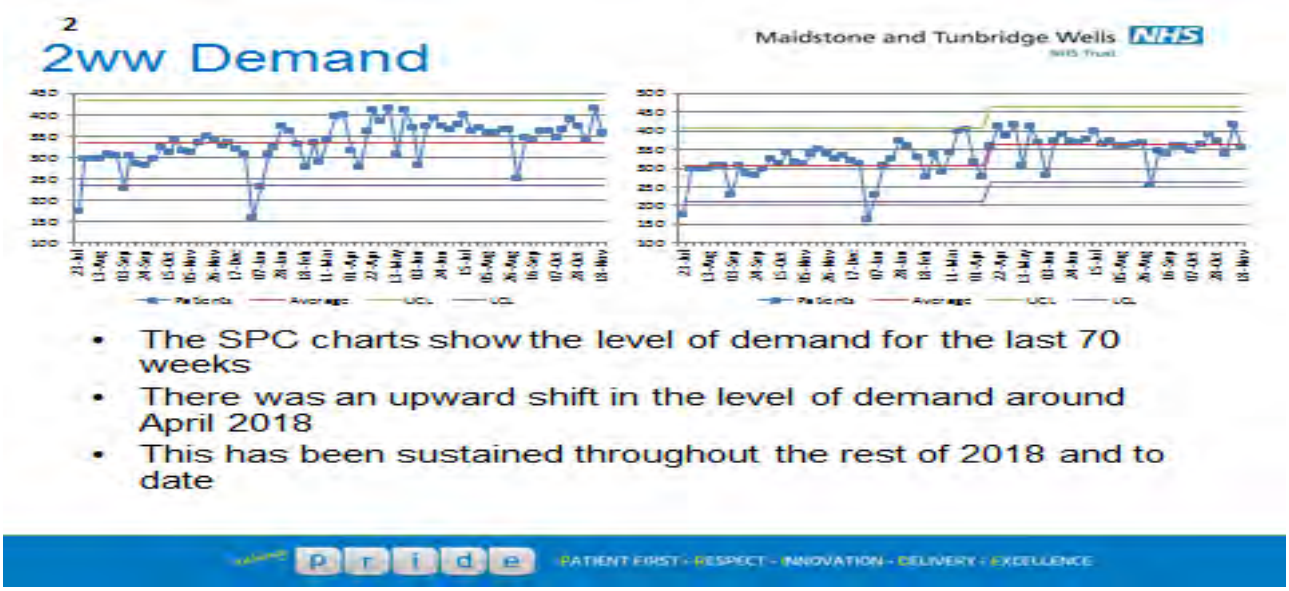
This includes a Cancer Transformation Manager 3 x Pathway Navigators (colorectal, UGI and prostate) and a straight to test nurse has been appointed and started at the beginning of November for the prostate pathway. The straight to test nurse and the pathway navigators are funded through the cancer alliance with clear objectives including:

- 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
- 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 during December.

The number of patients waiting over 104 days on the cancer pathway is another area for improvement and a key priority for the Trust. The peak number of patients was seen at the start of October but there has been a steady decrease in the number of patients over the last 6 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).

A revised trajectory is in development to take in to account actions that are being taken and when and what benefit will be seen.



6. Referral To Treatment – 18 weeks

October performance shows an improvement in the Incomplete RTT performance achieving 80.67% against a target of 83.63%. The updated recovery plan is focused on delivering the original activity plan during November to March as well as undertaking some additional activity.

The objective remains to achieve a waiting list position at the end of March 2019 that is no greater than the March 2018 position of 31,871. This will be achieved through activity, improved productivity and on-going validation.

6.1 October performance vs plan:

		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
TRUST	Trajectory Total WL	31871	30573	30211	29955	29700	29583	29329	29836
	Actual Total Waiting List	32074	32729	32888	34584	34420	34856	32386	31236
	Actual IP Waiting List	5741	5736	5841	7641	7519	7273	6986	7024
	Actual OP Waiting List	26333	26993	27047	26943	26901	27583	25400	24212
	Trajectory Backlog	6438	6186	5935	5685	5437	5416	5170	4884
	Actual Total Backlog	6451	6728	6547	7214	6743	7220	6607	6036
	Actual IP Backlog	2716	2682	2577	3530	3454	3352	3068	2939
	Actual OP Backlog	3735	4046	3970	3684	3289	3868	3539	3097
	Trajectory % Performance	**79.8%**	**79.8%**	**80.4%**	**81.0%**	**81.7%**	**81.7%**	**82.4%**	**83.6%**
	Actual Total % Performance	**79.9%**	**79.4%**	**80.1%**	**79.1%**	**80.4%**	**79.3%**	**79.6%**	**80.7%**

6.2 Elective Activity and New Outpatient Activity:

Currently the Elective activity YTD is on plan and the outpatient activity is 4,237 cases (-5.1%) below plan with general surgery and ophthalmology being furthest from plan. The inability to deliver the planned elective work internally is a risk to our ability to meet the trajectory. There is an assumption in our trajectory that the activity is delivered to plan.

A detailed piece of work has been undertaken to produce a revised forecast of future performance from November until the end of March 2019 based on the RTT Recovery Plan (as below). Prime Provider activity has not been included in this plan. The assumptions on which the forecast is based include additional activity in the main surgical specialties, a further drive on productivity and continued and on-going PTL validation.

Activity (Main Specialties):	Elective Activity YTD				Outpatient New Activity YTD			
	Actual	Plan	Variance	% Variance	Actual	Plan	Variance	% Variance
Trauma & Orthopaedics	2136	1714	422	24.6%	16348	13695	2653	19.4%
General Surgery (Not inc Endoscopy)	1891	2113	-222	-10.5%	10548	12279	-1731	-14.1%
Urology	1401	1528	-127	-8.3%	4110	3831	279	7.3%
ENT	1181	1293	-112	-8.7%	5484	5462	22	0.4%
Ophthalmology	3087	3538	-451	-12.7%	15778	17737	-1959	-11.0%
Gynaecology	1494	1591	-97	-6.1%	4561	4758	-197	-4.1%
Cardiology					3597	3897	-300	-7.7%
Gastroenterology					2356	2738	-382	-14.0%
Rheumatology					1425	1335	90	6.8%
Respiratory					2797	2597	200	7.7%
Diabetes					1059	992	67	6.7%
Endocrinology					942	877	65	7.4%
Neurology					1814	1924	-110	-5.7%
Care of the Elderly					953	1345	-392	-29.1%
Other	20024	19691	333	2%	6717	9423	-2706	-28.7%
Trust Total (All Specialties)	31214	31241	-27	0%	78489	82726	-4237	-5.1%

The key issues that contribute to lower that planned elective work remain:

- The inability to do a sufficient level of elective work caused by the historic and cumulative impact of increased non-elective activity (TWH specifically) and not using outsourcing to make up the gaps.
- The Trust has not yet met the challenging productivity opportunity in theatres which was intended to release more capacity
- 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 (General Surgery, Urology, Neurology & Endocrinology)

- Reduced activity in January 2018 to support Non-Elective flow and further reduction in February due to snow, which increased the size of the problem in the New Year.
- Reduction of WLI activity which was suspended pending the outcome of the Four-Eye work across elective and outpatients.

The majority of the RTT backlog continues to be concentrated in surgical specialties with the exception of 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. Operational teams are continuing their plans to increase elective activity and arrange extra clinics to ensure the backlog does not grow further.

6.3 Year-end forecast:

RTT Forecasted Performance	Mar-18	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 Waiting List	31871	32729	32888	34584	34420	34856	32388	31236	31832	31224	30477	29782	29068
Total Backlog	6680	6728	6547	7214	6743	7220	6609	6036	6808	6338	5826	5363	4897
Total %	79.04%	79.44%	80.09%	79.14%	80.41%	79.29%	79.59%	80.68%	78.61%	79.70%	80.88%	81.99%	83.15%

The impact from an earlier data quality issue means that the IPWL part of the Total Waiting List from July increased by 1528 patients and the IP Backlog increased by 921 patients which will have an ongoing effect. The validation process has demonstrated a reduction in both these lists in October 2018.

This forecast will be further affected by additional referrals from prime provider (circa 800). The operations team are managing the inherent risk to delivery which remain around workforce, capacity and agreed funding for additional activity.

6.4 Duplicate Pathways:

Duplicate pathways have been an issue particularly in Ophthalmology and General Surgery which has caused the waiting list size to be artificially inflated. Work continues to validate the remaining 2300 duplicate pathways. NHS North Commissioning Support Unit is providing an external review of how we can monitor this in order to support the operational teams and BI teams to avoid this becoming a recurring problem.

6.5 52 week breaches

Total Trust	Apr-18	May-18	Jun-18	Q1 Total	Jul-18	Aug-18	Sep-18	Q2 Total	Oct-18	YTD
RTT >52kw Breach Occurrences	3	2	8	13	8	5	9	22	9	44

The Trust has incurred 44 x 52 week breaches year to date, largely due to historic data and administration issues, particularly in one specialty, T&O. Additional training & support has been well received and continues to be a priority for all specialities.
The Trust has set itself a Weekly 52wk breach trajectory of improvement to get to zero by 31st March 2019:

Trajectory for Reduction in 52+ week Waiters to zero by week ending 31st March 2019																					
	Trajectory for Improvement by 31st March 2019																				
	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
TRUST	10	10	10	10	10	10	10	10	8	8	8	8	8	5	5	5	4	3	2	1	0

Oversight:

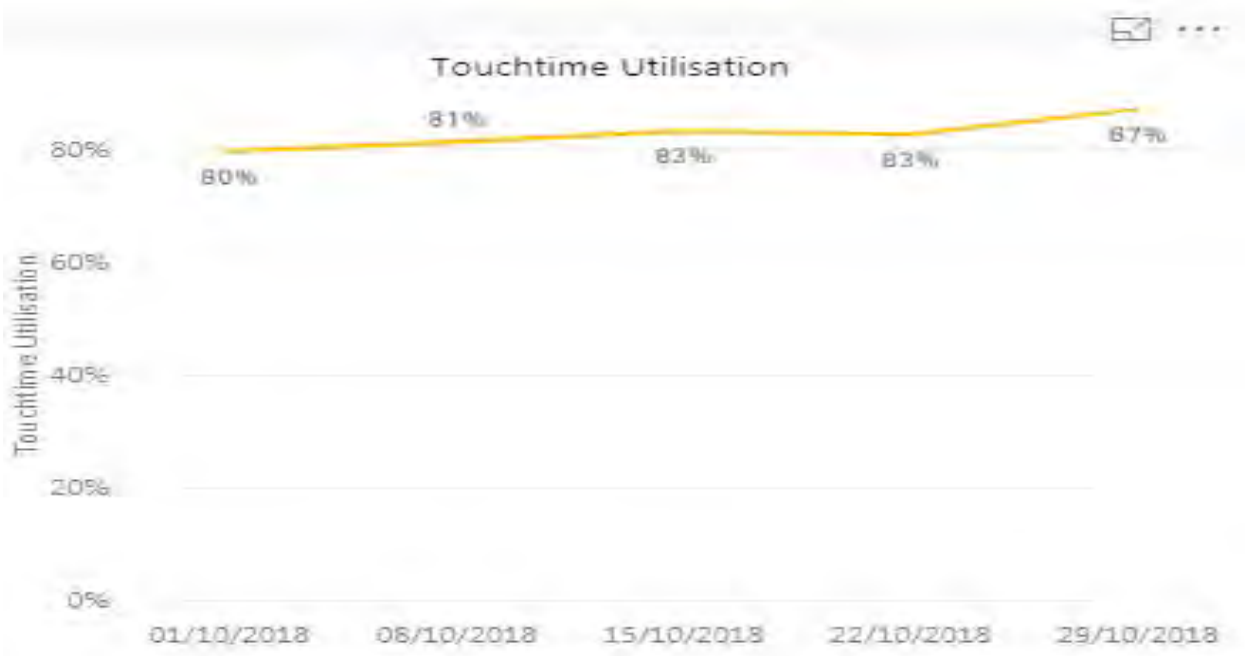
- Weekly monitoring of the specialty plans for activity, diagnostics, and theatre scheduling, backlog and waiting list size, through the PTL and specialty meetings.
- Daily focus on the 40+ week patients to ensure treatment occurs before 52 weeks.
- 52 Week Panel has been established to fully investigate the breaches and identify trends.
- Ensure backlog patients are booked chronologically to avoid long waits/52 week breaches.
- Two Operational Transformation Managers joined the Trust in 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 through to March 2019.

- A Validation plan has been implemented which included external assistance to validate the duplicate pathways.
- RTT recovery plan has been implemented and is monitored weekly.

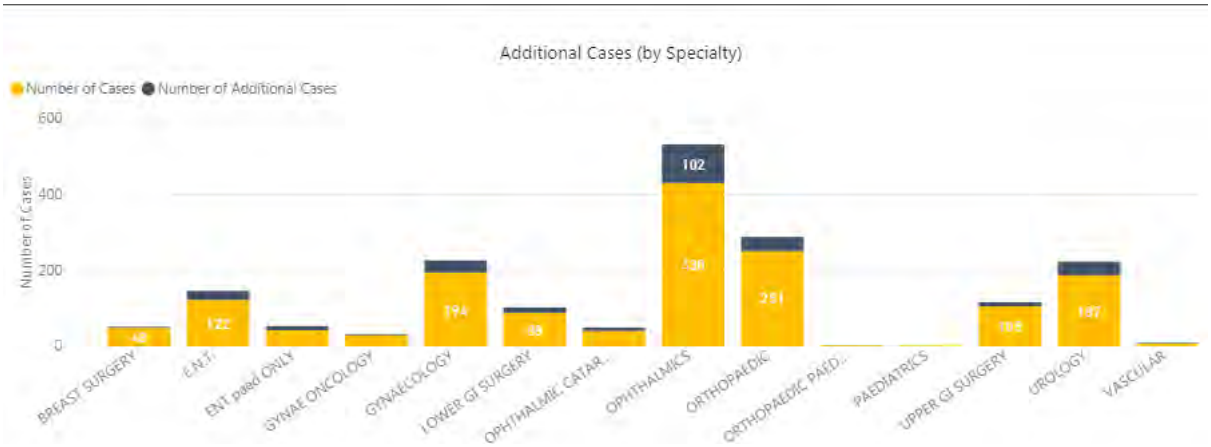
7. Theatre Productivity

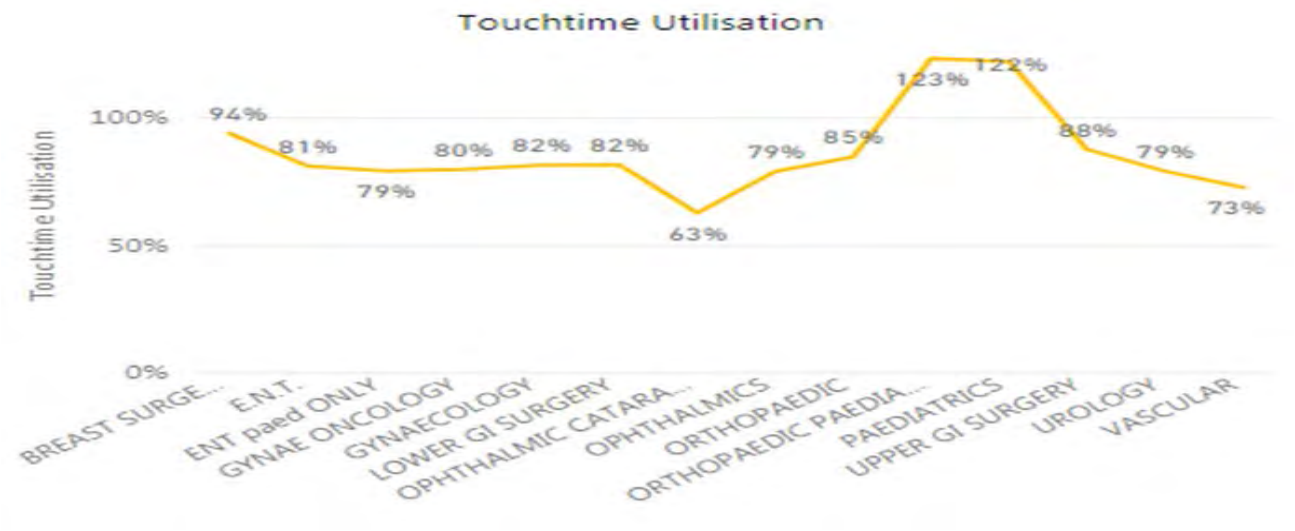
The graphs below are taken from the Four Eyes Theatre Dashboard and show the Theatre Utilisation from 1/10/18 – 29/10/18 overall and per speciality. The target for utilisation is 85% Overall Touch time Utilisation and this has to be delivered by monitoring that we have effective booking, listing and pre-operative assessment in place; start and finish times by specialty; number of cases per session; cancellations and DNAs; appropriate allocation of NCPOD lists and case-mix. Specialty level exception reports are provided and reviewed at the theatre utilisation group.

In order to improve theatre productivity the Trust has resurrected the Head and Neck task and finish group following the appointment of the new Clinical Director; Critical Care and T&O management team have meet and agreed that all lists in MOU will contain 5 majors or 4 majors and 2 day cases as standard; No face to face Pre-Operative Assessments for American Score of Anaesthesiology (ASA) grade 1 patients, screening and observations will take place in out-patients; MRSA screening validity has increased from 8-12 weeks and the Admission Lounge at Tunbridge Wells processes will be reviewed to support winter plan.



Touch time per Speciality, excluding Chronic Pain (CPU), Portacath and Endoscopy as the time stamps result in inaccurate data collection.




Touchtime Utilisation
Touchtime Utilisation
100%
50%
0%
94%
81%
79%
80%
82%
82%
63%
79%
85%
123%
122%
88%
79%
73%
BREAST SURGE...
E.N.T.
ENT paed ONLY
GYNAE ONCOLOGY
GYNAECOLOGY
LOWER GI SURGERY
OPHTHALMIC CATARA...
OPHTHALMICS
ORTHOPAEDIC
ORTHOPAEDIC PAEDIA...
PAEDIATRICS
UPPER GI SURGERY
UROLOGY
VASCULAR

Quality and Safety (October data)

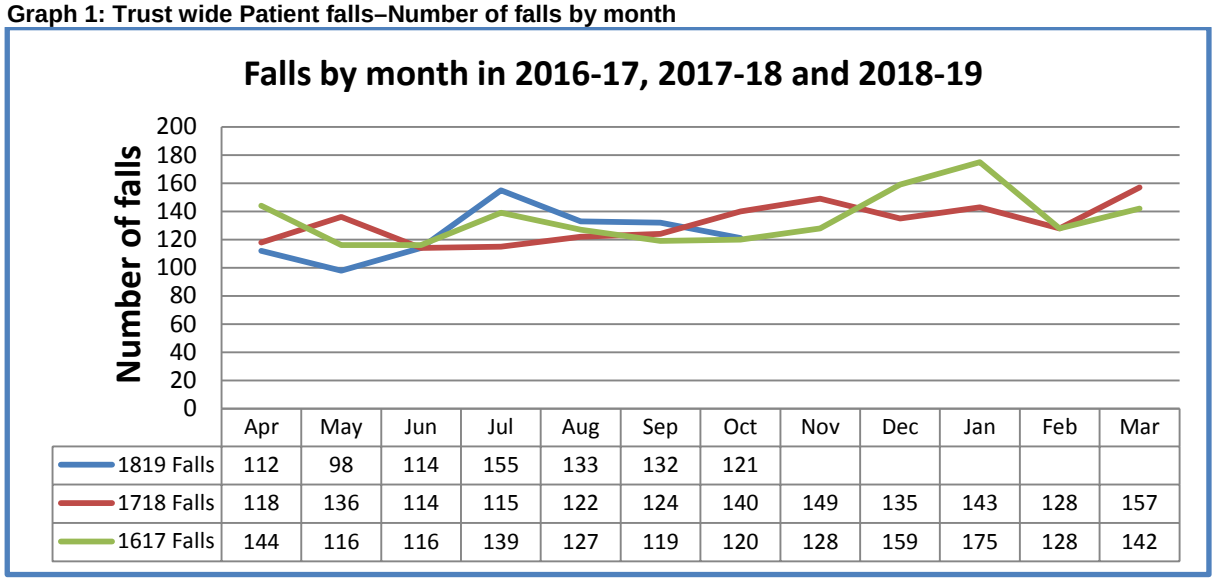
Patient Falls incidents

There were 121 falls incidents reported during October, compared to 132 for September 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 37 falls at Maidstone and 84 at Tunbridge Wells. The monthly falls rate per 1000 occupied bed days (OBD) for October was 5.81, comparison to previous months can be seen in Graph 2. The year to date falls rate for 2018/19 is 6.08 per 1000 OBD against the threshold of 6.0.

There were two falls resulting in injury declared as Serious Incident's (SI) in October 2018. Both sustained hip fractures.

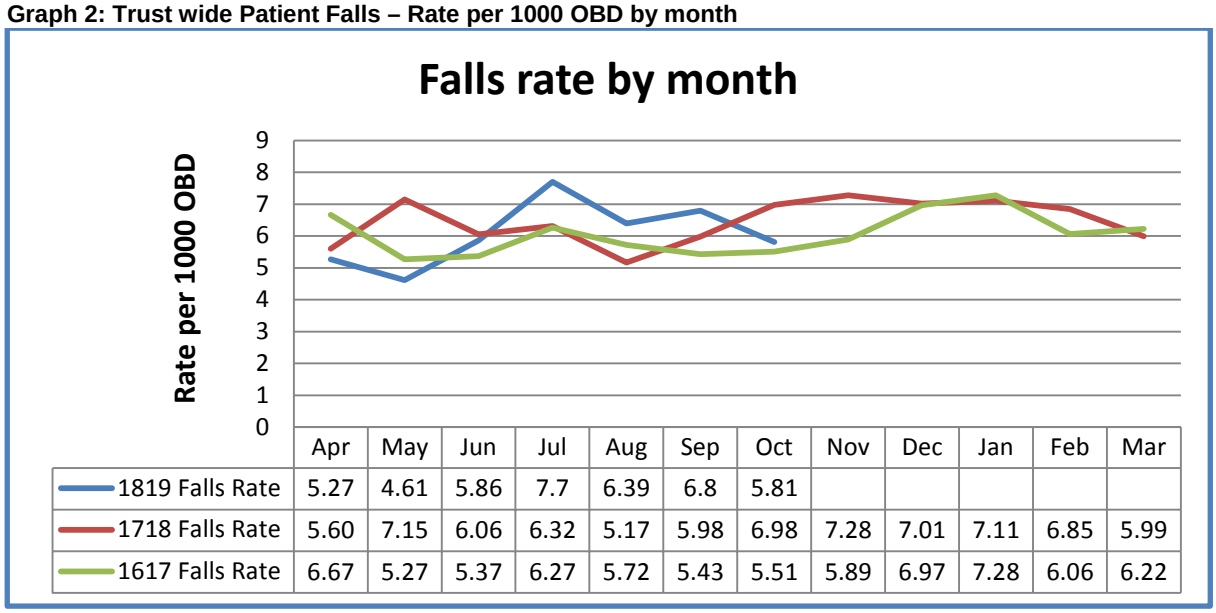
As part of the NHS Improvement Falls Collaborative project, three of the project team members attended the 90 day event on 18th October 2018. During the event the team gave a presentation of their project and the progress being made. Discussions are currently underway to identify a further three wards as part of the roll out programme, at present Ward 30 has been nominated by their matron to be involved.

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	132	121					
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	6.8	5.81					
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 October 2018 was 0.98 (per 1000 admissions) compared to 2.28 for the same month last year. This equates to 10 patients who have developed a pressure ulcer in hospital and 1 that deteriorated whilst in our care; 4 patients with a category 2 and 1 with a category 4 pressure ulcer (being investigated as a serious incident) 4 deep tissue injuries and 2 that are currently ungradable). The incidence for October is comparable with the preceding month at 0.87 per 1000 admissions but an improvement from the same period last year is evident.

Learning from our incident reviews has identified a need to raise awareness in regard to the delay in undertaking risk assessments and therefore the timely intervention of preventative measures to reduce harm. In October we also identified an increase of injuries to heels specifically with mobile frailty patients, education on the need for a full body assessment even on independent patients, unless they have capacity to decline assessment, needs to be promoted.

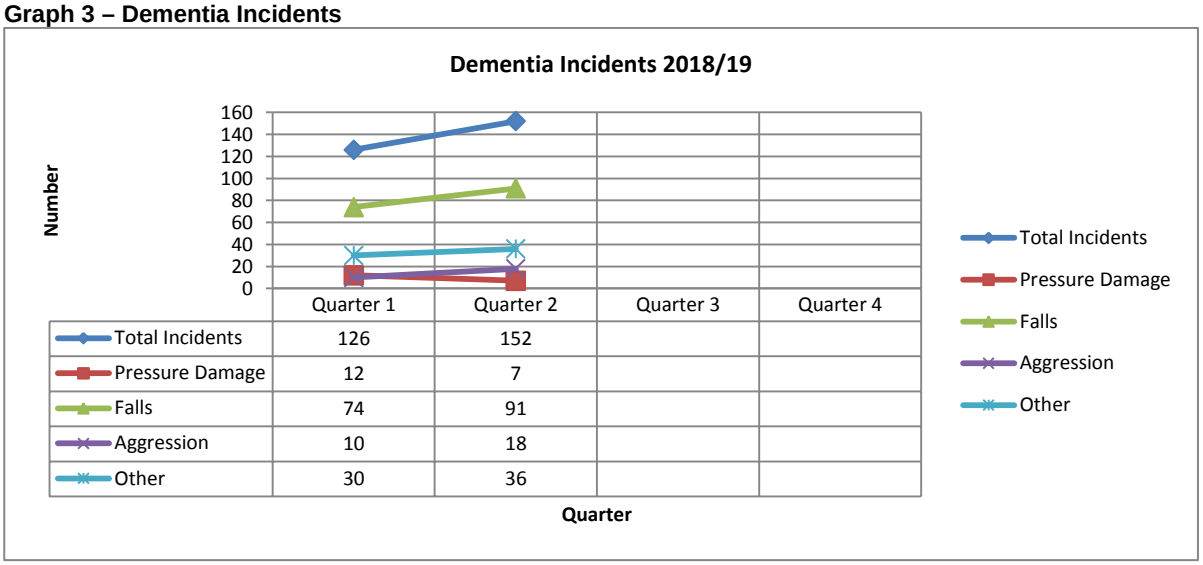
During the month of November the safety calendar is promoting the awareness of the prevention of pressure ulcers to coincide with the international 'Stop the Pressure' day. This takes place on the 3rd Thursday of November each year and was first promoted in Spanish speaking countries before spreading internationally. This year this took place on Thursday the 15th November with the main objective to raise awareness of pressure ulcers and to share prevention strategies. Our Tissue Viability nurse used this opportunity to invite all staff to 'adopt a pressure ulcer' and to wear a red dot on a bony prominence.

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.

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

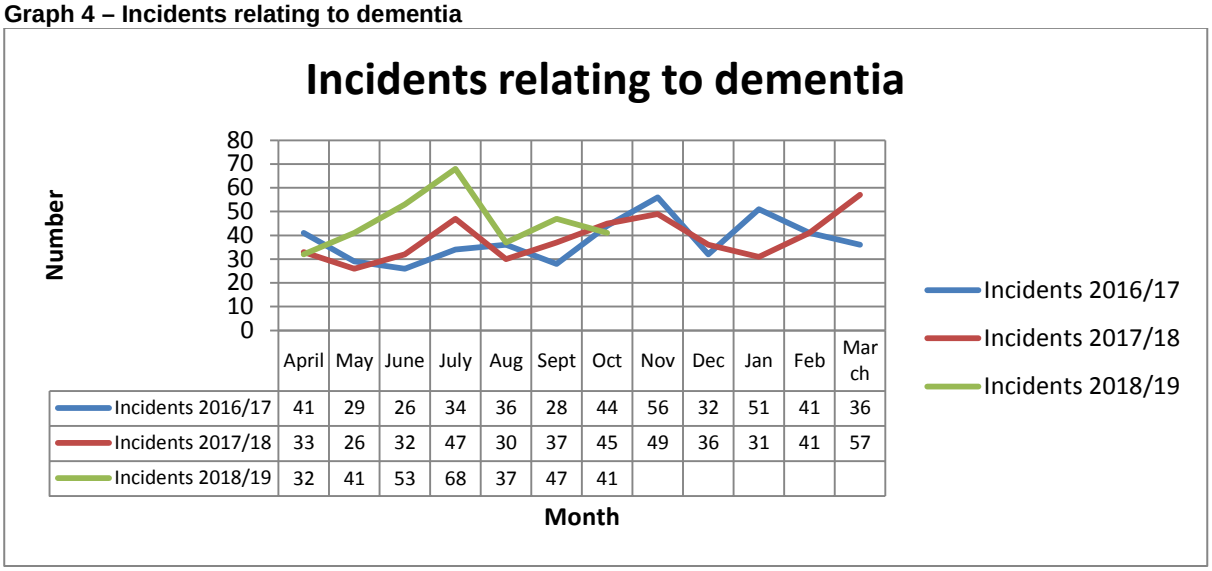


Graph 3 demonstrates the number of incidents per category that occurred during Quarter's 1 & 2 (2018/19); comparison with data from Quarter 2 (2017/18) it is evident that there has been an increase of total incidents from 114 to 152; Pressure damage incidents have increased from 2 to 7;

Falls incidents have increased from 78 to 91 and aggression incidents from 3 to 18. Other incidents have also increased from 31 to 36.

There continues to be an increase in incidents compared with Quarter 1 for total incidents; falls; aggression and other incidents.

Graph 4 – Incidents relating to dementia



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Incidents 2016/17	41	29	26	34	36	28	44	56	32	51	41	36
Incidents 2017/18	33	26	32	47	30	37	45	49	36	31	41	57
Incidents 2018/19	32	41	53	68	37	47	41					

Graph 4 plots the number of incidents relating to dementia patients per month for 2016/17; 2017/18 and 2018/19. The most significant increases can be seen in July and September compared with the previous 2 years. There has been a decline in incidents in October from the previous 2 years and since last month. There were 26 incidents at TWH and 15 at Maidstone, of these falls continues to be the main cause of incidents totalling 23 (16 at TWH and 7 at Maidstone). However, there has been a significant decline in aggressive incidents with only 3 in October (2 at TWH and 1 at Maidstone).

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.

In response to the numbers of incidents relating to aggression from patients some additional work is being supported as below:

- Additional bespoke Conflict Resolution training provided to some wards where there has been increased reports of such incidents.
- Early escalation to the integrated discharge team especially for those patients with behaviour issues where their behaviour may exacerbate by a prolonged stay in hospital.
- Liaison with psychiatric liaison teams for further input for these patients when no organic cause for change in behaviour has been identified.
- Continue to monitor these incidents and ensure that behaviour charts are being used by the staff, to understand what the 'triggers' may be and what mechanisms can be put in place to address these.

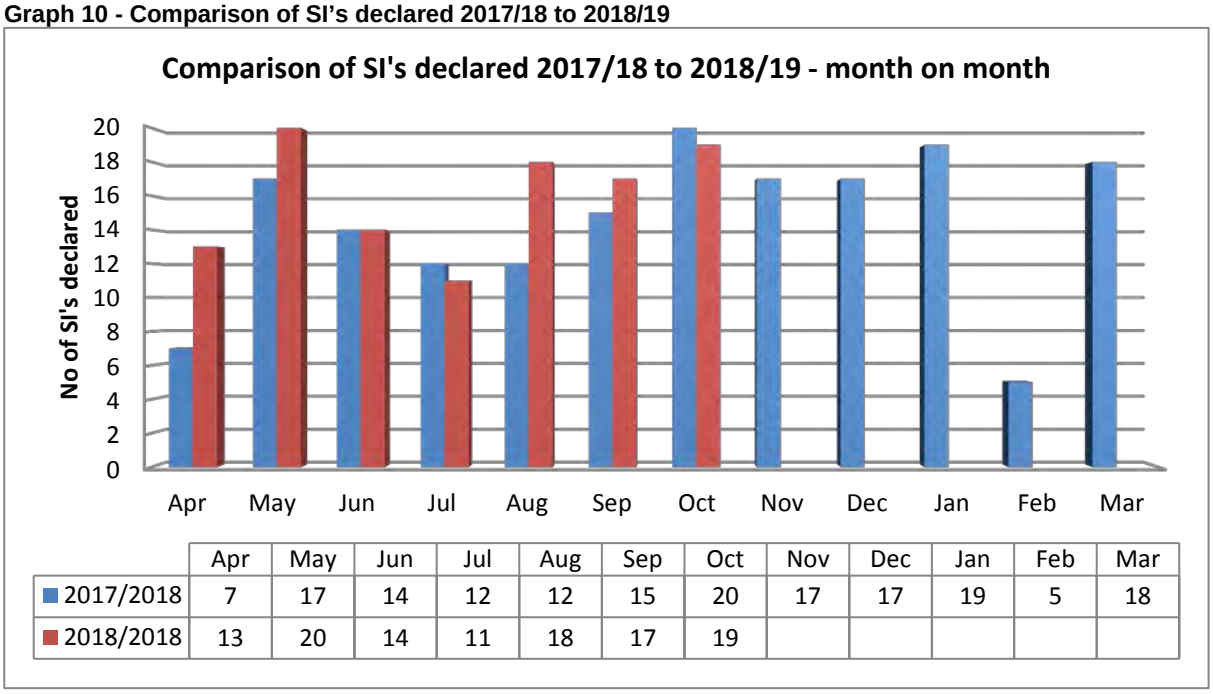
Serious Incidents (SI's):

There were 19 Serious Incidents reported in October 2018.

- 14 Main SI's in 7 divisions
  - 5 in Acute & Emergency
  - 2 each in Cancer, Haematology & Diagnostics, Specialist Medicine & Therapies and Trauma & Orthopaedics
  - 1 each in Children's Services, Critical Care and Women's & Sexual Health
- 2 falls – 1 in Specialist Medicine & Therapies and 1 in Surgery
- 2 Safeguarding in Specialist Medicine & Therapies
- 1 Pressure damage- Specialist Medicine & Therapies

The total number of SI's open remains increased year to date at 76 compared to 63 during 2017/18.

Graph 10 - 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	17	14	12	12	15	20	17	17	19	5	18
2018/2018	13	20	14	11	18	17	19					

During the month of October, 9 SI's were closed and 6 SI's were downgraded; the category of those closed incidents are below:

- Abuse/allegation incident declared May 2018
- Diagnostic incident declared June 2018
- Surgical/invasive incident declared July 2018
- Maternal/Obstetric – mother only incident declared July 2018
- Diagnostic incident declared Aug18
- Abuse/allegation incident declared Sept18

The learning from the Falls panel identified the need for patients with cognitive impairment will require additional assessment in regard to pain on mobilising and for discharge arrangements. Also the need for an appropriate assessment for use of falls alarm with sensor pad for patient's known to remove the clip and cord.

Learning from the Safeguarding Panel included the need to record the patient's capacity for decision making prior to undertaking an invasive clinical procedure and to then document evidence of consent within the health records.

Learning from the VTE panel has identified the need for documentation regarding capacity assessments, best interest meetings or whether it was explained to the patient the importance of prophylaxis. Also the need to review the treatment regime for prophylaxis when the patient's clinical condition changes. The panel also identified that the nursing staff had been proactive in requesting the medical staff to review the dalteparin prescription.

Learning from the main panel included:-

- Checklist to be used consistently for all invasive procedures within ophthalmology.
- Checklist for patient ID prior to storing images introduced in ophthalmology outpatient department.
- Review of process within ophthalmology outpatient department.
- Patient's BMI to be considered when instrumentation is being decided for surgery.
- Double sets to be made available within orthopaedics for patients with higher BMI's.
- Review and update of the Critical drugs guidance policy by all qualified ward staff (local)
- Sharing of Root Cause Analysis findings for failure to give time critical medications to be shared and discussed with Head Pharmacist, Clinical Director, Ward Sister/Matron for dissemination with their teams.

Single Sex Compliance:

There were 10 incidences of mixed sex accommodation reported during the month of October. These occurred on SAU at TWH on the 1st October affecting 3 patients and SSSU 4th October affecting 7 patients. Both areas provide care in bay areas and both areas were unmixed on the same day. The mixes occurred due to high operational demands.

Friends and Family Test:

Overall response rates for October have shown a decrease. Engagement in the process had been challenged as a result of the documented disruption in usual service and the ability to provide individual departmental data. This has since been resolved. In addition, the Trust continues to work collaboratively with IWGC to ensure MTW numbers correlate with IWGC numbers and final upload. This can be attributed to cards used that are not accepted if photocopied or damaged in any way. Regular meetings with IWGC continue to enable a cross check of cards collected and uploaded.

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 way of working had been temporarily interrupted due to unforeseen circumstances however; this has now also been resolved. MTW and IWGC are continuing to move ahead with the ability to receive communication alerts on a weekly basis in line with the weekly collection. Nominated lead's contact details are currently being aligned to correct departments.

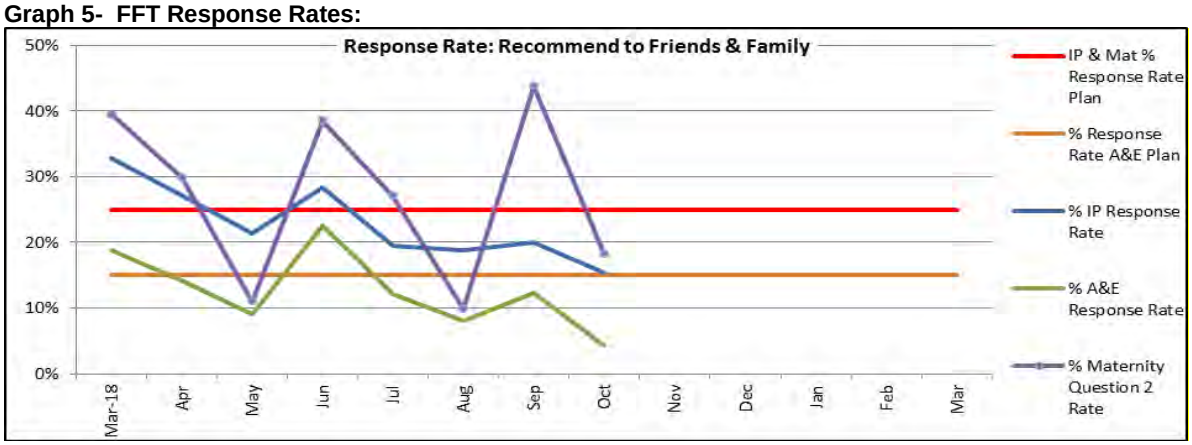
A collection methodology review identified an opportunity to use stock base IPads specifically dedicated to IWGC to increase accessibility to the survey to promote and increase response rates. Using resources already held within the Trust, IT has developed a new 'platform' on the Trusts IPads. This means there are now dedicated IPads which are only setup to provide the IWGC feature and will be aligned to each department to minimise the risk of equipment moving between areas. The App has been uploaded to 32 IPads which have been delivered and are actively being rolled out to departments. IT has also undertaken a review of the Community Midwives' current tablets and has been able to successfully push out the IWGC app to all Surface tablets to promote responses.

Response rates for October: IP: decreased from 20.1% in September to 15.3% in October. This was a further drop in the number of actual respondents against an increase in the number of eligible inpatients. A&E: decreased from 12.3% in September to 4.2%. For illustration, the actual number of A&E responses was 405. Maternity Q2 decreased from 43.8% in September to 18.2% in October.

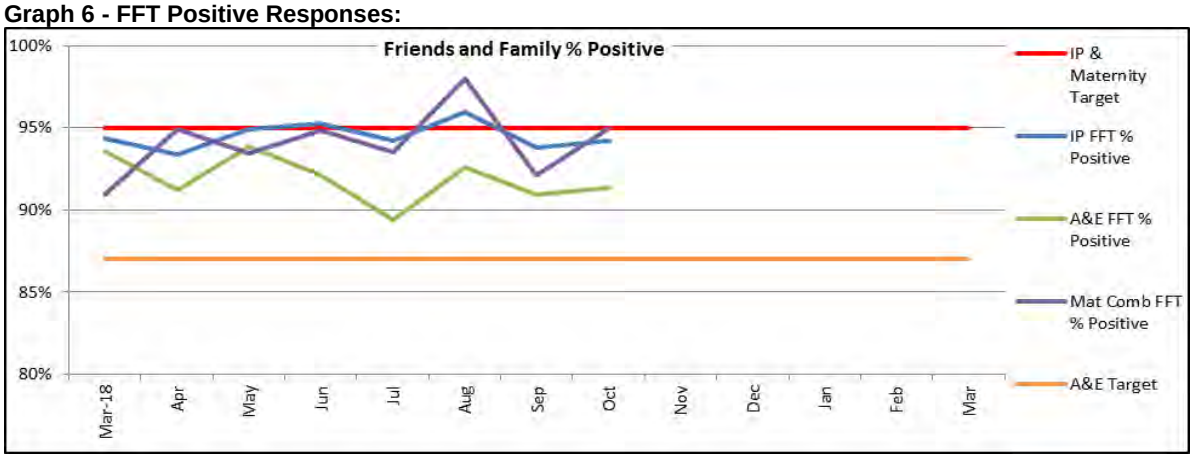
For the % Positive for October, inpatients has increased slightly from 93.8% in September to 94.2% in October despite the reduction in respondents, A&E increased from 90.9% in September to 91.4% in October and Maternity (all 4 combined) increased from 92.1% in September to 95.0% in October.

In terms of number of respondents from OP, the response rate has decreased slightly from 1914 in September to 1769 in October.

Graph 5- FFT Response Rates:



Graph 6 - FFT Positive Responses:



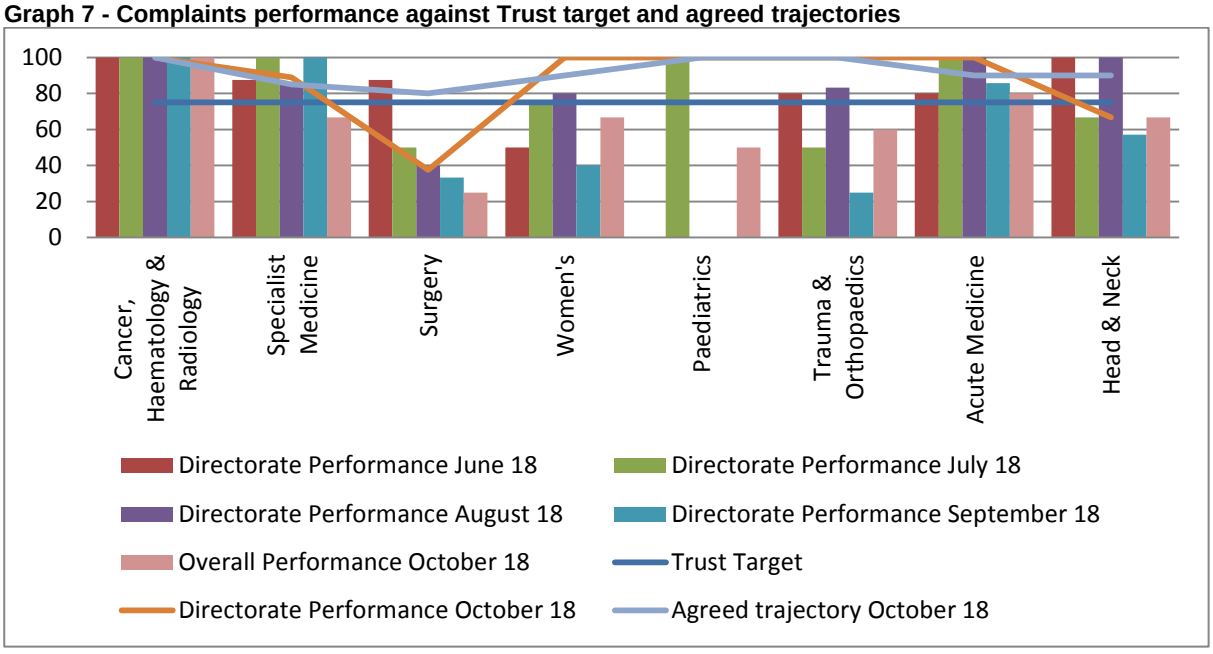
Complaints:

There were 59 new complaints reported for October which equates to a rate of 2.84 new complaints per 1,000 occupied bed days. This is an increase compared to 2.2 for September. There were 139 open complaints at the end of October, compared to 144 in September.

65.3% 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 5 (below) provide information on the performance for year to date against the Trust overall target and the agreed performance trajectories

Graph 7 - Complaints performance against Trust target and agreed trajectories



Only two of the directorates listed above failed to achieve or exceed their performance trajectory for October. These were Surgery (25% against a target of 80%) and Head and Neck (66.7% against a target of 90%). Pathology & Pharmacy (who have not been subject to a recovery trajectory due to the very small number of complaints received in a year) only achieved 50% performance. All other directorates achieved or exceeded their performance trajectory.

Overall, the Trust did not reach the 75% performance target for October. In total, 8 complaints breached due to delays within the lead directorate, which account for 16.3% of the lost performance. However, a further 9 complaints breached for other reasons: 1 due to capacity issues within the central complaints team, 5 responses were rejected by the executive team at a stage too late for recovery, 1 due to wait for external comments and 2 where there was a delay in contributing directorates submitting their comments. These delays accounts for 18.4% of the lost performance.

There continues to be focused work on clearing the backlog of complaints, with positive progress being made on closing older cases, particularly those open over 90 days. 'Deep dive' meetings took place in November with key directorates where their efforts were recognised but further local actions identified to support them to achieve the necessary standards. The complaints action plan has been shared with NHS Improvement for their input and updated accordingly.

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.

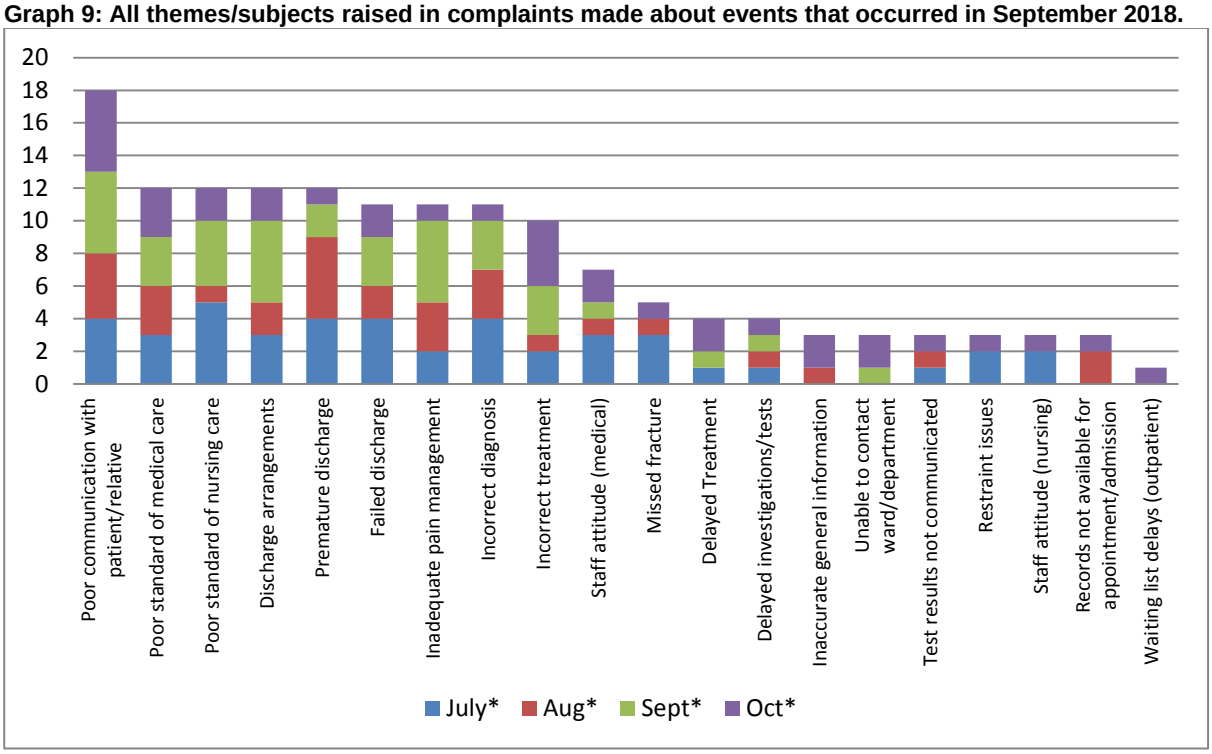
Graph 8 - Complaints by Sub-subject – most frequently raised in September 2018

	Oct*	Sept*	Aug*	July*
Poor communication with patient/relative	5	5	4	4
Poor standard of medical care	4	3	1	2
Poor standard of nursing care	3	3	3	3

*reflects the date of the event being complained about

The following graph (Graph 7) shows an expanded view of the themes of complaints that occurred in October 2018.

Graph 9: All themes/subjects raised in complaints made about events that occurred in September 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 (July – October). However, unlike recent months, this is showing a rising trend.

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

- Poor communication with patients/relatives
- Discharge arrangements
- Inadequate pain management
- Incorrect treatment
- Delayed treatment

- Inaccurate general information
- Unable to contact ward/department

Other areas show stable or slightly reducing trends, with the most significant reduction in complaints about premature discharge and incorrect diagnosis.

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.

Safe staffing: Planned versus actual for October 2018

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for October 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 include:

Cornwallis: Reduced RN fill rate due to vacancy and sickness levels alongside an inability to fill with temporary staff.

John Day: Increased fill rate with RMN requirements across 11 days and additional RN requirements for increased acuity

Chaucer: Increased fill rate at night due to escalation throughout October. Nurse: patient ratio increased on a week day basis to facilitate the AFU pathway which is reflected in the CHPPD.

Mercer: 3 falls above threshold Increased CSW fill rate at night with Enhanced Care required on 19 occasions.

UMAU (Maidstone): Reduced fill rate of due to lack of available temporary. Ward escalation at night throughout month

Ward 22: Reduced RN fill rate due to lack of available temporary staff

CCU (TWH): I fall above threshold. Decreased RN rate due to staff redeployment to other areas on 9 occasions to support safe staffing alongside lack of available temporary staff.

Ward 33 / Gynae: Decrease RN and CSW fill rate due to lack of available temporary staff for shifts across 12 days

MAU (TWH): Increased fill rate due to escalation throughout the month. Additional CSW on a nightly basis

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

Ward 12: 2 falls above threshold which has shown a reduction. Reduced fill rate for CSW's due to lack of available temporary staff on 16 occasions

Ward 20: 9 falls above threshold which is an increase on previous month. Increased fill rate with enhanced care requirements through the month. Follow up Quality review undertaken 31st October with subsequent action planning. Ongoing review planned to monitor against actions.

Ward 2: 2 falls above threshold. Staffing requirements for AFU Mon - Fri. Episodes of enhanced care requirements and escalation on 16 occasions.

Neonatal Unit: Increased intensive care, and number of babies. Supernumerary shifts recorded and supported across 21 occasions.

MSSU: Supporting supernumerary staff on 3 occasions escalated on 3 occasions and increased staff requirements due to theatre lists on 2 occasions.

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.

The next programme of Safe Staffing reviews are being mapped and a new methodology is being worked up. With the introduction of apprenticeships and the imminent start for the new Trainee Nursing Associates (TNAs) this will impact on the current workforce structure. The new methodology will need to consider the future structure of new learners, apprentice's and the introductions of TNA's leading to the Nursing Associate role. The NMC have published a new version of 'The Code' which now includes Nursing Associates. It is proposed that reviews will be undertaken in collaboration with the Chief Nurse or Deputies, Associate Director of Nursing for the division, Ward Manager, Matron, Finance, Professional standards and Health Roster representation.

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

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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 remains at 100% (not including maternity) for the month of October. 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?	Score if True
New or no line manager in post (within last 6 months)		1
Vacancy rate higher than 3%		3
Unfilled shifts is higher than 6%		2
Sickness absence rate higher than 3.5%		2
No monthly review of key quality indicators by peers, e.g. peer review or governance team meeting		3
Planned annual appraisals not performed		2
No involvement in Trust-wide multi-disciplinary meetings		2
No formal feedback obtained from patients during the month, e.g. questionnaires or surveys		3
2 or more formal complaints in a month (Wards) or 3 or more (A&E or OPD) or 1 or more (CCU & IC		3
No evidence of resolution to recurring themes		3
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak		2
Hand hygiene audits not performed		3
Cleanliness audits not performed		3
Ward/Department appears untidy		2
No evidence of *effective* multi-disciplinary/multi-professional team working		1
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)		2
Overall Score:		

Insert comments below (if appropriate):

Oct-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	98.1%	89.1%	100.0%	122.4%	7.7	8.3%	100.0%	5	0	5	Fill rates effected by staff sickness and enhanced care requirements.	140,066	138,232	1,834
MAIDSTONE	Cornwallis	89.7%	112.1%	96.1%	90.2%	6.2	51.7%	91.8%	2	0	5	Reduced day RN fill rate due to vacancy and lack of available temporary staff	91,179	80,339	10,840
MAIDSTONE	Culpepper (Inc CCU)	95.8%	98.6%	100.0%	100.0%	10.8	100.0%	90.0%	2	0	0	1 fall above threshold	109,337	103,409	5,928
MAIDSTONE	John Day	109.4%	116.4%	110.7%	91.7%	6.6	50.8%	87.1%	8	0	6	3 falls above threshold Increased fill rate with RMN requirements across 11 days and additional RN requirements for increased acuity	130,805	138,187	(7,382)
MAIDSTONE	Intensive Treatment Unit (ITU)	91.1%	64.3%	90.2%	N/A	29.9			0	0	0	Reduced occupancy throughout the month. Inability to cover with temporary staff on 4 occassions and escalation during the last 3 days of the month	157,740	171,260	(13,520)
MAIDSTONE	Pye Oliver	98.5%	86.2%	100.0%	95.9%	5.7	54.9%	92.9%	2	1	5	Reduced fill rate due to lack of available temporary staff.	110,219	116,454	(6,235)
MAIDSTONE	Chaucer	103.6%	88.1%	132.3%	183.9%	13.5	95.5%	100.0%	1	0	3	Increased fill rate due to escalation throughout the month.	118,267	122,364	(4,097)
MAIDSTONE	Lord North	104.6%	103.9%	100.5%	90.6%	7.2	0.0%	-	1	0	2		102,318	108,328	(6,010)
MAIDSTONE	Mercer	104.1%	103.9%	101.5%	130.9%	6.4	80.0%	83.3%	9	1	2	3 falls above threshold Increased CSW fill rate at night with Enhanced Care required on 19 occasions	101,048	105,417	(4,369)
MAIDSTONE	Edith Cavell	98.3%	104.8%	101.1%	106.6%	5.5	53.8%	100.0%	1	4	2		71,882	88,930	(17,048)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	83.8%	84.7%	94.5%	96.7%	12.6	0.2%	100.0%	1	0	7	Reduced fill rate due to a of lack of available temporay staff. Escalated throughout the month	131,489	130,331	1,158
TWH	Stroke/W22	80.4%	101.5%	99.3%	95.7%	9.8	18.8%	66.7%	9	0	7	2 falls above threshold Redcued RN fill rate due to lack of avaialble temporary staff for shifts throughout the month	150,502	145,047	5,455
TWH	Coronary Care Unit (CCU)	89.4%	96.8%	80.0%	-	12.8	65.8%	92.0%	1	0	3	1 fall above threshold Decreased RN rate due to staff redeployment to other areas on 9 occasions to support safe staffing alongside lack of available temporary staff.	67,825	56,641	11,184
TWH	Gynaecology/ Ward 33	72.1%	99.0%	99.9%	58.1%	10.2	0.0%	-	0	0	1	Decrease RN and CSW fill rate due to lack of available temporary staff for shifts across 12 days	79,636	75,698	3,938
TWH	Intensive Treatment Unit (ITU)	97.4%	89.5%	99.2%	N/A	29.1	0.0%	-	1	0	3	1 fall above threshold STS in month and staff support MITU last 4 days in month	187,483	174,540	12,943
TWH	Medical Assessment Unit	95.8%	95.2%	126.9%	205.3%	5.9	32.9%	93.1%	3	0	7	Increased fill rate due to escalation throughout the month. Additional CSW on a nightly basis	184,788	184,443	345
TWH	SAU	98.9%	87.1%	100.0%	97.9%	8.1			0	0	0	Escalated at night on 7 occassions. Reduced fill rate due to lack of available temporary staff	61,940	60,215	1,725
TWH	Ward 32	91.3%	129.9%	114.3%	107.7%	7.0	15.7%	100.0%	12	0	9	6 falls above threshold Enhanced care requirements. CSW backfill RN shifts due to lack of available temporary staff	139,808	152,131	(12,323)
TWH	Ward 10	98.6%	92.2%	75.8%	150.0%	6.1	0.0%	-	3	0	10	1 fall above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity	120,565	111,193	9,372
TWH	Ward 11	92.9%	111.7%	96.8%	117.7%	6.2	0.8%	100.0%	0	0	3	Patient escort required on 2 occassions	126,638	114,487	12,151
TWH	Ward 12	94.0%	92.7%	62.6%	91.5%	6.1	9.4%	75.0%	8	0	10	2 falls above threshold Reduced CSW fill rate due to lack of available temporary staff on multiple shifts across 16 days	121,446	142,081	(20,635)
TWH	Ward 20	92.0%	112.7%	98.9%	146.8%	6.0	7.1%	100.0%	16	0	9	9 falls above threshold Enhanced care requirements throughout the month.	123,611	112,118	11,493
TWH	Ward 21	96.4%	94.9%	100.0%	106.5%	6.1	31.2%	95.8%	3	1	4		134,850	143,570	(8,720)
TWH	Ward 2	90.7%	88.9%	105.3%	99.9%	6.7	27.5%	92.9%	9	1	3	2 falls above threshold Enhanced care required on 4 episodes and AFU escalated on16 occassions	131,973	125,781	6,192
TWH	Ward 30	94.7%	107.6%	103.9%	113.5%	6.2	0.0%	-	8	0	10	3 falls above threshold Enhanced care requirements throughout month	122,715	119,087	3,628
TWH	Ward 31	100.2%	95.4%	100.8%	97.7%	6.7	0.0%	-	11	2	3	5 falls above threshold	139,943	126,589	13,354
Crowborough	Birth Centre	70.3%	100.0%	91.0%	94.4%		26.4%	95.0%	0	0		Considered action to prioritise the night with Community teams support during the day	71,096	74,265	(3,169)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	91.4%	96.2%	97.3%	96.9%	5.9			0	0			690,933	667,148	23,785
TWH	Hedgehog	146.0%	51.0%	105.1%	-	12.7	0.0%	-	0	0	7	Increase fill rate reflective of 7 x RMN requirements in month. Inability to cover CSW can increase RN fill rate according to clinical needs	182,315	185,240	(2,925)
MAIDSTONE	Birth Centre	97.8%	72.4%	97.9%	87.0%				0	0			62,876	67,228	(4,352)
TWH	Neonatal Unit	85.9%	76.5%	109.0%	-	10.8			0	0	2	Increased intensive care, and number of babies. Supernumarary shifts recorded across 21 occasions	178,696	180,365	(1,669)
MAIDSTONE	MSSU	123.6%	127.9%	85.4%	-		19.3%	96.7%	2	0	0	2 falls above threshold Supporting supernumerary staff on 3 occasions, escalated on 3 occasions and increased staff requirements due to theatre lists on 2 occasions	41,893	45,054	(3,161)
MAIDSTONE	Peale	106.1%	112.4%	100.3%	88.6%	8.4	38.1%	100.0%	1	0	3		76,274	76,250	24
TWH	SSSU	112.8%	126.0%	101.8%	183.6%	6.5			0	0	11	Increased fill rate due to escalation throughout the month.	128,087	92,386	35,701
MAIDSTONE	A&E	75.9%	98.2%	98.2%	96.8%		8.7%	91.8%	0	0		Reduced fill rate due to lack of available temporary staff.	205,934	214,365	(8,431)
TWH	A&E	97.0%	87.7%	96.3%	95.5%		0.1%	60.0%	3	0			325,498	366,714	(41,216)
												Total Established Wards	**5,121,675**	**5,115,887**	**5,788**
												Additional Capacity be Cath Labs	36,509	36,085	424
												Whatman	99,470	2,990	96,480
												Other associated nursing costs	2,730,350	2,408,846	321,504
												Total	7,988,004	7,563,808	424,196

RAG Key

Under fill

Over fill

Infection Prevention and Control

MRSA

There were no cases of trust-attributable MRSA blood stream infection in October.

C. difficile - There were two cases of post-72 hour *C. difficile* infection in September against a monthly limit of two cases.

The closure criteria for the outbreak of C. difficile declared on 12 September have been met and the outbreak was closed on 6 November.

The Trust is currently 8 cases above trajectory for the year to date with a rate of 16.9 cases per 100 000 bed days ytd. This is compared with a rate of 13.3 for the same period last year.

One case of cross infection has been identified. A Serious Incident has been declared and investigation is ongoing.

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

One case of hospital-attributable MSSA blood stream infection was seen in October. Review of earlier cases continues at the C. difficile panel

Gram negative bacteraemia

Eleven cases of hospital-attributable gram negative blood stream infection were seen in October. Five cases were due to *E. coli* , four due to *Klebsiella* and two due to *Pseudomonas* species

We are working with community colleagues to improve continuity of catheter care across health and social care.

Surgical Site Infection

The Trauma and Orthopaedics directorate have been undertaking a look back of patients with surgical sites infections over a number of years. This work is ongoing and due to be presented to the T&O clinical governance meeting in November to finalise an action plan.

All cases of possible infection are reviewed to determine whether or not infection is present. No cases are reported to the national database without this review having taken place.

Kent and Medway System Infection Management Leadership

Ruth May and Professor Stephen Powis attended the K&M system leadership meeting on 19 October to discuss infection prevention, antimicrobial stewardship and healthcare associated infection across the whole health economy.

Kent and Medway is one of three health economy pilot sites across England that NHSI and NHSE are supporting to understand what leadership needs to be in place for infection management, ranging from preventing infections to antimicrobial stewardship (AMS). Learning and experience of how cross-system leadership in the field of infection prevention and antimicrobial resistance can be developed and supported to engage and assist reductions in infections across healthcare boundaries will enable us to determine the impact on healthcare associated infections, including Gram negative bloodstream infections. This will support the ambition to halve the number of these infections by March 2021.
Following the meeting, the following actions were suggested by NHSI/NHSE to support the ongoing cross-system improvement work:

- Support the reduction of HCAIs and improve AMS by reviewing and acting on regular reports from the Kent and Medway Director of Infection Prevention and Control (DIPC) - *review in IPCC*

- All organisations to have completed a self-assessment against *The Health & Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance* and *National Institute for Health and Care Excellence (NICE) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use Baseline Assessment Tool* and boards to have oversight of the content. A gap analysis together with an action plan stating requirements needed to meet compliance to be produced. *Both completed annually and reported to the IPCC*
- Assurance to be provided to the Kent and Medway DIPC that each organisation or trust is reducing HCAIs, reducing antibiotic prescribing and improving antimicrobial stewardship. *Local data reported and available on PHE fingertips website*
- To strengthen senior professional engagement, all boards to ensure that their DIPCs and/or Directors of Public Health are attending the Kent and Medway Infection Control and Antimicrobial Stewardship Committee. *DIPC or deputy attends meetings*
- We would encourage all providers to submit the voluntary risk factor data for Gram negative bloodstream infections and antimicrobial prescribing/review as this will give a wider view of areas for interventions to drive improvements. *Data routinely submitted*
- We would like to use Kent and Medway as a reference site for this new way of developing system wide improvement plans to address this very important agenda. *Further updates to be included in DIPC reports to Board*

Financial commentary

- The Trusts surplus including PSF was £3.1m in October which was on plan, the Trust was £1.6m adverse to the CIP target and had to release £1.6m of reserves. The Trust also benefited by £0.8m of non-recurrent benefits.
- The Trusts normalised run rate in October was £0.7m deficit pre PSF which was £2.5m adverse to plan.
- In October the Trust operated with an EBITDA surplus of £5.5m which was £0.1m adverse to plan.
- The Trust year to date has a deficit including PSF of £0.5m which is on plan, the key variances to plan are: CIP Slippage (£2.9m), overspends within pay budgets (£1m) and non pay budgets (£2.4m) offset by non-recurrent items (£1.9m), release of contingency reserve (£3.8m) and £0.2m underspend within income and depreciation.
- The key current month variances are as follows:
    - Total income net of pass-through related income is £1m adverse to plan. Clinical Income excluding HCDs is £1.8 adverse. The key adverse activity related variances were out patients (£0.5m), Electives (£0.4m) and day cases (£0.2m) which is due to the Prime Provider CIP slippage (£1m). Other Operating Income excluding pass-through costs is £0.8m favourable to plan in the month which mainly relates to £0.4m Fleming rebate benefit and a release of Oncology SLA provision.
    - Pay budgets underspent by £1.9m in October, £2.1m due to the release of contingency reserve (£0.4m) and directorate held pay reserve (£1.7m) therefore the revised normalised overspend of £0.2m. The main pressures in the month related to £80k Consultant arrears of pay within Specialty Medicine, and higher than planned medical agency spend within General Surgery (£0.1m) due to non-delivery of directorate recovery actions.
    - Non Pay adjusted for pass through costs and reserves was overspent by £0.8m in October although £0.75m underspend is associated with Prime Provider activity slippage therefore the normalised position was an adverse variance of £1.6m. Non pay costs in October were £0.3m higher than forecasted levels this was mainly within Clinical Supplies and Services, £0.1m within Theatres, £0.1m within Cardiology and £0.1m within ENT.
- The Trust achieved £1.2m savings in October which was £1.6m adverse to plan and £2.9m adverse year to date. This is mainly due to STP Medical rate slippage (£0.8m), Prime Provider (£1.3m), Private Patient income slippage (£0.3m).
- The Trust held £12.6m of cash at the end of October which is higher than the plan of £1m. This is primarily due to the Trust receiving income earlier than forecasted in the first half of the year. This cash balance will gradually reduce as pressure points within the second half of 2018/19 materialise. There was a delay from Roche Diagnostics in sending the quarterly invoices relating to the annual managed service contract c£1.4m per quarter. In October the Trust received the relevant invoices relating to the 3 quarters owed to Roche, these have been authorised and the first quarter was paid at the end of October and quarters 2 and 3 paid at the start of November. 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 and is forecasting to spend £11.6m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) NHSI have indicated that it is extremely unlikely that capital expenditure reliant on DHSC financing will not be available in 18/19 - therefore the Trust is no longer forecasting the purchase of CT scanners (£2.5m) through a potential capital loan in this year; the Trust will reserve its right to bring this back into the planning submission for 2019/20; 3) the outturn forecast for depreciation is £300k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred. The combination of these factors means that the outturn is projected to be £2.83m lower than original plan

The Trust is forecasting to deliver its financial plan for the year, however it has identified £20.1m of potential risks that require controlling. The main risks include: £10.8 risk adjusted CIP shortfall,

£3.2m pay pressures and £3.5m non pay pressures. The Trust is working to control these potential risks, such as by continuing to take corrective action on budgetary overspends and has set control targets for each division. The Trust will also have to implement other mitigating actions which will include the full release of the remaining Trust contingency reserves and also other non-recurrent measures.

Workforce Commentary

October Dashboard

Workforce Commentary

As at the end of October 2018, the Trust employed 5148.2.6 whole time equivalent substantive staff, an 84.6WTE 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 (September) remained unchanged at 3.39%, 0.09% above target. Directorates demonstrating the highest sickness rates include Facilities (6.02%), ICT (4.79%) and (HR 4.78%), 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 5.66%, an increase from the previous month. At a trust level, the breakdown in September is 50.9% short-term, 49.1% long term. 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.

The Winter Flu campaign commenced on 3rd October 2018. The trust objective for the 2018/19 campaign is 85% (70% achieved in 2017/18). As of 15th November 54.1% of frontline staff have been vaccinated and the trust is on trajectory for its target. Increased use of peer vaccinators has driven the higher rate of uptake to date.

Statutory and mandatory training compliance has remained at 82.9% and remains below the target percentage. The drop is in part attributed to the window during August and early September when training course completion could not be recorded due to the migration to a replacement learning management system. In addition the data now incorporates the PREVENT basic and level 3 training compliance which was introduced in April 2017 and has been on an improvement trajectory since that date. The training is incorporated into the Safeguarding Children and Adults training at level 3. Since September of this year we have had access to the national e learning content as an alternative to face to face training. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required.

Turnover has continued to decrease since last month to 9.1%, lower than target, with outliers in Finance (16.84%), Human Resources (13.54%) and Head and Neck (14.67%). Turnover has been on a continuous downward trend since January of this year reflecting a range of inputs with regards recruitment and retention. 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.

Whilst the Integrated dashboard continues to show appraisal uptake as being below target, further data cleansing has revised this figure to 89.28%, just short of the 90% target. HR Business Partners and directorate management teams are working to identify remaining individuals who have not yet returned completed appraisal documentation and the data is a focus for Divisional Performance Reviews.

Trust Performance Dashboard

Position as at: 31 October 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 From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	4.47	9.6	13.3	16.9	3.6	5.6	11.5	13.3	
'1-02	Number of cases C.Difficile (Hospital)	1	2	16	24	8	8	26	34	
'1-03	Number of cases MRSA (Hospital)	0	0	0	2	2	2	0	2	
'1-04	Elective MRSA Screening	98.5%	99.0%	98.5%	99.0%	0.5%	1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	No data	93.0%	No data	99.0%	No data	No data	98.0%	No data	
'1-06	**Rate of Hospital Pressure Ulcers	2.28	0.98	2.05	1.42	- 0.63	- 1.59	*3.01*	1.46	3.00
'1-07	***Rate of Total Patient Falls	6.25	5.81	5.78	6.08	0.30	0.08	*6.00*	5.79	
'1-08	***Rate of Total Patient Falls Maidstone	5.76	4.84	5.05	5.87	0.82			5.09	
'1-09	***Rate of Total Patient Falls TWells	5.93	6.38	6.13	6.20	0.07			5.46	
'1-10	Falls - SIs in month	2	2	19	16	- 3				
'1-11	Number of Never Events	1	0	1	1	0	1	*0*	1	
'1-12	Total No of SIs Open with MTW	63	76			13				
'1-13	Number of New SIs in month	20	19	97	112	15	42			
'1-14	***Serious Incidents rate	0.89	0.91	0.65	0.79	0.14	0.73	*0.0584 - 0.6978*	0.79	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.26	-	1.21	1.02	- 0.19	- 0.21	*0 - 1.23*	1.02	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
'1-17	VTE Risk Assessment - month behind	96.6%	96.1%	96.4%	96.1%	-0.3%	1.1%	95.0%	96.1%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.8%	97.3%	96.6%	97.7%	1.1%	2.7%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	3.98%	2.56%	3.42%	2.23%	-1.18%	-0.8%	*3.00%*	2.23%	
'1-20	C-Section Rate (non-elective)	14.0%	14.9%	13.7%	13.3%	-0.37%	-1.7%	*15.0%*	13.3%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******			1.0878	1.0371	- 0.1	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR			103.9	103.7	- 0.2	3.7	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.1%	0.9%	1.1%	1.0%	-0.2%				
2-04	****Readmissions <30 days: Emergency	12.3%	14.1%	11.7%	14.2%	2.4%	0.6%	*13.6%*	14.2%	14.1%
2-05	****Readmissions <30 days: All	11.8%	13.5%	11.0%	13.6%	2.7%	-1.0%	*14.7%*	13.6%	14.7%
2-06	Average LOS Elective	3.70	3.02	2.55	3.05	0.50	- 0.15	*3.20*	3.05	
2-07	Average LOS Non-Elective	6.82	7.05	7.43	6.93	- 0.50	0.13	*6.80*	6.93	
2-22	NE Discharges - Percent zero LoS	37.2%	46.5%	36.1%	44.9%	8.8%			44.9%	
2-08	******FollowUp : New Ratio	1.76	1.60	1.69	1.57	- 0.12	0.05	*1.52*	1.57	
2-09	Day Case Rates	88.0%	87.6%	88.0%	87.5%	-0.5%	7.5%	80.0%	87.5%	82.2%
2-10	Primary Referrals	10,623	9,504	64,664	71,548	10.6%	3.7%	121,638	121,488	
2-11	Cons to Cons Referrals	4,587	5,849	33,898	41,385	22.1%	23.9%	56,704	70,271	
2-12	First OP Activity (adjusted for uncashed)	16,043	18,626	111,235	124,370	11.8%	4.6%	204,495	211,179	
2-13	Subsequent OP Activity (adjusted for uncashed)	26,352	27,634	201,677	182,163	-9.7%	-17.7%	379,945	309,311	
2-14	Elective IP Activity	635	564	4,073	3,696	-9.3%	-18.9%	7,674	6,276	
2-15	Elective DC Activity	3,577	3,978	24,824	25,923	4.4%	0.1%	44,403	44,017	
2-16	**Non-Elective Activity	5,059	5,540	33,421	37,179	11.2%	8.9%	58,582	63,413	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	14,336	14,992	100,443	106,031	5.6%	1.2%	174,428	178,533	
2-18	Oncology Fractions	5,393	5,586	39,900	37,389	-6.3%	-6.5%	67,890	74,778	
2-19	No of Births (Mothers Delivered)	506	543	2,497	3,514	40.7%	0.8%	5,977	6,024	
2-20	% Mothers initiating breastfeeding	82.3%	77.7%	82.3%	81.4%	-1.0%	3.4%	78.0%	81.4%	
2-21	% Stillbirths Rate	0.2%	0.00%	0.20%	0.14%	*-0.1%*	*-0.3%*	*0.47%*	0.14%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	8	10	13	27	14	27	0	27	
3-02	*****Rate of New Complaints	2.01	2.84	3.46	2.16	-1.3	0.85	*1.318-3.92*	2.06	
3-03	% complaints responded to within target	61.0%	65.3%	74.3%	62.7%	-11.6%	-12.3%	75.0%	70.1%	
3-04	****Staff Friends & Family (FFT) % rec care	66.7%	78.2%	66.7%	78.2%	11.5%	-0.8%	79.0%	78.2%	
3-05	*****IP Friends & Family (FFT) % Positive	95.6%	94.2%	95.3%	94.5%	-0.7%	-0.5%	95.0%	94.5%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.9%	91.4%	91.4%	91.6%	0.2%	4.6%	87.0%	91.6%	85.5%
3-07	Maternity Combined FFT % Positive	93.9%	95.0%	93.6%	94.1%	0.5%	-0.9%	95.0%	94.1%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.3%	82.7%	83.0%	83.6%	0.5%			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	89.3%	90.75%	89.9%	92.8%	2.9%	1.9%	90.8%	91.9%	76.4%
4-02	Emergency A&E >12hr to Admission	0	1	0	2	2	2	*0*	2	
4-03	Ambulance Handover Delays >30mins	425	486	2,176	2,270	94			4,540	
4-04	Ambulance Handover Delays >60mins	70	67	266	274	8			548	
4-05	RTT Incomplete Admitted Backlog	2,298	2,930	2,298	2,930	632	563	2,151	2,151	
4-06	RTT Incomplete Non-Admitted Backlog	718	3,200	718	3,200	2,482	683	1,995	1,995	
4-07	RTT Incomplete Pathway	85.9%	80.7%	85.9%	80.7%	-5.2%	-3.0%	85.5%	85.5%	
4-08	RTT 52 Week Waiters (New in Month)	3	8	4	38	34	38	*0*	38	
4-09	RTT Incomplete Total Backlog	3,504	6,130	3,504	6,130	2,626	1,246	4,146	4,146	
4-10	% Diagnostics Tests WTimes <6wks	99.65%	99.5%	99.7%	99.5%	-0.1%	0.5%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	4	1	3	3	-	- 6	9	9	
4-12	*Cancer two week wait	93.6%	78.0%	92.1%	79.0%	-13.1%	-14.0%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.4%	71.3%	87.9%	65.4%	-22.4%	-27.6%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	95.3%	95.1%	92.6%	96.4%	3.8%	0.4%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	70.9%	60.1%	66.2%	62.2%	-4.0%	-20.0%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	65.1%	71.7%	65.7%	-6.0%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	15.0	88.5	86.0	-2.5	86.0	*0*	86.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	74	54	74	54	-20				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	51	41	51	41	-10				
4-20	Delayed Transfers of Care	5.36%	4.52%	5.52%	4.77%	-0.75%	1.27%	3.50%	4.77%	
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%	85.3%	92.4%	89.8%	-2.6%	9.8%	80%	89.8%	
4-23	*******Stroke:% to Stroke Unit <4hrs	65.2%	62.9%	59.2%	57.6%	-1.7%	-2.4%	60.0%	57.6%	
4-24	*******Stroke: % scanned <1hr of arrival	75.8%	58.1%	64.5%	57.2%	-7.3%	9.2%	48.0%	57.2%	
4-25	*******Stroke:% assessed by Cons <24hrs	80.3%	88.1%	85.1%	85.1%	0.0%	5.1%	80.0%	85.1%	
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	6	11	20	9	20	*0*	20	

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	35,049	40,695	256,592	269,145	4.9%	0.3%	466,408	466,408	
5-02	EBITDA	(602)	5,533	13,580	16,920	24.6%	-1.8%	38,910	38,910	
5-03	Surplus (Deficit) against B/E Duty	(2,789)	3,075	(3,865)	(497)			11,743	11,743	
5-04	CIP Savings	2,075	1,221	11,355	7,120	-37.3%	-29.0%	24,111	24,111	
5-05	Cash Balance	4,142	12,640	4,142	12,640			1,000	1,000	
5-06	Capital Expenditure	843	547	5,070	2,449			*13,762*	13,430	
5-07	Establishment WTE	5,597.5	5,631.7	5,597.5	5,631.7	0.6%	0.0%	5,631.7	5,631.7	
5-08	Contracted WTE	5,038.2	5,148.2	5,038.2	5,148.2	2.2%	2.6%	5,016.9	5,016.9	
5-09	Vacancies WTE	559.3	483.5	559.3	483.5	-13.5%	-21.4%	614.7	614.7	
5-11	Vacancy Rate (%)	10.0%	8.6%	10.0%	8.6%	-1.4%	-2.3%	10.9%	10.9%	
5-12	Substantive Staff Used	4,902.2	4,996.2	4,902.2	4,996.2	1.9%	-0.8%	5,037.3	5,037.3	
5-13	Bank Staff Used	324.8	372.1	324.8	372.1	14.6%	1.9%	365	365.1	
5-14	Agency Staff Used	274.7	271.0	274.7	271.0	-1.3%	18.2%	229.3	229.3	
5-15	Overtime Used	48.0	48.9	48.0	48.9	1.8%				
5-16	Worked WTE	5,549.6	5,688.1	5,549.6	5,688.1		1.0%	5,631.7	5,631.7	
5-17	Nurse Agency Spend	(751)	(823)	(4,178)	(5,361)	28.3%				
5-18	Medical Locum & Agency Spend	(1,313)	(1,261)	(8,520)	(10,519)	23.5%				
5-19	Temp costs & overtime as % of total pay bill	16.5%	17.4%	16.1%	17.0%	0.9%				
5-20	Staff Turnover Rate	11.8%	9.4%		9.1%	-2.4%	-1.4%	*10.5%*	9.1%	11.05%
5-21	Sickness Absence	3.4%	3.4%		3.4%	0.0%	0.1%	*3.3%*	3.4%	4.3%
5-22	Statutory and Mandatory Training	88.8%	82.9%		87.1%	-5.9%	2.1%	85.0%	87.1%	
5-23	Appraisal Completeness	86.5%	84.7%		84.7%	-1.8%	-5.3%	90.0%	84.7%	
5-24	Overall Safe staffing fill rate	98.1%	99.2%	98.4%	96.7%	-1.7%		93.5%	96.7%	
5-25	****Staff FFT % recommended work	60.6%	50%	60.6%	50%	-10.6%	-12.0%	62.0%	50%	
5-26	***Staff Friends & Family -Number Responses	33	78	33	78	45				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.8%	15.3%	23.7%	21.5%	-2.1%	-3.5%	25.0%	21.5%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.2%	4.2%	21.4%	11.8%	-9.7%	-3.2%	15.0%	11.8%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	28.9%	18.2%	31.7%	24.9%	-6.7%	-0.1%	25.0%	24.9%	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.

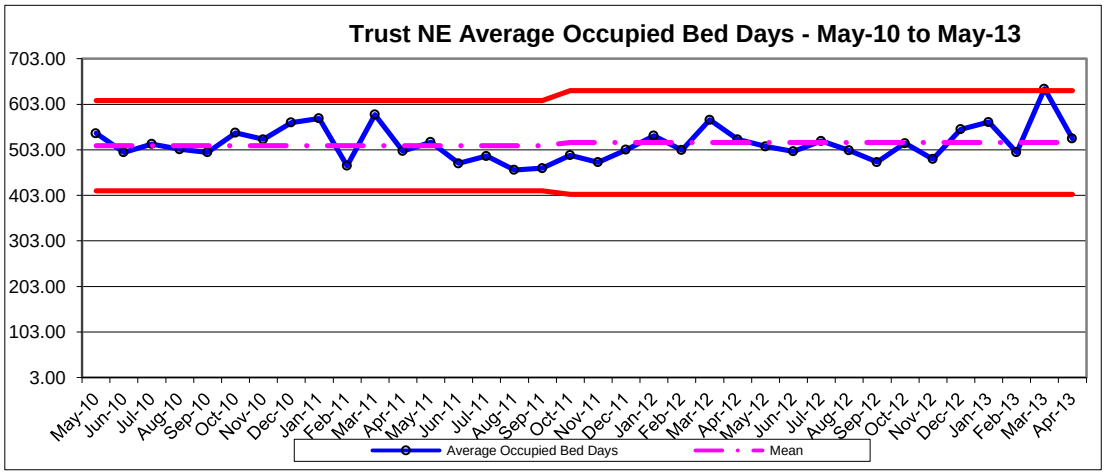
Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

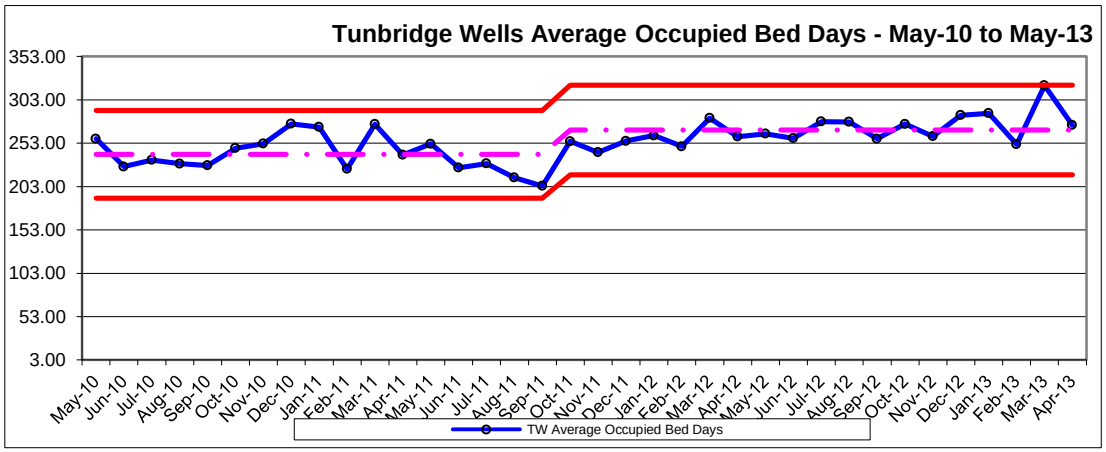
Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

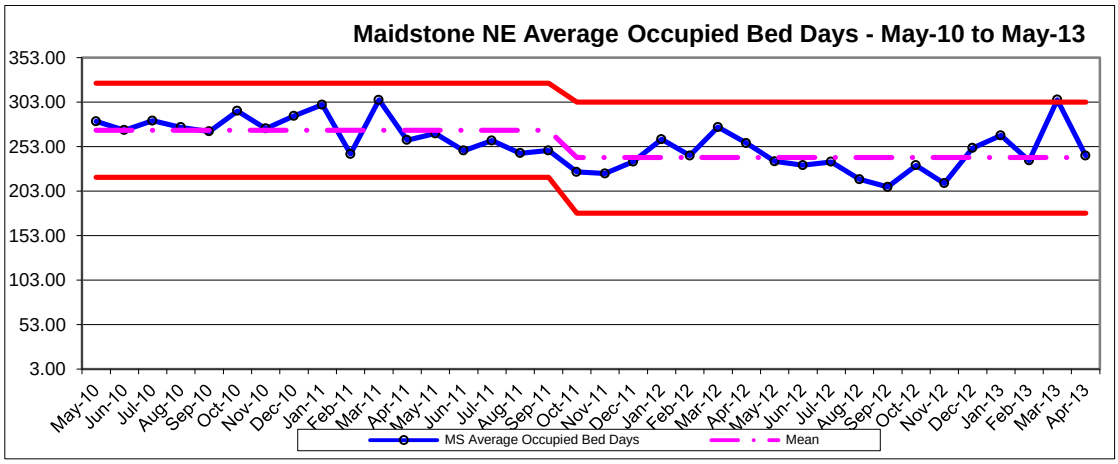
Changes to Control Lines

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:

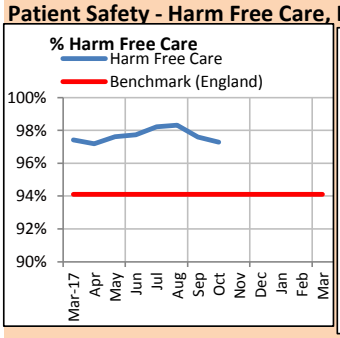


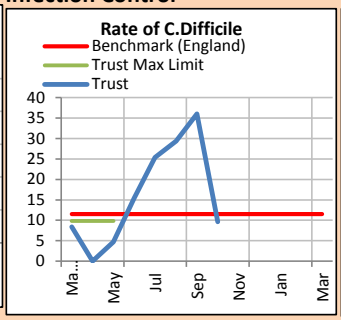


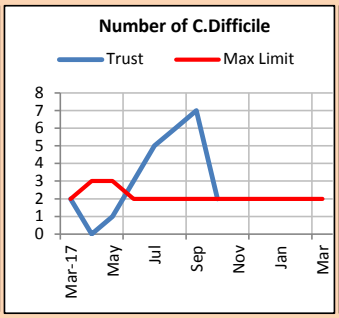
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

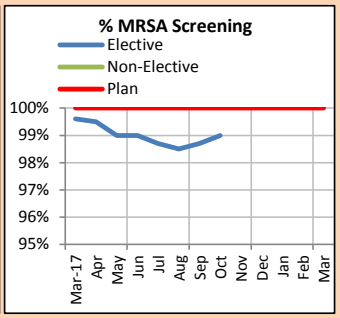
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

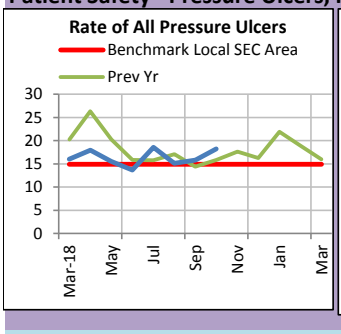


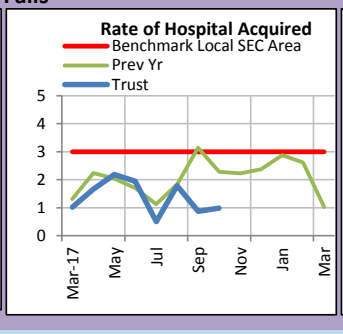


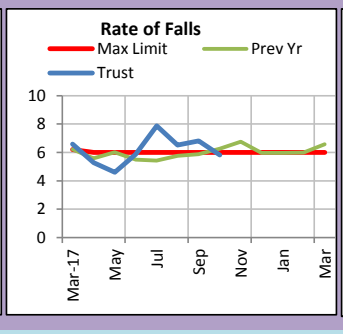


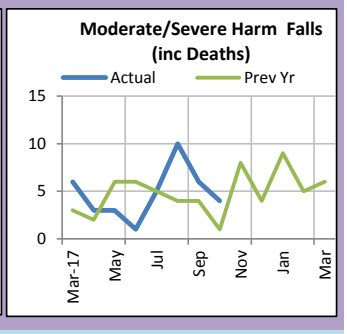


Patient Safety - Pressure Ulcers, Falls

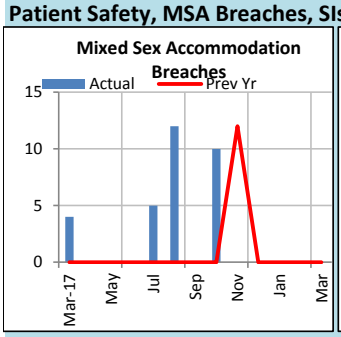


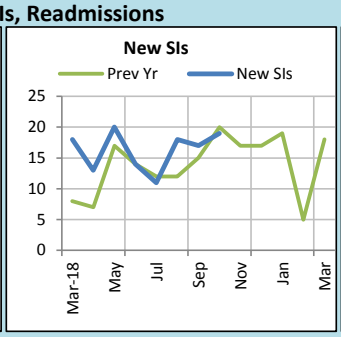


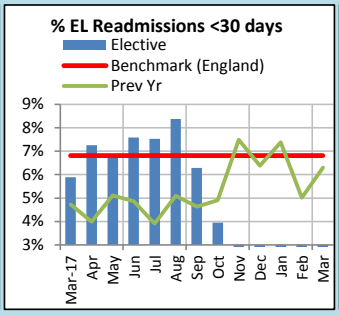


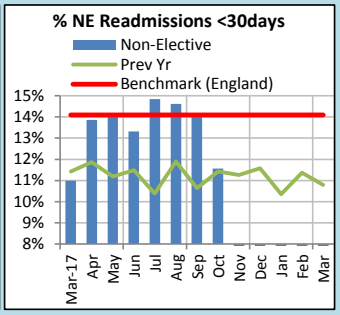


Patient Safety, MSA Breaches, SIs, Readmissions

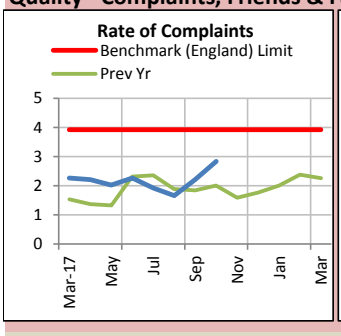


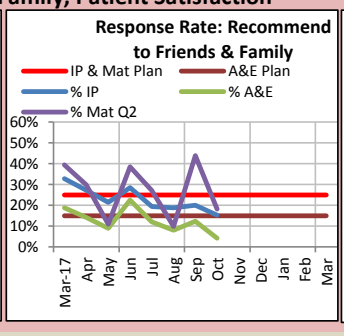


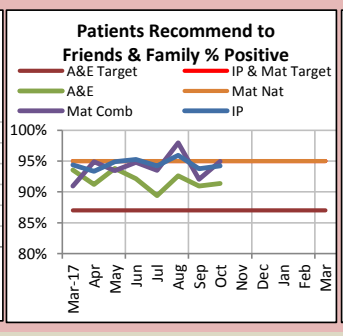


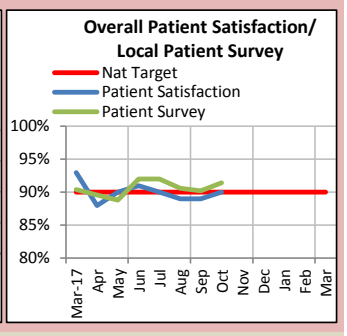


Quality - Complaints, Friends & Family, Patient Satisfaction

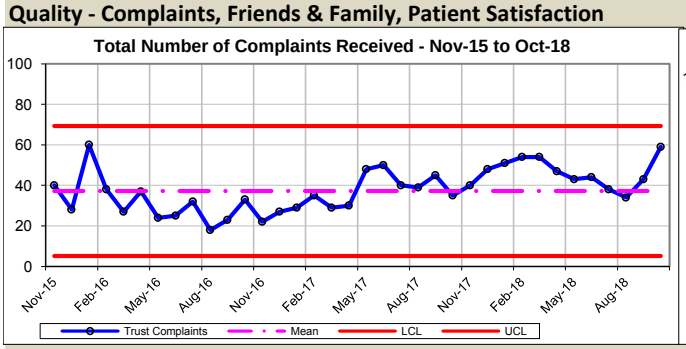


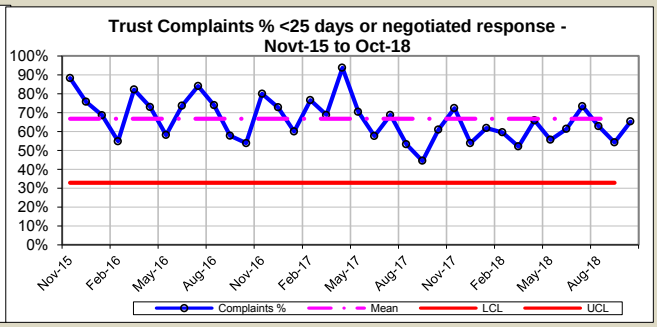




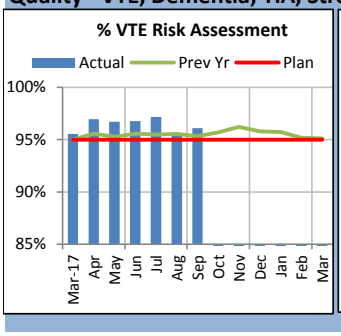


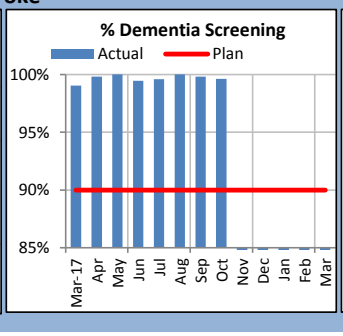
Quality - Complaints, Friends & Family, Patient Satisfaction

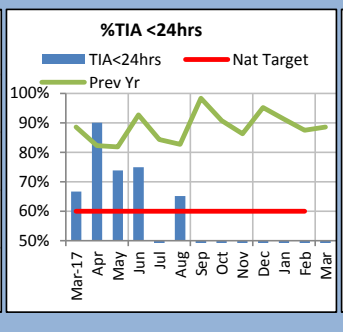


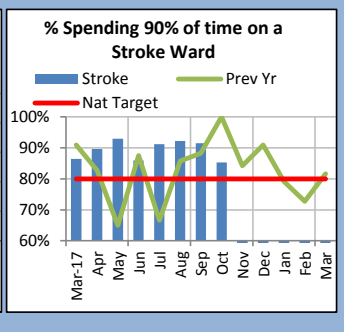


Quality - VTE, Dementia, TIA, Stroke



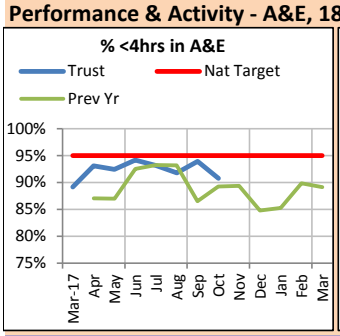


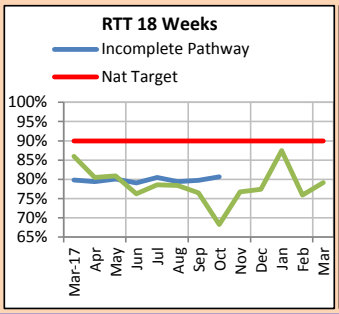


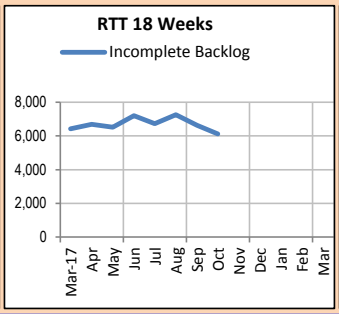


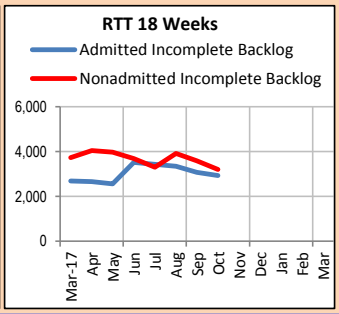
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

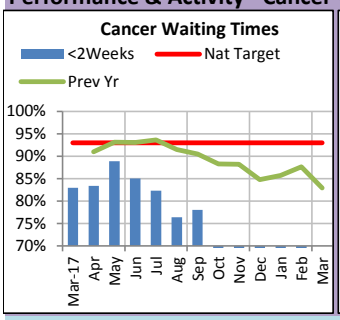


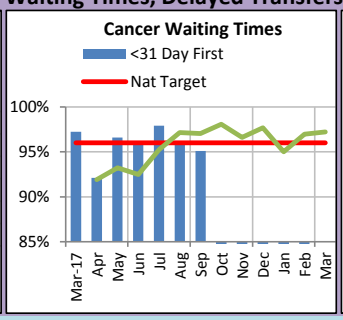


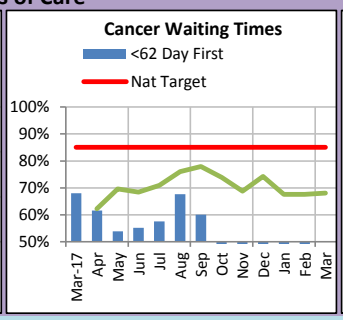


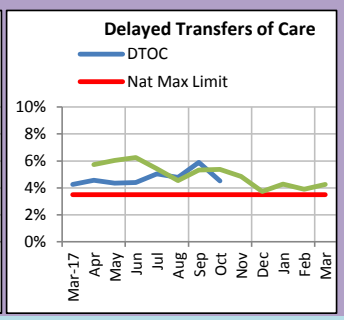


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

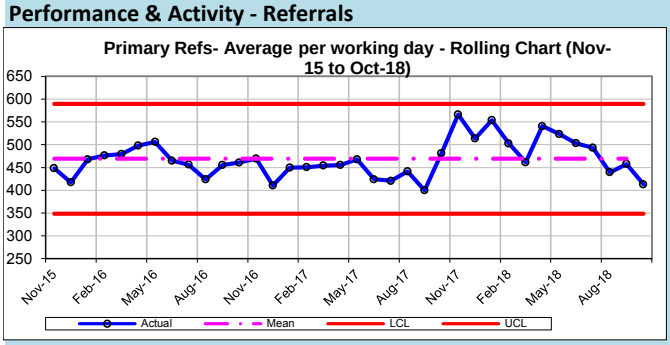


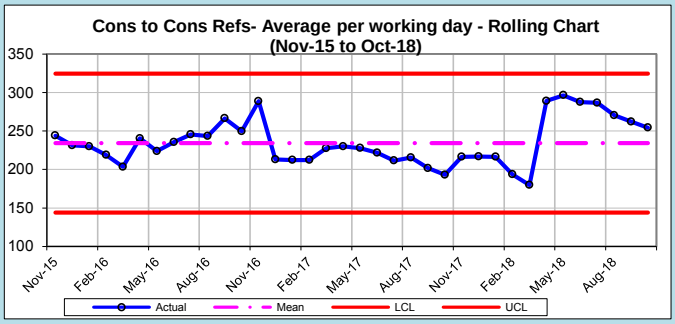




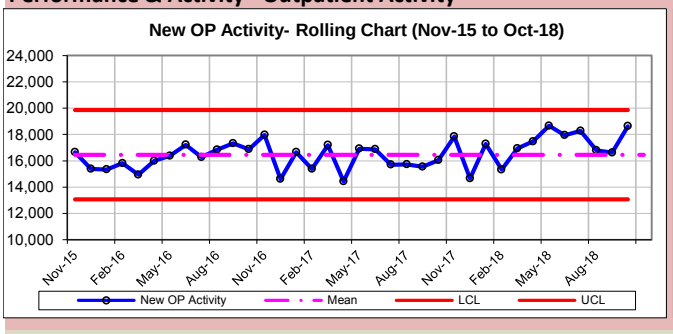


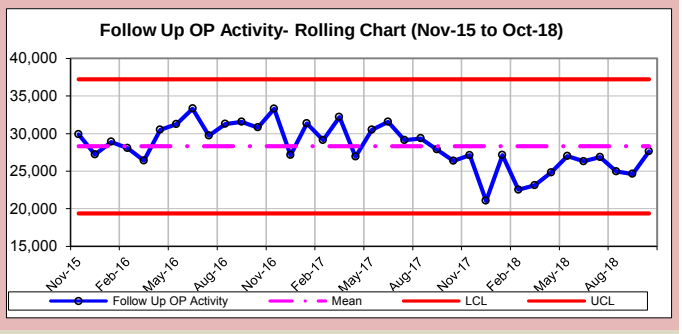
Performance & Activity - Referrals



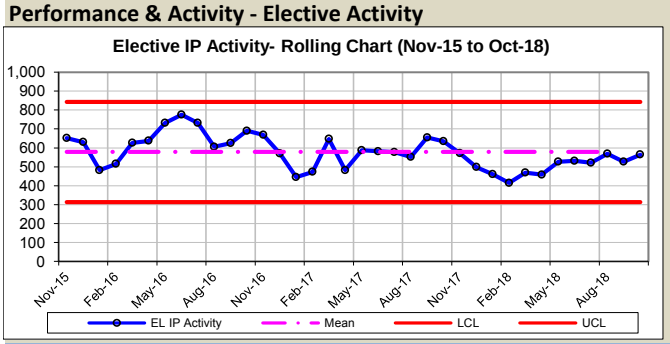


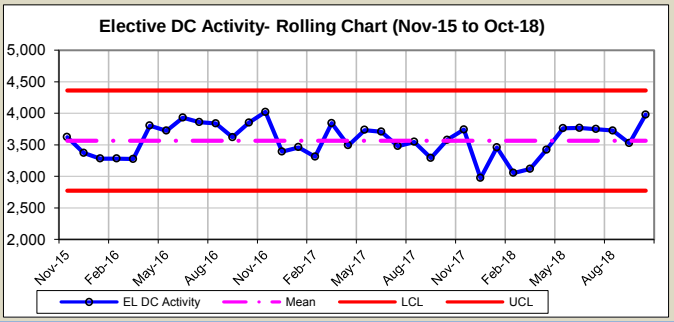
Performance & Activity - Outpatient Activity



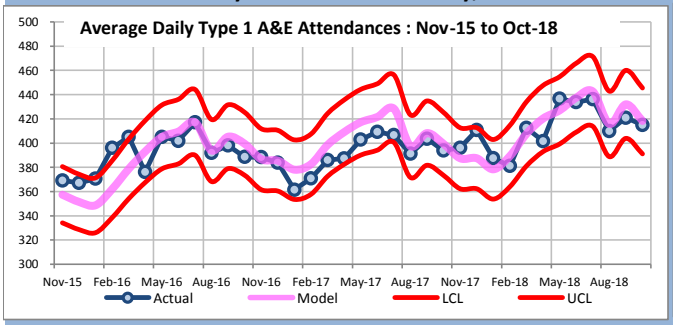


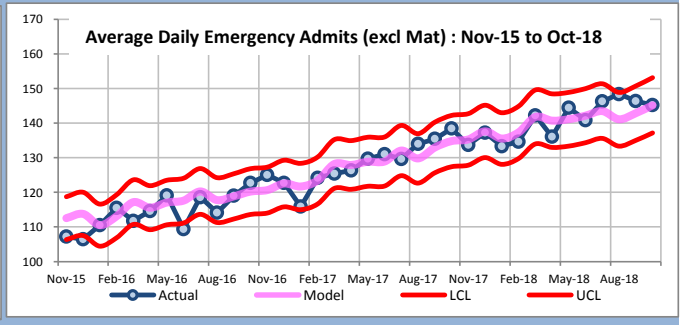
Performance & Activity - Elective Activity





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

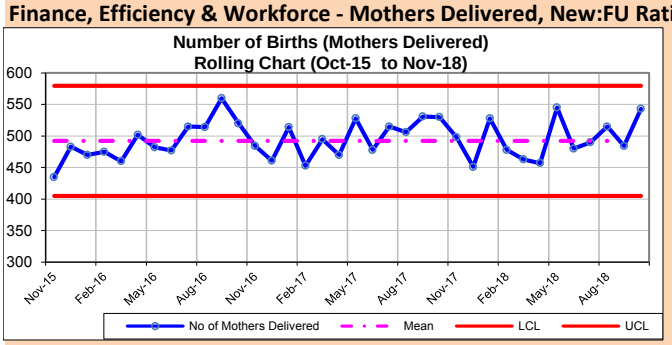


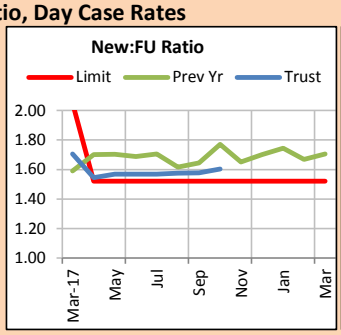


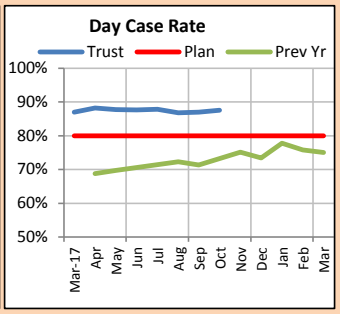
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

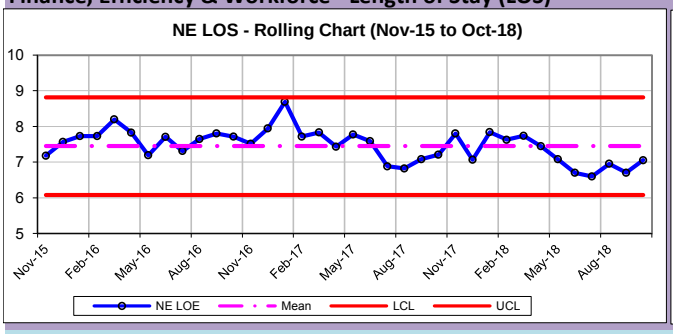
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

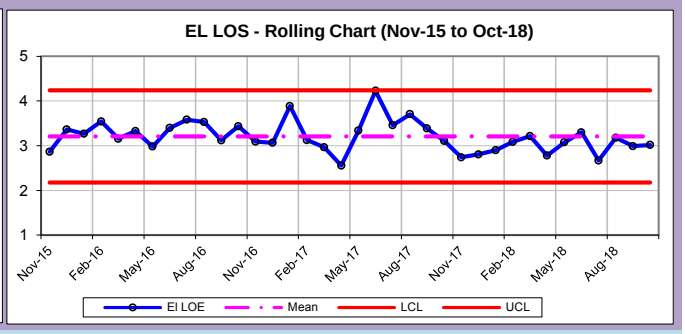




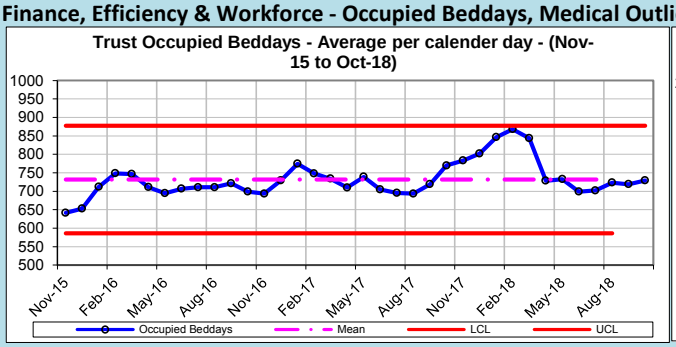


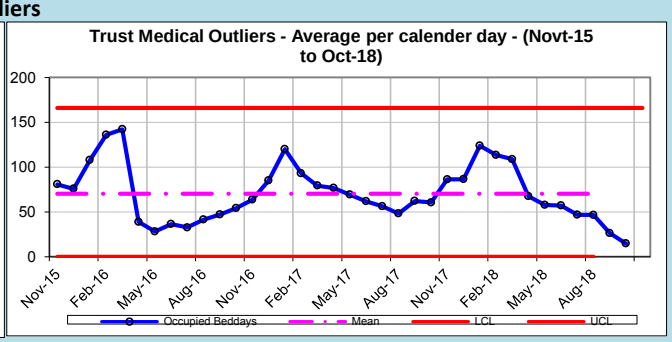
Finance, Efficiency & Workforce - Length of Stay (LOS)



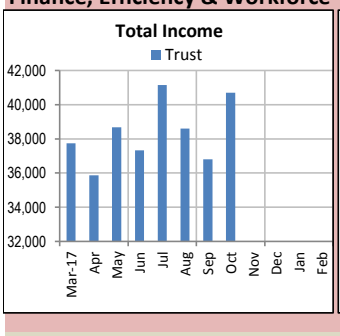


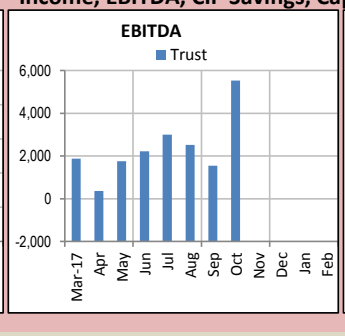
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

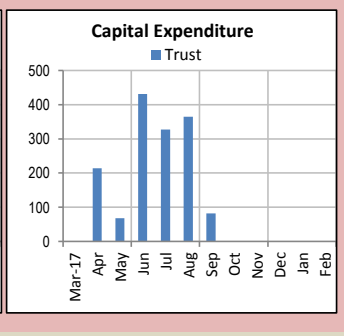




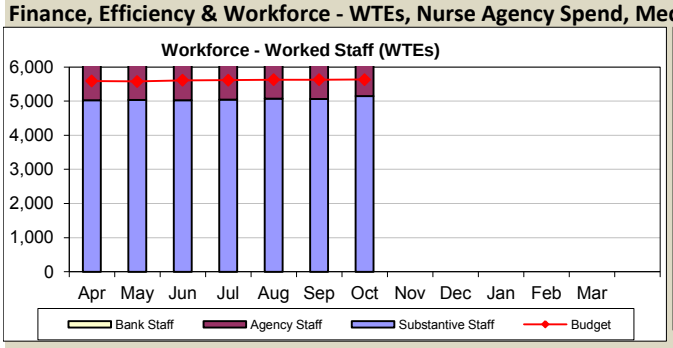
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

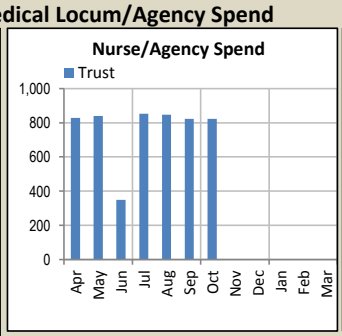


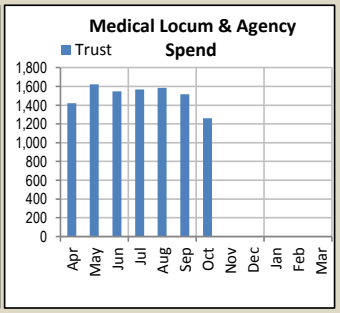




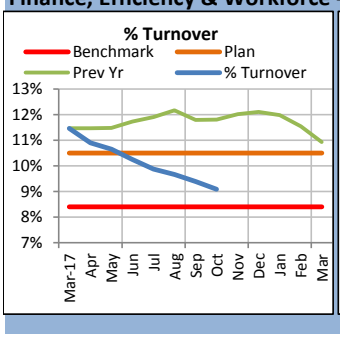
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

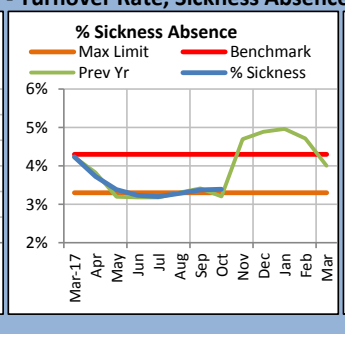


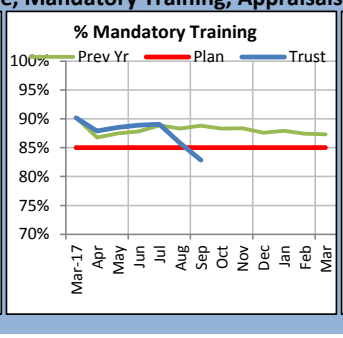


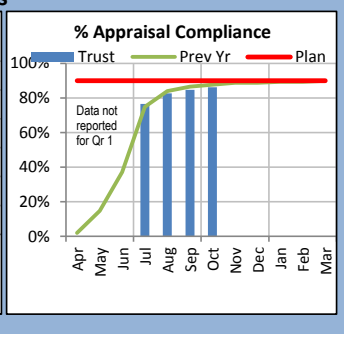


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 7
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for October 2018

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

October 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	40.7	41.2	(0.5)	0.5	(1.0)		269.1	271.2	(2.1)	(0.5)	(1.6)		463.6	471.1	(7.5)	
Expenditure	(35.2)	(35.6)	0.5	(0.5)	0.9		(252.2)	(254.0)	1.8	0.5	1.3		(432.0)	(432.2)	0.2	
EBITDA (Income less Expenditure)	5.5	5.6	(0.1)	(0.0)	(0.1)		16.9	17.2	(0.3)	(0.0)	(0.3)		31.6	38.9	(7.3)	
Financing Costs	(2.7)	(2.5)	(0.2)	0.0	(0.2)		(18.0)	(17.8)	(0.2)	0.0	(0.2)		(21.2)	(28.2)	7.0	
Technical Adjustments	0.3	0.0	0.3	0.0	0.3		0.5	0.0	0.5	0.0	0.5		1.3	1.0	0.3	
Net Surplus / Deficit (Incl PSF)	**3.1**	**3.1**	**0.0**	**(0.0)**	**0.0**		**(0.5)**	**(0.5)**	**0.0**	**0.0**	**0.0**		**11.7**	**11.7**	**(0.0)**	
CIPs	1.2	2.9	(1.6)		(1.6)		7.1	10.0	(2.9)		(2.9)		24.1	24.1	0.0	
Cash Balance	12.6	1.0	11.6		11.6		12.6	1.0	11.6		11.6		1.0	1.0	0.0	
Capital Expenditure	0.5	1.2	0.6		0.6		2.4	4.5	2.1		2.1		10.9	13.8	2.8	
Capital service cover rating							4	4					4	4		
Liquidity rating							4	4					4	4		
I&E margin rating							3	3					1	1		
Agency rating							4	4					4	4		
Finance and use of resources rating							3	3					3	3		

Summary:

- The Trusts surplus including PSF was £3.1m in October which was on plan. Year to date the Trust has a deficit of £0.5m which is on plan however the key variances within plan are: CIP Slippage (£2.9m,) overspends within pay budgets (£1m) and non pay budgets (£2.4m) offset by non-recurrent items (£1.9m) , release of contingency reserve (£3.8m) and underspends within income and depreciation (£0.2m).
- The Trust has spent £7.2m more than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £7.1m savings YTD which is £2.9m adverse to plan (29% slippage)

Key Points:

- The Trusts normalised run rate in October was £0.7m deficit pre PSF which was £2.5m adverse to plan.
- The Trust in October delivered 90.67% A&E 4 hour performance which achieved the requirement for PSF funding (90%), the Trust therefore fully delivered the YTD PSF income for both A&E and the delivery of the financial plan.
- Year to date Non Pay pressures (£2.4m) net of pass-through and CIP slippage is now double the YTD pay pressures. The main non pay pressures relate to clinical supplies specifically within T&O (£0.6m), Cancer (£0.3m), Pathology (£0.3m) and ENT (£0.2m).

Risks:

- The Trust is forecasting to deliver the plan but there are several risks within this forecast which include CIP risk adjusted slippage (£10.8m), Divisional Pay pressures (£3.2m) and non pay overspends (£3.5m). The Trust will have to implement recovery plans and mitigating actions to deliver the financial plan are covered in section 5 of this report.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure October 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	38.9	40.0	(1.1)	0.5	(1.5)	261.7	265.5	(3.8)	(0.5)	(3.3)
Expenditure	(36.8)	(35.6)	(1.1)	(0.5)	(0.7)	(256.2)	(254.0)	(2.2)	0.5	(2.7)
Trust Financing Costs	(2.7)	(2.5)	(0.2)	0.0	(0.2)	(18.0)	(17.8)	(0.2)	0.0	(0.2)
Technical Adjustments	0.3	0.0	0.3	0.0	0.3	0.5	0.0	0.5	0.0	0.5
Net Revenue Surplus / (Deficit) before Exceptional Items	**(0.3)**	**1.8**	**(2.1)**	**(0.0)**	**(2.1)**	**(12.0)**	**(6.3)**	**(5.7)**	**(0.0)**	**(5.7)**
Exceptional Items	2.1		2.1		2.1	5.8		5.8		5.8
Net Position	**1.8**	**1.8**	**0.0**	**(0.0)**	**0.0**	**(6.2)**	**(6.3)**	**0.0**	**(0.0)**	**0.0**
PSF Funding	1.3	1.3	0.0	0.0	0.0	5.7	5.7	(0.0)	0.0	(0.0)
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	3.1	3.1	0.0	(0.0)	0.0	(0.5)	(0.5)	0.0	(0.0)	0.0

Key messages:
The Trust benefited by £2.1m of exceptional adjustments this month which included: £1.6m release of contingency reserves, £0. 4m non recurrent Fleming rebate, £0.2m release of Oncology debt provision for provider to provider SLAs and £0.1m rates rebate assumption for 2018/19.

Income:
Income YTD net of pass-through related costs and exceptional items is £3.3m adverse to plan, which is due to CIP slippage (£3.5m) and Private Patient income £0.5m partly offset by income over performance within non AIC contracted clinical income (£0.7m)

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £2.7m adverse, which is due to budget overspends within Pay budgets (£1m) and Non Pay (£2.3m) partly offset by CIP overperformance of £0.6m.
The main pressures within expenditure budgets (net of pass though, CIP and exceptional items) relates to: Clinical Supplies and Services (£2.1m) and Medical (£1m).

Reserves: The Trust has fully released the YTD held reserves.

PSF: The Trust in October delivered 90.67% A&E 4 hour performance which achieved the requirement for PSF funding (90%), the Trust therefore fully delivered the YTD PSF income for both A&E and the delivery of the financial plan.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure October 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	30.0	31.8	(1.8)	(0.1)	(1.8)	205.4	207.4	(2.0)	(0.4)	(1.7)	348.6	356.3	(7.7)
High Cost Drugs	3.7	3.5	0.2	0.2	(0.0)	25.4	25.6	(0.2)	(0.2)	(0.0)	43.2	43.2	0.0
Total Clinical Income	**33.7**	**35.4**	**(1.7)**	**0.1**	**(1.8)**	**230.8**	**233.0**	**(2.2)**	**(0.5)**	**(1.7)**	**391.9**	**399.6**	**(7.7)**
PSF	1.3	1.3	0.0	0.0	0.0	5.7	5.7	(0.0)	0	(0.0)	12.7	12.7	0
Other Operating Income	5.7	4.6	1.2	0.4	0.8	32.6	32.5	0.1	0.0	0.1	59.0	58.8	0.1
Total Revenue	40.7	41.2	(0.5)	0.5	(1.0)	269.1	271.2	(2.1)	(0.5)	(1.6)	463.6	471.1	(7.5)
Substantive	(17.6)	(19.1)	1.5	0.0	1.5	(129.7)	(133.6)	3.9	0.2	3.7	(226.7)	(228.8)	2.1
Bank	(1.0)	(1.0)	(0.0)	0.0	(0.0)	(7.4)	(7.0)	(0.4)	(0.0)	(0.4)	(12.5)	(12.3)	(0.3)
Locum	(0.6)	(0.5)	(0.2)	0.0	(0.2)	(4.2)	(3.1)	(1.1)	0	(1.1)	(8.0)	(5.5)	(2.5)
Agency	(1.8)	(1.9)	0.1	(0.0)	0.1	(13.8)	(12.0)	(1.8)	(0.0)	(1.7)	(24.7)	(22.2)	(2.4)
Pay Reserves	0.4	(0.1)	0.4	0.0	0.4	(0.3)	(1.4)	1.1	0	1.1	3.2	(1.8)	5.0
Total Pay	(20.7)	(22.6)	1.9	0.0	1.9	(155.3)	(157.0)	1.7	0.2	1.5	(268.7)	(270.6)	2.0
Drugs & Medical Gases	(4.4)	(4.2)	(0.2)	(0.2)	(0.0)	(30.9)	(31.4)	0.5	0.2	0.3	(53.3)	(52.0)	(1.3)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(1.3)	(1.3)	(0.0)	0	(0.0)	(2.1)	(2.2)	0.0
Supplies & Services - Clinical	(3.1)	(2.7)	(0.4)	0.1	(0.5)	(20.0)	(18.4)	(1.6)	0.4	(2.0)	(34.4)	(32.1)	(2.3)
Supplies & Services - General	(0.5)	(0.4)	(0.1)	0.0	(0.1)	(3.2)	(3.1)	(0.1)	0.0	(0.1)	(5.4)	(5.0)	(0.3)
Services from Other NHS Bodies	(0.8)	(0.8)	0.0	0.0	(0.0)	(5.5)	(5.7)	0.2	0.2	0.0	(10.3)	(9.9)	(0.4)
Purchase of Healthcare from Non-NHS	(0.3)	(0.4)	0.1	0.0	0.1	(2.1)	(3.3)	1.2	(0.0)	1.2	(5.9)	(5.2)	(0.6)
Clinical Negligence	(1.6)	(1.6)	0.0	0.0	0.0	(11.1)	(11.1)	0.0	0	0.0	(19.0)	(19.0)	0.0
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	0.0	(2.2)	(2.0)	(0.1)	(0.3)	0.2	(4.1)	(3.5)	(0.6)
Premises	(1.7)	(1.6)	(0.1)	(0.1)	(0.0)	(13.8)	(13.4)	(0.4)	(0.0)	(0.4)	(23.5)	(21.4)	(2.1)
Transport	(0.1)	(0.1)	(0.1)	0.0	(0.1)	(1.0)	(0.9)	(0.1)	0	(0.1)	(1.7)	(1.3)	(0.4)
Other Non-Pay Costs	(1.1)	(0.6)	(0.4)	(0.3)	(0.1)	(5.8)	(5.1)	(0.7)	(0.1)	(0.6)	(8.6)	(8.1)	(0.5)
Non-Pay Reserves	(0.4)	(0.2)	(0.2)	0.0	(0.2)	0	(1.3)	1.3	0	1.3	5.1	(1.8)	6.9
Total Non Pay	(14.5)	(13.0)	(1.5)	(0.5)	(1.0)	(96.9)	(96.9)	0.0	0.3	(0.3)	(163.3)	(161.6)	(1.7)
Total Expenditure	(35.2)	(35.6)	0.5	(0.5)	0.9	(252.2)	(254.0)	1.8	0.5	1.3	(432.0)	(432.2)	0.2
EBITDA	5.5	5.6	(0.1)	(0.0)	(0.1)	16.9	17.2	(0.3)	(0.0)	(0.3)	31.6	38.9	(7.3)
	0.0	*0.0*	*0.0*	*%*		*6.3%*	*6.4%*	*15.2%*	*0.0%*	*20.0%*	*6.8%*	*8.3%*	*96.7%*
									(0.0)	0.0			
Depreciation	(1.1)	(1.1)	0.1	0	0.1	(7.6)	(7.8)	0.2	0	0.2	(13.2)	(13.5)	0.3
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(1.0)	(0.9)	(0.0)	0	(0.0)	(1.6)	(1.6)	(0.1)
Dividend	(0.1)	(0.1)	0.0	0	0	(0.7)	(0.7)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.4)	(1.2)	(0.2)	0	(0.2)	(8.6)	(8.3)	(0.3)	0	(0.3)	(5.2)	(11.9)	6.8
Total Finance Costs	(2.7)	(2.5)	(0.2)	0.0	(0.2)	(18.0)	(17.8)	(0.2)	0	(0.2)	(21.2)	(28.2)	7.0
Net Surplus / Deficit (-)	2.8	3.1	(0.3)	(0.0)	**(0.3)**	(1.0)	(0.6)	(0.5)	(0.0)	(0.5)	10.4	10.7	(0.3)
Technical Adjustments	0.3	0.0	0.3	0.0	0.3	0.5	0.0	0.5	0.0	0.5	1.3	1.0	0.3
Surplus/ Deficit (-) to B/E Duty Incl PSF	3.1	3.1	0.0	(0.0)	**0.0**	(0.5)	(0.5)	0.0	0.0	0.0	11.7	11.7	(0.0)
Surplus/ Deficit (-) to B/E Duty Excl PSF	1.8	1.8	0.0	(0.0)	**0.0**	(6.2)	(6.3)	0.0	0.0	0.0	(1.0)	(1.0)	(0.0)

Commentary

The Trusts surplus including PSF was £3.1m in October which was on plan, year to date the Trust has a deficit of £0.5m which is on plan.

The Trusts normalised run rate in October was £0.7m deficit pre PSF which was £2.5m adverse to plan.

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 £1.8m adverse to plan in October. The key adverse variances in month were Outpatients (£0.5m) Daycases (£0.2m) and Electives (£0.4m) . This is mainly in relation to the delay to the Prime Provider tender process.

The Trust achieved the A&E target for October as well as the financial plan therefore has fully delivered the YTD PSF income .

Other Operating Income excluding pass-through costs is £0.8m favourable to plan in the month, this is due to £0.4m Flemming rebate benefit and a release of Oncology SLA provision.

Pay budgets underspent by £1.9m in October, £2.1m due to the release of contingency reserve (£0.4m) and directorate held pay reserve (£1.7m) therefore the revised normalised overspend of £0.2m. The main pressures in the month related to £80k Consultant arrears of pay within Specialty Medicine, and higher than planned medical agency spend within General Surgery (£0.1m) due to non delivery of directorate recovery actions.

Non Pay adjusted for pass through costs and reserves was overspent by £0.8m in October although £0.75m underspend is associated with Prime Provider activity slippage therefore the normalised position was an adverse variance of £1.6m. Non pay costs in October were £0.3m higher than forecasted levels this was mainly within Clinical Supplies and Services, £0.1m within Theatres, £0.1m within Cardiology and £0.1m within ENT.

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

Maidstone and Tunbridge Wells NHS Trust

2b. Run Rate Pay Analysis

Analysis of 13 Monthly Performance (£m's)

		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Change between Months (+ = Reduction)
Substantive	Consultants	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(3.0)	(3.1)	(3.1)	(3.0)	(2.8)	(3.1)	(3.0)	0.1
	Other Medical	(2.3)	(2.3)	(2.2)	(2.3)	(2.0)	(2.4)	(2.2)	(2.3)	(2.3)	(2.3)	(2.2)	(2.3)	(2.2)	0.1
	Nurses-Trained	(4.9)	(5.0)	(5.0)	(4.9)	(4.9)	(4.8)	(5.0)	(5.1)	(5.0)	(5.2)	(5.1)	(5.0)	(4.8)	0.2
	Nurses-Untrained	(1.2)	(1.3)	(1.2)	(1.2)	(1.1)	(1.2)	(1.2)	(1.2)	(1.2)	(1.4)	(1.2)	(1.2)	(1.1)	0.1
	Scientific, Therapeutic & Technical	(3.1)	(3.1)	(3.0)	(3.1)	(3.0)	(3.1)	(3.1)	(3.2)	(3.1)	(3.3)	(3.2)	(3.2)	(2.9)	0.2
	Admin, Clerical & Management	(2.5)	(2.4)	(2.5)	(2.5)	(2.6)	(2.5)	(2.7)	(2.7)	(2.8)	(2.8)	(2.8)	(2.9)	(2.5)	0.3
	Support Staff	(1.0)	(1.0)	(1.0)	(1.0)	(0.9)	(1.0)	(1.1)	(1.1)	(1.0)	(1.4)	(1.2)	(1.2)	(1.1)	0.1
	Substantive Total	**(17.9)**	**(18.0)**	**(17.8)**	**(17.9)**	**(17.5)**	**(17.9)**	**(18.3)**	**(18.7)**	**(18.4)**	**(19.4)**	**(18.5)**	**(18.9)**	**(17.6)**	**1.3**
		0	0	0	0	0	0	0	0	0	0	0	0	0	
Agency	Consultants and Other Medical	(0.9)	(0.8)	(0.8)	(1.0)	(0.9)	(1.3)	(0.9)	(1.0)	(1.0)	(0.9)	(0.9)	(0.8)	(0.6)	0.1
	Nurses-Trained and UN Trained	(0.8)	(0.7)	(0.7)	(0.9)	(0.6)	(1.0)	(0.8)	(0.8)	(0.3)	(0.9)	(0.8)	(0.8)	(0.8)	(0.0)
	Scientific, Therapeutic & Technical	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	0.0
	Admin, Clerical & Management	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Support Staff	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.1)	(0.0)
	Agency Total	**(2.0)**	**(1.8)**	**(1.9)**	**(2.3)**	**(1.8)**	**(2.6)**	**(2.0)**	**(2.1)**	**(1.7)**	**(2.1)**	**(2.1)**	**(1.9)**	**(1.8)**	**0.1**
		0	0	0	0	0	0	0	0	0	0	0	0	0	
Bank/Locum	Consultants and Other Medical	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	(0.6)	(0.7)	(0.7)	(0.6)	0.1
	Nurses-Trained and UN Trained	(0.8)	(0.8)	(1.0)	(1.0)	(1.0)	(1.1)	(0.9)	(0.8)	(0.9)	(0.9)	(1.0)	(0.9)	(0.9)	0.0
	Scientific, Therapeutic & Technical	(0.0)	(0.0)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Admin, Clerical & Management	(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
	Support Staff	(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
	Bank Total	**(1.4)**	**(1.5)**	**(1.7)**	**(1.7)**	**(1.7)**	**(2.0)**	**(1.5)**	**(1.6)**	**(1.6)**	**(1.6)**	**(1.9)**	**(1.8)**	**(1.7)**	**0.1**
Total	Consultants and Other Medical	(6.6)	(6.6)	(6.4)	(6.7)	(6.4)	(7.2)	(6.7)	(7.1)	(6.9)	(6.8)	(6.7)	(6.9)	(6.4)	0.5
	Nurses-Trained and UN Trained	(7.6)	(7.8)	(7.9)	(8.0)	(7.6)	(8.1)	(7.9)	(8.0)	(7.4)	(8.3)	(8.1)	(7.9)	(7.6)	0.4
	Scientific, Therapeutic & Technical	(3.4)	(3.3)	(3.2)	(3.3)	(3.3)	(3.3)	(3.3)	(3.4)	(3.4)	(3.6)	(3.5)	(3.4)	(3.2)	0.3
	Admin, Clerical & Management	(2.7)	(2.6)	(2.7)	(2.8)	(2.8)	(2.7)	(2.8)	(2.8)	(2.9)	(3.0)	(3.0)	(3.0)	(2.7)	0.3
	Support Staff	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.1)	(1.1)	(1.1)	(1.1)	(1.4)	(1.3)	(1.2)	(1.1)	0.1
	Total	**(21.3)**	**(21.3)**	**(21.4)**	**(21.9)**	**(21.0)**	**(22.4)**	**(21.8)**	**(22.4)**	**(21.7)**	**(23.1)**	**(22.5)**	**(22.6)**	**(21.0)**	**1.5**

Maidstone and Tunbridge Wells NHS Trust

3a. Cost Improvement Plan

Savings by Division

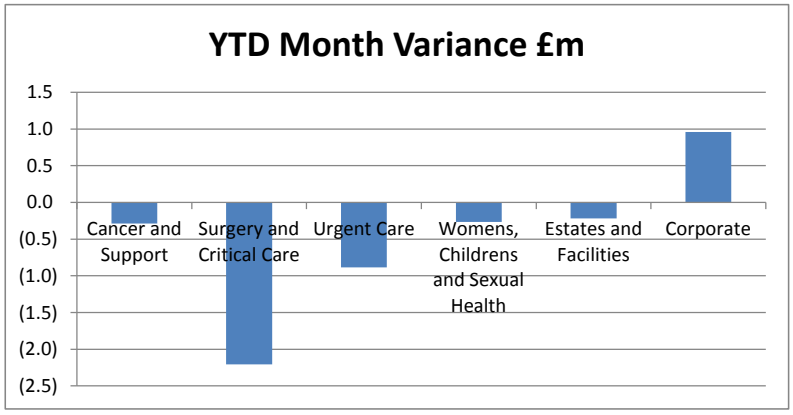
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Support	(0.06)	0.36	(0.42)	0.96	1.25	(0.29)	1.70	3.01	(1.32)
Surgery and Critical Care	0.34	1.35	(1.01)	2.60	4.81	(2.21)	3.42	11.38	(7.96)
Urgent Care	0.00	0.37	(0.37)	0.62	1.50	(0.88)	1.41	3.66	(2.25)
Womens, Childrens and Sexual Health	0.11	0.24	(0.14)	0.70	0.96	(0.26)	1.16	2.11	(0.95)
Estates and Facilities	0.11	0.45	(0.35)	0.68	0.89	(0.22)	2.00	2.95	(0.94)
Corporate	0.73	0.08	0.65	1.57	0.61	0.96	3.61	1.00	2.61
Total	**1.22**	**2.85**	**(1.63)**	**7.12**	**10.02**	**(2.90)**	**13.30**	**24.11**	**(10.81)**

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	0.21	0.15	0.05	1.68	2.45	(0.77)	2.96	3.17	(0.20)
Non Pay	0.62	1.01	(0.38)	4.71	3.35	1.36	8.42	8.40	0.02
Income	0.39	1.70	(1.30)	0.74	4.23	(3.49)	1.92	12.55	(10.63)
Total	**1.22**	**2.85**	**(1.63)**	**7.12**	**10.02**	**(2.90)**	**13.30**	**24.11**	**(10.81)**

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	0.93	1.90	(0.98)	6.26	7.65	(1.39)	8.84	16.99	(8.15)
Amber	0.18	0.22	(0.04)	0.47	1.19	(0.72)	3.47	2.73	0.75
Red	0.11	0.73	(0.62)	0.40	1.19	(0.79)	0.98	4.39	(3.41)
Total	**1.22**	**2.85**	**(1.63)**	**7.12**	**10.02**	**(2.90)**	**13.30**	**24.11**	**(10.81)**



Comment

The Trust was £1.6m adverse to plan in the month and £2.9m adverse YTD. The main schemes adverse to plan YTD are:
- STP Medical Rates £0.8m (£0.2m adverse in month)
- Prime Provider £1.3m (£0.8m adverse in month)
- Private Patient Income £0.3m.
- Estates and Facilities £0.2m.

The Trusts risk adjusted savings forecast is £10.8m adverse to plan, the main schemes forecasting slippage are:
- Estates and Facilities Subsidiary £1.75m (although £0.6m new schemes have been added to reduce impact to £1.1m)
- Private Patient Income = £1m
- STP Medical Rates = £1.7m
- Prime Provider = £4.5m, the forecast currently assumes £1m benefit in 2018/19
- Medicines Management = £1.2m (£0.7m relates to Avastin)
- Urgent Care Centre = £0.4m
- Satellite Service Review = £0.3m
- Endoscopy Income = £0.2m
- Procurement = £0.5m

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast

Year End Forecast October 2018/19

		Risks													Mitigations				
	Annual Plan £m	*CIP Non Delivery* £m	*Pay Pressures*	*AEC/Frailty and Winter Pressures*	*Agreed Business Cases (Best Care and Extension AEC and Frailty)*	*Non Pay Pressures T&O and Diagnostics*	*Reduction in Non Recurrent Income Support*	*2017/18 Benefits*	*RTT and Cancer Recovery Plan*	*Virtual Ward*	*Pass through Items*	*PSF Funding*	*Other*	*Risk Adjusted Forecast* £m	***Variance* £m**	*Asset Sales* £m	*Release Reserves* £m	*Divisional Target* £m	*PSF Funding* £m	***Revised Variance* £m**
Income	471.1	(10.6)					(0.7)	1.8	0.8	0.6	0.5	(8.3)	(0.4)	454.8	**(16.3)**				8.3	**(8.0)**
Pay	(270.6)	(0.2)	(3.2)	(1.7)	(1.6)			0.7	(0.4)					(277.0)	**(6.4)**		4.3	4.1		**2.0**
Non Pay	(161.6)	0.0			(0.4)	(3.5)		(0.5)	(0.4)	(0.6)	(0.5)			(167.5)	**(5.9)**		2.5	2.2		**(1.2)**
Other Finance Costs	(28.2)												0.2	(28.0)	**0.2**	7.0				**7.2**
Technical Adjustments	1.1													1.1	**0**					**0**
Surplus/ Deficit (-) to B/E Duty	**11.7**	**(10.8)**	**(3.2)**	**(1.7)**	**(2.0)**	**(3.5)**	**(0.7)**	**2.0**	**0**	**0**	**0**	**(8.3)**	**(0.2)**	**(16.7)**	**(28.4)**	**7.0**	**6.8**	**6.3**	**8.3**	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Pre PSF	**(1.0)**	**(10.8)**	**(3.2)**	**(1.7)**	**(2.0)**	**(3.5)**	**(0.7)**	**2.0**	**0**	**0**	**0**		**(0.2)**	**(21.1)**	**(20.1)**	**7.0**	**6.8**	**6.3**		**(0.0)**

Commentary

The Trust is forecasting to deliver the plan however the Trust will have to implement mitigations of £20.1m to ensure the Trust meets the control target.

The Trusts risk adjusted forecast includes the following core pressures
- CIP Delivery of £13.3m (£10.8m shortfall, mainly within Income associated with Prime Provider and Urgent Care Centre slippage)
- Divisional Pay Pressures (£3.2m)
- Non Pay pressure particularly within T&O and Diagnostics (£3.5m)
- Additional costs for agreed business cases (£2m) which includes Best Care programme and extension of AEC and Frailty service)
- Pressures associated with Winter and AEC and Frailty above planned levels (£1.7m)

The forecast assumes the Trust will receive £3m non recurrent income support (£0.7m less than planned) from West Kent CCG, KC HFT and NHSE.

Mitigations- £20.1m recovery actions will be required to be implemented, this would involve the following:
- Full Release of Contingency Reserves £6.8m.
- Increase profit on sale of assets to £10.3m, £7m better than plan.
- Divisions have been set control targets which includes £6.3m run rate reduction target, Divisions have to provide a response to the CEO and CFO by 23rd November and will then meet weekly to focus on key actions needed to improve the financial position. Divisions have been asked to specifically review three main elements: 1) Complete a detailed orecast review to ensure current forecast assumptions are valid e.g. confirmation of start dates of new starters, 2) Review Investment decisions to understand impact of stopping investment, delaying investment start date or only a partial investment and 3) Reducing Run Rate spend e.g. reduce agency and increase bank staff and additional non pay controls.

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

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

October 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	Reported	October Plan	Variance	September Reported
Property, Plant and Equipment (Fixed Assets)	288.8	290.7	(1.9)	289.5
Intangibles	2.5	2.2	0.3	2.6
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.4
Total Non-Current Assets	**292.5**	**294.1**	**(1.6)**	**293.5**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.4	8.4	(1.0)	7.3
Receivables (Debtors) - NHS	22.3	26.5	(4.2)	18.8
Receivables (Debtors) - Non-NHS	15.3	13.0	2.3	14.4
Cash	12.6	1.0	11.6	13.5
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**57.6**	**48.9**	**8.7**	**54.0**
Current Liabilities				
Payables (Creditors) - NHS	(4.9)	(4.5)	(0.4)	(4.7)
Payables (Creditors) - Non-NHS	(37.4)	(33.3)	(4.1)	(39.2)
Deferred Income	(14.8)	(11.1)	(3.7)	(12.9)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Working Capital Loan	(29.0)	(29.0)	0.0	(16.9)
Other loans	(0.1)	(0.1)	0.0	(0.1)
Borrowings - PFI	(5.0)	(5.2)	0.2	(5.0)
Provisions for Liabilities and Charges	(1.8)	(2.0)	0.2	(1.8)
Total Current Liabilities	**(95.2)**	**(87.4)**	**(7.8)**	**(82.8)**
Net Current Assets	(37.6)	(38.5)	0.9	(28.8)
Borrowings - PFI > 1yr	(189.8)	(190.1)	0.3	(190.3)
Capital Loans	(9.1)	(9.1)	0.0	(9.1)
Working Capital Facility & Revenue loans	(14.0)	(14.0)	0.0	(26.1)
Other loans	(1.3)	(1.3)	0.0	(1.3)
Provisions for Liabilities and Charges- Long term	(0.9)	(0.8)	(0.1)	(1.0)
Total Assets Employed	**39.8**	**40.3**	**(0.5)**	**36.9**
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	(197.3)	(196.8)	(0.5)	(200.2)
Total Capital & Reserves	**39.8**	**40.3**	**(0.5)**	**36.9**

Commentary:
The month 7 balance sheet position is consistent with the plan that was submitted in June. The overall working capital within the month results in a 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 cash in October in advance of the planned expectation of November.

Non-Current Assets -
Capital additions for 2018/19 have been reduced from the plan of £14.5m to £11.6m to reflect the reduction in the in year capital programme including the removal of £2.5m loan following recent notification from NHSI on capital funding, £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 £13.2m to reflect the slippage in the capital programme. The month 7 capital spend is £0.5m against a plan of £1.2m.

Current Assets -
Inventory of £7.4m is a reduction from the planned value of £8.4m. The main stock balances are pharmacy £3m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.3m.
NHS Receivables have increased from the month 6 position by £3.5m to £22.3m. Of the £22.3m reported balance, £11.7m relates to invoiced debt of which £4.1m is aged debt over 90 days. Invoiced debt over 90 days has increased slightly by £0.5m from the mth 6 reported position. The remaining £10.6m 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 increased slightly £0.9m to £15.3m from the month 6 reported position. Included within the £15.3m balance is trade invoiced debt of £2.9m 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 Trust is currently using a company called Patient Billing Ltd which are supporting the PPU department with improving the quality of invoices and debt collecting.
The cash balance of £12.6m is higher than plan of £1m by £11.6m, this is due to the Trust receiving income in October which was earlier than the plan of November. These were quarter income form Health Education England £3.3m and Quarter 3 PFI support of £2m from NHSE. As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as these pressures materialise.

Current Liabilities -
NHS payables have increased from the September's reported position by £0.2m to £4.9m. Non-NHS trade payables have decreased by £2m to £39.2m, giving a combined payables balance of £43.9m.

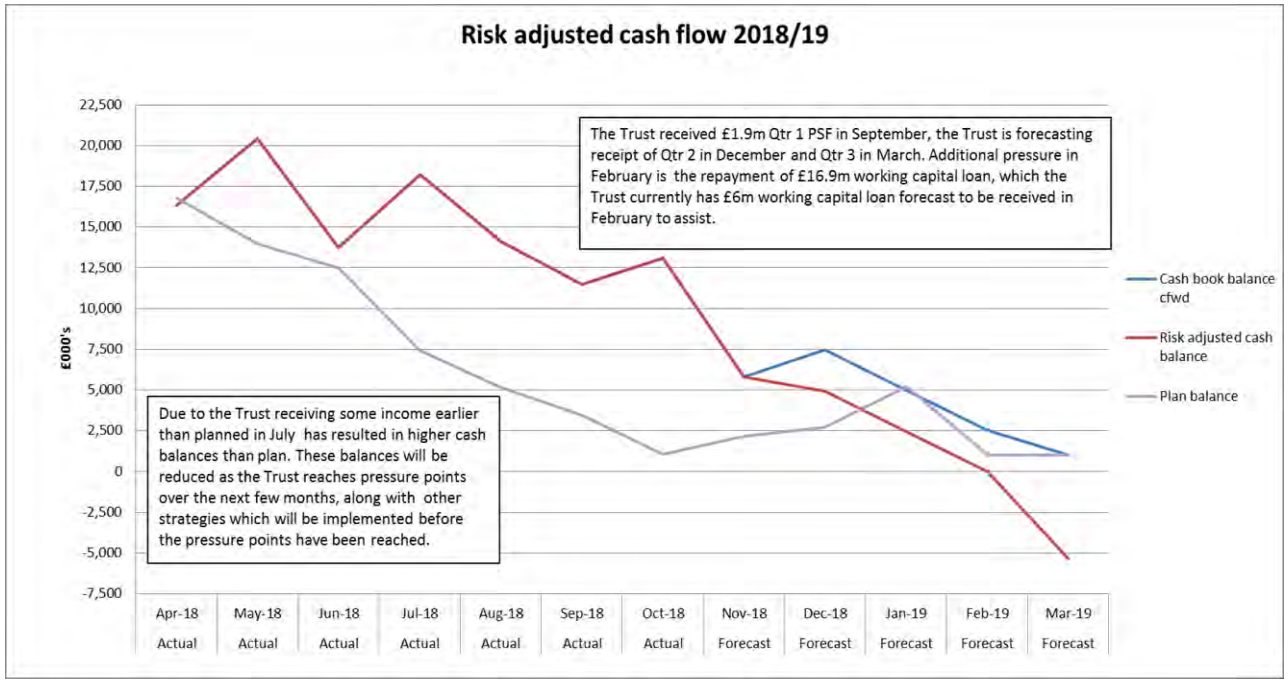
Of the £42.3m combined payables balances, £13.9m relates to actual invoices and £28.4m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments. Included within the £13.9m actual invoice are £2.8m qtrs 2 & 3 Roche Diagnostics relating to the managed service contract which have only just been issued, these will be both be paid in November.
Deferred income of £14.8m primarily is in relation to £8.2m advanced contract payment received from WK CCG in April, which reduces by £2.28m over each of the remaining 11 months. Also included within the deferred income balance is £2.2m relating to qtr 3 Health Education Income received in October and £1.3m qtr 3 PFI support both will reduce over the next two months.
Included within the £29m working capital loan are £16.9m which is repayable in February 2019 and £12.132m repayable in October 2019 (previously in long term creditors).
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 £13.990m which was taken out in 2017/18 and is repayable in 2020/21.

Capital and Reserves-
For each area within this element for month 7 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	1.50%	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%	1.414	0.10	0.00	2023/24

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 cash flow forecast reflects the actual postion up to October and the forecast is based on the revised forecast of the I&E and balance sheet position.

Due to uncertainities within the financial position the current cash flow assumes a working capital loan in February of £13m, this has increased from the planned version of £6m.

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 £13m. 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			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Forecast*	*Variance*	
	£000	£000	£000	£000	£000	£m	£m
Estates	1,775	1,580	195	5,788	5,788	0	2,253
ICT	650	307	343	1,002	1,353	351	564
Equipment	1,239	327	912	6,501	3,317	-3,184	2,447
PFI Lifecycle (IFRIC 12)	233	235	-2	471	471	0	471
Donated Assets	600	0	600	700	700	0	97
Total	**4,497**	**2,448**	**2,049**	**14,462**	**11,629**	**-2,833**	**5,832**
Less donated assets	-600	0	-600	-700	-700	0	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0	0
Contingency Against Non-Disposal							
Adjusted Total	**3,897**	**2,448**	**1,449**	**11,360**	**8,527**	**-2,833**	**5,832**

**Committed = actual Year to Date spend/accruals/purchase orders & known contractual commitments*

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 FOT is £11.6m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) NHSI have indicated that it is extremely unlikely that capital expenditure reliant on DHSC financing will not be available in 18/19 - therefore the Trust is no longer forecasting the purchase of CT scanners (£2.5m) through a potential capital loan in this year; the Trust will reserve its right to bring this back into the planning submission for 2019/20; 3) the outturn forecast for depreciation is £300k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred. The combination of these factors means that the outturn is projected to be £2.83m lower than original plan.

The Estates Backlog Maintenance programme of works is underway, with other Estates projects progressing. 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 (£300k) to support the ICT EPR project. Linac 4 replacement at Maidstone is now up and running. Linac 5 enabling work has begun, delivery of the Linac machine is due mid-December. Linac 5 replacement funding has 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 - November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-10	Detailed review of the Best Care programme (incl. 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, assurance

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW Best Care

exceptional people, outstanding care

Trust Board

November 2018

Content

1a. Executive Summary

Workstreams Update	Workstreams Update
KEY PROGRESS Best Patient flow – Hospital@Home pilot to identify eligible patients for Virtual Ward pathway started. Private Patients Day Unit proposal agreed, supported by the Nash Group. Teams continue to assess operational readiness for Prime Provider. Best Safety – Medical Productivity – joined National Wave 2 project, Trust asked to lead on national workshop based upon excellent work achieved to date and to provide feedback on national documents - e-rostering and e-john planning. Best Workforce – Recruitment schedule in progress to map reduction in temporary workforce upon forecasted substantive appointments. Divisions continue to explore and roll out new roles to offset difficult to recruitment areas. Plans in place to reduce/remove Non Framework agency usage.	**KEY PROGRESS** Best Quality – System wide dementia show and tell event scheduled. CNST – additional payment of £470k. Analysis underway of additional schemes identified in W&C Best Use of Resources - Assets Sales – PWC appointed to assist with the commercial and legal negotiation with preferred bidders.
KEY RISKS Best Patient flow – Hospital@Home readiness for 1st December, will now start at lower than planned number of patients transferred. Slow progress on Therapies project following National AHP Event. Best Safety – 7 Day service within Urgent Care constraints due to vacancies, work ongoing with the team. Best Workforce – Conversion of medical agency to bank may be impacted due to need to offer NHS pension at 14.3%. Nursing shifts requested over 6 weeks in advance behind target and dropped from previous month. Reviewing data capture working with rostering team and Chief Nurse team.	**KEY RISKS** Best Quality – establish alternative method of data collection for PJ Paralysis as current process onerous on clinical staff Best Use of Resources – Avastin = High court judgement challenges the statutory role of Medicines and Healthcare Products Regulatory Agency (MHRA) and European Medicines Agency (EMA), legal advice due end of 2018. Operational readiness plan agreed with CD, showing duration of tasks but not start dates subject to the legal advice.

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	7th Nov 2018
WORKSTREAM LEAD	Steve Orpin	PMO SUPPORT	Caroline Tsatsaklas & Toyin Falana

DESCRIPTION	MILESTONE ACTUAL (M7)	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD (M8)
		LAST MONTH	THIS MONTH	
Estate & Facilities	• CVs for potential interim project manager to work with Director of E&FM on new opportunities and deliver recovery plan currently being reviewed. • TWH LED Business Case submitted for Salix funding prior to deadline. • Operational Variations raised with PFI partner on potential energy procurement scheme at TWH. • Continued roll out of the CAFM across other directorate services • Commercial and legal documentation issued to EKHUFT for the Renal unit land rent. • Contract awarded for LED schemes at satellite sites			• Appoint project manager • Business cases for new car parks with Finance, pending agreement • Commence LED scheme works at satellite sites • Complete Operational Variation agreements with PFI on energy procurement scheme • Complete Operational Variation agreements for TWH LED scheme with PFI partner once Salix agreement received
Procurement	Overall rag rating remains amber as work on some schemes are still in progress and delivering to plan, and others have missed milestones and have been mitigated against. Currently £284K behind target of £4.2m • £54K out of £150K catering provisions contract delivered, the rest of it is in plan for delivery this month. • Delivered Patient Temperature Service contract worth £20K • Theatre consumables contract partially delivered £34K out of £43K. The rest of which will deliver in M8. • Started trailing products for orthotics service, savings of £150K in plan • Procedure packs £150K started FYE • Additional delivery of £18K for Radiology consumables, £20K on linen, £7K on patient warming. • National procurement league table released, overall MTW is in 35th position out of 136 Trusts , and on price benchmarking, MTW is in 25th position out of 136 Trusts.			• Purchased procurement analytical software which will help identify opportunities to help close gap, go live date planned for Dec2018. • Deliver the remaining of catering provisions savings. • Conduct analysis of switching supply route, to obtain cheaper products. • Deliver Endoscopy maintenance - £25K savings • Deliver the remaining of Theatre consumable contract savings.
Medicine Management	• Task and finish group to implement Avastin across the Trust now in place, group met on the 2nd Nov 2018, and main discussions were around the implications of the outcome of the judicial review and what it means for the Trust.			• Complete and finalise paper for Avastin, and develop a High level plan to Trust Board on 29th Nov and Finance & Performance Committee on the 27th Nov.
	• Joint Formulary Resource Business Case is currently being updated with numbers by finance lead. • Weekly recovery meetings still in progress. • Adalimumab – fortnightly implementation meeting with the wider STP team progressing well, implementation plan in place. JC to recalculate savings from a one off 55% reduction of Humera biosimilar in Nov, new framework starts from the 1st Dec.			• Implement Adalimumab with new contract value • Finalise Joint Formulary Business Case (agree £17K shortfall funding) and obtain execs sign off. • Dossette Boxes / MAR Chart – proposal paper completed and scheduled to be presented on the 8th Nov 2018 at the EAIC meeting.

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		This Month	Last Month	
Medicines Management.	• Subcutaneous Methotraxate – Proposal paper completed and will be presented at the EAIC on the 8th Nov 2018. • Outsourcing – meeting needs to be rescheduled due to cancellation of the last one. Financial baseline model and business case will be ready for discussions at the meeting.			• Aseptic Service – develop proposal paper for submission to NHSE (deadline moved to end of Nov) • Ethernacept – quantify savings (deadline moved to the end of Nov.) • Outsourcing - reschedule steering group meeting, make a decision on preferred option • Paed Feed – Primary Care and MTW dieticians to agree pathway, meeting scheduled for mid Nov.
AIC Diagnostics	**Pathology** **AIC** • LFT – pop up box messages agreed by clinical lead and will be added unto ICE • Feacal Calprotectin – IBD pathway finalised, whilst work on IBS pathway is still ongoing. • Direct Access Request – 18/19 request data for FBCs shows an increase in the no. of requests made between April – Aug 2018. **STP** - project has had to re-set due to lesson learnt from DVH/MFT. • Draft SOC planned completion for 2nd week in Nov. • Send away tests – Viapath initial offer rejected, requested further offer in October, meeting with CEO Viapath booked 7th and 16th Nov 2018			**Pathology** **AIC** • LFT guidance- chemistry team to work with technician in getting access on telepath by end of Nov. • Sodium – Update Guidance (deadline moved to end of Nov) • Faecal Calprotectin – update pathway to include NICE Guidance , update comment code on telepath and send out Comms, go live planned for 1st Nov. • Direct Access Request – obtain 18/19 data for all other tests requests. • Immunology – clinical lead to sign off guidance and add all agreed adjustments on Sunquest ICE, also complete an Outline Business Case for Thyroid Receptor Antibodies by end of Nov. • FIT Testing - continue to progress with work **STP –** Vision workshop - 23 Nov 2018, SOC approval – December 2018 Trust Board, OBC approval – Sept 2019, FBC approval – December 2019.
	Radiology • MRI – scoping paper still being produced, tender ongoing. • Ultrasound – Process of tender completed, subcontracting to an external provider confirmed. • I-refer up and running • NG12 uptake audit completed on the 19th Oct 2018, and shows about 388 NG 12 forms used at both sites between Apr – Oct 2018. • Direct Access Requests – data obtained for ultrasound, guided injections and Virtual Colonoscopy all shows activities have gone up between April 2018 – Oct, 382 for CT and 34 VCs, VCs have significantly gone up. • Electronic Results –plan in place to resolve ongoing issues , go live planned for 1week in December. • Obstetric Scanning – Go live delayed till January due to issues with GDPR.			**Radiology** • Internal demand - meeting with A&E consultants will be rescheduled due to cancellation from A&E. (deadline moved to the end Nov) • NG12 – continue to monitor demand • Ultrasound – CCG to contact top 10 users by the 2nd week of Nov. • Direct Access Requests – send data to practices and reiterate screening process information through comms by the 30th Nov 2018.

Non Recurrent Savings / Financial Mitigation Schemes				
Contingency Reserve	£3.4m of reserve already in use YTD, in line with forecast			Hold money until the need arises for use. (£2.3m left).
Assets Sales	• Springwood – Tenders evaluated and recommendations made to Trust Board 25TH Oct • High Street – Tenders evaluated and recommendations made to Trust Board 25th Oct • Due diligence works have commenced on bidders with highest offers. • Finance appointed PWC to provide guidance on accounting for sale			Finance to confirm outcome from work by PWC, in order to proceed to full commercial and legal negotiation with preferred bidders.
West Kent CCG Income	Confirmation of a £3m savings from the CCG.			Prepare a three way paper (CCG/MTW/KCHFT) to set out a case for accessing.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE last reviewed	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.	11/18		
Procurement - Slippage on STP work plan - issues with confirming projects start date and leads Difficulties with analysing data due to different systems amongst the Trusts.	Discuss issue at group meetings . Supply chain has agreed do all the analytical work and supply data.	11/18		
Outcome of judicial process in September 2018 went in in favour of CCGs involved, but there may be other factors that may prevent / delay the implementation of Avastin and any planned savings.	Await MHRA national advice around medicines law which is expected within the next few weeks, this will determine the next steps to take. Also Trust Legal team to clarify the professional indemnity implications of the outcomes especially for Pharmacy and clinicians.	11/18		
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.	07/18		

CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
Develop paper and high level plan for Avastin.	11/18	On Track		
Finalise Joint Formulary Business Case	11/18	On Track		
Implement Adalimumab	12/18	On Track		
Agree Preferred option for Outsourcing	11/18	On Track		
Agree a pathway for paediatric feed.	11/18	On Track		
Quantify Ethernacept savings	10/18	Delayed but mitigated		
Finalise Business Case for car parks	11/18	On Track		
Confirm outcome from work by PWC	11/18	On Track		
Appoint E&FM Project manager	11/18	On Track		
Viapath Offer Meeting	11/18	On Track		

KPIS	Target	LAST MONTH	THIS MONTH
Number of tenders completed each month	13	9	13
National metrics - % of spend under a catalogue	80	96.8	96
% of spend under a purchase order	80	75.5	75

Finance Narrative

Month 7 Delivery

Delivery - £568K

Variance - £683K

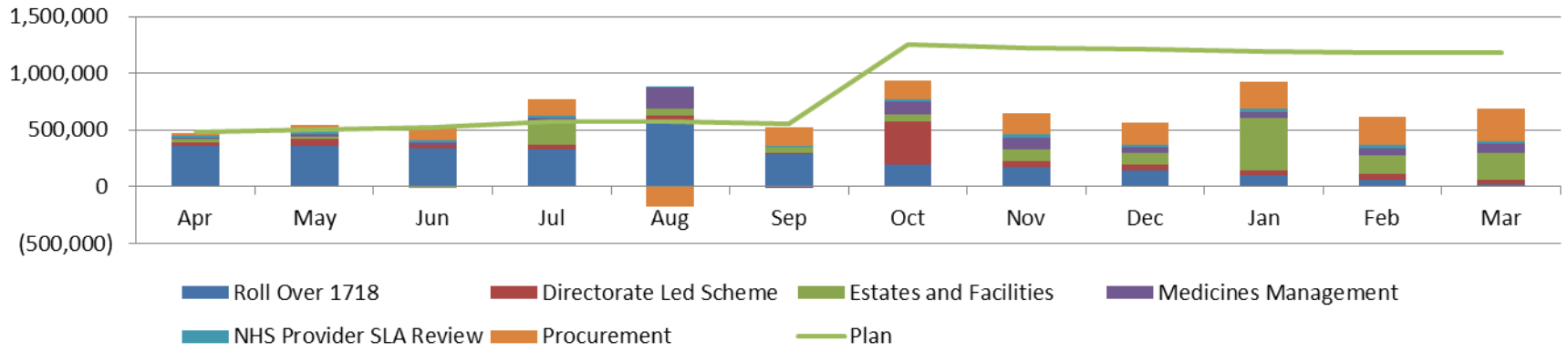
Key Drivers behind the adverse position are:

EFM - £300K (E&F Change and NEPTS),

Medicines Management - £176K (Avastin, Stretch Target although these are offset by growth avoidance)

Procurement - £174K (Stretch Target)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Roll Over 1718	362,105	357,275	337,632	324,483	573,617	290,388	191,061	179,624	146,787	101,328	64,958	18,738	2,947,997
Directorate Led Scheme	31,970	66,778	36,408	50,128	54,009	5,326	18,897	46,456	46,456	44,856	44,856	44,856	490,996
Estates and Facilities	23,083	23,083	-11,417	183,393	62,628	49,310	55,109	103,628	103,629	456,528	166,070	239,071	1,454,116
Medicines Management	17,633	17,264	17,553	44,246	182,380	-2,221	112,728	104,927	49,334	58,053	66,760	75,479	744,136
NHS Provider SLA Review	13,833	15,250	15,250	27,645	14,479	14,479	25,645	25,645	25,645	25,645	25,645	25,645	254,807
Procurement	26,222	70,291	131,120	144,131	-172,752	162,500	165,041	188,003	197,753	239,420	245,670	282,878	1,680,276
Plan	478,343	499,430	528,168	574,543	575,478	550,883	1,251,693	1,226,511	1,216,516	1,195,557	1,184,127	1,178,088	



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:

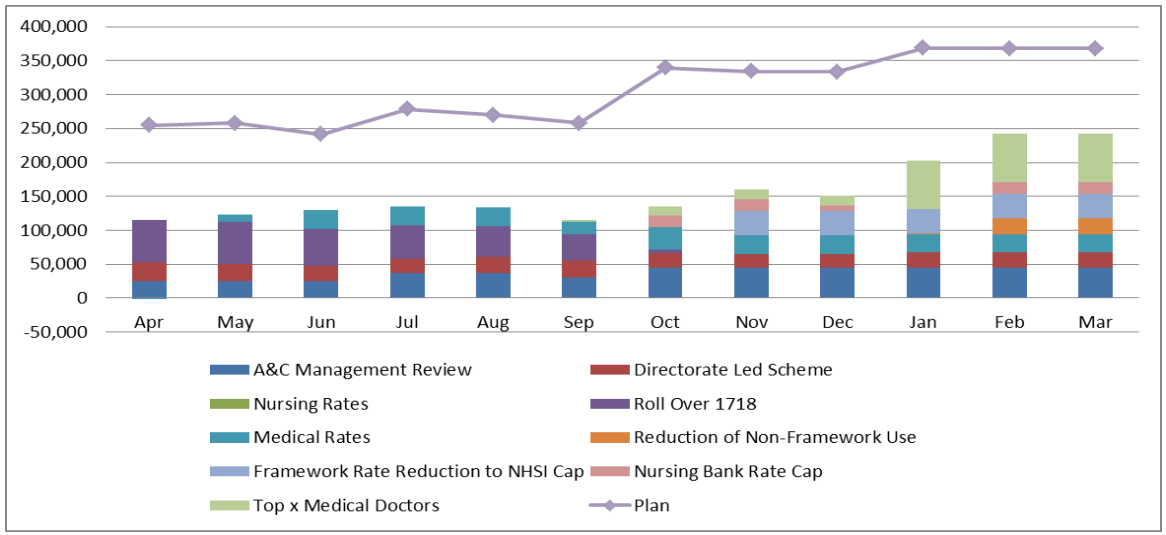
- **Recruitment**
- **Temporary Staffing**
- **New Roles and Apprenticeships**
- **Workforce Productivity**

WORKSTREAM	Best Workforce	BEST CARE BOARD DATE	November 2018
WORKSTREAM LEAD	Simon Hart/Tracey Karlsson	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	• Best Workforce revised structure / governance proposals authorised by the October Best Workforce Board and implemented. • Medical Led Authorisation Group Terms of Reference agreed. Priorities agreed as cleansing the medical recruitment pipeline, moving medical locums from agency, and standardising medical bank rates. • Paul Sigston meeting with CDs on 7th November 2018 to facilitate further engagement with temporary staffing control requirements. • 14 bank locums going through recruitment checks (subsequent to the 18 agency workers identified). Three started in October 2018. • Appointed 4 x Tier 1 Agencies with a further rate reduction effective 5th November 2018. • Contracts issued to Tier 2 & Tier 3 Agencies effective 12th November 2018. • Both of the above rate reductions aim to ensure that all nursing shifts are at or below cap by 1st December 2018. • Ambition ad-hoc bookings ceased with effect from 5th November 2018, leaving 13 regular Ambition workers. CNMT to agree exit strategy at 8th November 2018 meeting.			• Paul Sigston has proposed review on a case by case basis in relation to agency locums not accepting offers. • Paul Sigston to start conversations with initial nine locums. • CDs to determine standard set of medical locum bank rates. • Longer term plan to be completed in December 2018 to meet STP break glass rates. • CNMT monitoring as part of monthly reporting to ensure agency reduction. • Updates required from HRBP's relating to medical locum bank shifts. • Complete Deep Dive of non standard offers.
New Roles and Apprentice-ships	• As at 5 Nov, 76 apprenticeships enrolled on programme. The figure for apprentices has gone down as we have had some completers. These signed up in previous levy year so do not affect the KPI, which has improved. • 3 Physician Associates now working in T&O with 5 more due to start in other areas this financial year. This is an increase from 1 to 8. • 18 Trainee Nursing Associates are due to start apprenticeships on 03/12/2018. • First Medical Workforce Working Group met that will focus on trust-wide implementation of Physician Associates, Medical Training Initiative Fellowships and Dr Assistants. • Working Groups for Advance Clinical Practitioner and Apprenticeship Administrator to meet in November.			• Working Groups to complete plans. 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. • Potentially 5 more Physician Associates due to start subject to exam results. A further 2 more out for advert – Haematology and Paediatrics. 2 PA Students on placements in the Trust – previously in Medicine returning next week to commence placement in Emergency Medicine • Determine KPI for spread across MTW of new roles and apprenticeships.
Directorate CIPs	• Delivery of directed CIP schemes currently reporting £533K at risk of delivery. PMO Team met to agree approach in order to determine how best to identify further CIPs.			• FMs at directorate meetings to review CIPs and determine plans to deliver or identify new CIPs. • PMO Leads to also work together to review CIPs. • Finalise and distribute Deep Dive review of Vacancy Removal report.
E-Rostering	• Revision of existing e-Rostering templates now included within CNMT meetings.. • Complete review of e-Rostering practice / governance with a focus on hours balances / roster approval and finalisation commenced with contract review / benefits realisation meeting scheduled with Allocate for 7th November 2018. • Monitoring of finalisation for payroll has highlighted increased HR validation. Options appraisal to be submitted to November 2018 E-Rostering Project Board.			• Draft business case to be completed for single rostering system. • Roster challenge meetings to commence with matrons. • Complete roster performance training to matrons by 30th November 2018. • Confirmation of successful completion of Phase 2 rollout of Allocate. • Full Allocate system evaluation / summary of benefits achieved to date.
Recruitment	• Further meeting with Clearmedi scheduled for 22nd November 2018. • Medical Recruitment KPIs shared on 6th November 2018. Further meeting to take place by 9th November 2018 with PMO to identify priorities and validate current status . • Medical task and finish group to meet on 19th November 2018 to progress actions.			• HRBPs to review medical recruitment pipeline with GMs and report any anomalies. • HRBPs to determine vacancies and ensure that medical locum usage is against budgeted establishment. • Deliver identified improvements within medical recruitment.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE - £341k saving target for Q1 was not achieved. This has put at risk the £2m of identified STP savings. Personalised plans to mitigate the original unachieved savings may not deliver additional savings.	Medical Led Authorisation Group Terms of Reference and priorities agreed. Group to make decisions on any agency locums not accepting offers / personalised plans and to identify further savings.	May-18		
ISSUE - Agencies are not providing quality CVs at a reduced rate.	Medical Led Authorisation Group ToR to include agency challenge.	Aug-18		
ISSUE – Transparent and robust information not available on medical vacancies / gaps due to multiple rostering systems and approaches.	Business case to be completed for single rostering system by 30/11/18. PMO launched recruitment project with full review of medical recruitment activity, roles, responsibilities and timelines, identifying quick wins.	Oct-18		
RISK – If bank rates were to be reduced to align to STP Q2 rates, directorates including ED, H&N, Paeds, Obs & Gynae will have difficulty ensuring safe fill rates.	Grow Our Bank recommended proposal now to involve a multistep approach that is to be determined with CDs input. First step is to move agency locums to bank without fee. Longer term plan needed on stepping down all rates across STP. Finance to recalculate proposed savings ensuring all on-costs included.	Oct-18		
RISK - Potential for apprenticeships levy not to be used. Spend for 03/18-04/19 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. 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	
Public Sector Target for workforce on Apprenticeships Apr 18 to Mar 19	2.30%	0.78%	0.94%	↑
Medical				
Medical Shifts Requested		2,166	2,580	↑
Percentage of Medical agency shifts over STP break glass rates	0%	94.8%	94.5%	↓
Percentage of Medical shifts requested more than 6 weeks in advance	> 80%	6.1%	16.7%	↑
Percentage of Medical shifts requested Retrospectively	< 5%	25.5%	24.4%	↓
% Medical Shifts covered by bank workers	> 70%	43.5%	39.2%	↓
% Medical Shifts covered by Framework agency workers	< 24%	38.3%	32.6%	↓
% Medical Shifts covered by Non-Framework agency workers	< 1%	1.0%	0.7%	↓
% Medical Shifts Unfilled	< 5%	17.3%	27.5%	↑
Nursing				
Nursing Shifts Requested		5,699	5,245	↓
Percentage of Nursing agency shifts over NHSI Caps	0%	37.5%	42.6%	↑
Percentage of Nursing shifts requested over 6 weeks in advance	> 80%	30.7%	19.0%	↓
Percentage of Nursing shifts requested Retrospectively	< 5%	6.3%	8.7%	↑
% Nursing Shifts covered by bank workers	> 70%	42.5%	48.9%	↑
% Nursing Shifts covered by Framework agency workers	< 24%	33.7%	39.2%	↑
% Nursing Shifts covered by Non-Framework agency workers	< 1%	3.5%	4.2%	↑
% Nursing Shifts Unfilled	< 5%	20.3%	11.8%	↓
Average roster performance score for ALL nursing areas	> 85%	71.10%	70.96%	↓

FINANCE NARRATIVE

Year to Date

The Best Workforce achievement to date is £888k against a plan of £1.9m. The shortfall of £1m is largely within the STP Medical rate CIP underachievement (£826k).

The key achieving CIP in Months 1 – 7 are the 2017/18 Roll Over schemes reporting 36% of the workstream.

Forecast Position

The Best Workforce schemes are forecasting year end achievement of £1.9m against the target of £3.7m and therefore forecasting a year end shortfall of £1.8m.

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 (elective and non elective)	BEST CARE BOARD DATE	Nov
WORKSTREAM LEAD	Angela Gallagher	PMO SUPPORT	Fiona Redman / Sarah Smith/ Caroline Tzsatsaklas

DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH and AIC Frailty	Allscripts frailty flag developed / training complete on medical wards both sites. Working with CCG and KCHFT to share Comprehensive Geriatric Assessment (CGA). IT developing short term solution using 'Docman' to recognise CGA and filing in patient CPMS record. Darzi fellow application successful to set up interface geriatrics model following joint application from MTW/ WKCCG/ KCHFT. New MAFU coding in place using subspecialty of Frailty for those receiving frailty input. System tested and built. Agreement to use Rockwood score across KCHFT and MTW. Frailty nurse DVH visit complete. Action plan in place			Meet with SECAMB to develop direct admission to Frailty unit at TW. Developing new CGA within CPMS working with CCG. Part A community; Part B acute. Darzi Fellow – MTW to be linked with similar projects within Kent and Sussex plus fellow and sponsor matching 12-14 Dec. Develop project governance and agree funding. Following introduction of subspecialty of Frailty, accurate data expected from week of 10th Dec. Recruitment of agency staff to support 12 hour/ 7 days for Frailty unit at TW pending approval of business case at Finance Committee end Nov. Review of readmissions (10 plus admissions over last calendar year) to identify themes and improved referral to virtual MDT.
Out of Hospital Capacity :	Virtual Ward (rebranded as Hospital@Home) - Governance structure in place. Clinical Coordinators appointed (one from MTW, one from KCHFT)-will work with Divisions and clinicians to ensure that pathways in place. Clinical leads appointed for Urgent and Planned Care. Discussions underway between SLA teams KCHFT and MTW along with Finance. Working with CHC on possible escalation to default to Rapid Response (Fast Track patients) if sufficient recruitment in place Home First project data analysis underway Stranded patient meeting with LOS work stream – to streamline review i.e. Red NQ (non qualified) patients will be dealt with by Matrons, Green Q (qualified) patients dealt with by MDT. Health and housing project TW -has been unable to progress due to closure of TAFU			Use of CUR to review stranded and super stranded patients. Meeting in place with external partners to deliver NOF pathway from early Jan 19. In discussion with E Sussex commissioners regarding Pway 3 equivalent services from Dec 18. Virtual ward Exec prog board to take place on 5/11. Virtual ward aim to trial 1 patient through the process from mid Nov and go live Dec 1st with agreed KPIs across all organisations. Virtual ward OP policy to be approved at implementation and delivery board 22/11/18. VW Governance to be discussed at MTW Quality Committee 14/11
Length of Stay Increased number of 0 LOS	Red2Green campaign planned with Comms from 5/11: 5 day campaign to roll out S-A-F-E-R each day and Red/ Green and Virtual Ward. Training with MH Flow Coordinators to embed CUR report running plus use of CUR at Board Rounds (Pye, Mercer, Stroke, John Day) complete by 2.11 Discharge Bag in place on all wards Access to N drive for all Flow Coordinators for the daily filing of the CUR reports to ensure all appropriate people have access to the reports Box for Discharge Lounge on CUR			5 day campaign for rollout of SAFER and R2G to start Mon 19.11.18 – delayed due to priorities within Comms to 19/11 Training with TW Flow Coordinators to embed CUR report running (Spec Med wards) to be complete by 16.11 CUR feed from The Oak Group to Beautiful Information set up in order to use CUR on Smarties at 1pm bed meeting with top 5 diagnostic delays by last week Nov, with all Matrons/GMs/AGMs to have access to Smarties to access daily CUR feed Daily reports run by Flow Coordinators by 10am and saved in Excel spreadsheet on N drive on daily basis. Box for Hospital@Home (Virtual Ward) and suitable for CLD to go on CUR.CUR software update to be agreed with MTW IT in order to improve reporting by 16.11 Joint working with clinicians to improve EDN completion led by Laurence Maiden Matrons to ensure all LOS data (October data) available on ward from 10.11.18 in hard copy. Criteria led discharge – work with triumvirates and link to Best Quality workstream
Therapies	Audit completed against therapy representation at Board Rounds – highlights good representation. 'Sara Stedy' agreed as standard Trust equipment and Therapy teams working with nursing leads to ensure funding identified for key areas. NHSI AHP improving Flow Collaborative project concluded 16.10.18 with presentation in Manchester. Report to be submitted to Exec Lead (Chief Nurse) by 23.11 and to CNMT for review of recommendations. Early OT intervention established on all wards TDI (information system) relaunched on 1.1..18 – currently being validated.			Therapies Directorate to cross to new Division but to continue to deliver against Best Flow. Explore development of new roles within ward workforce. Continue to embed TDI and development of performance reports Identify plan for next 3 – 6 months
AEC	Task and finish group set up with KCHFT/ WKCCG to push out planned ambulatory patients to Tonbridge Cottage from 2.1.19 Continue to work with other specialties to agree exclusion criteria for non Medicine AEC patients, i.e. Surgery, T&O, ENT Business case submitted to increase hours for AEC Embedding of ENP team in AEC Attendance at "Maximising Ambulatory" conference by lead ENP and AMU consultant to allow project to be clinically led. Audit to count planned ambulatory patients complete			CCG to agree funding to support planned ambulatory clinic for KCHFT Review of impact on planned ambulatory to MTW by Contracts/ BI/ Coding/ Finance. Recruit to staffing posts on AEC TW for 7 days 7 – 8 pending approval by Finance Committee Surgery exclusion criteria to be agreed by 16.11. Date to be agreed with T&O and ENT Develop vision for Emergency Floor (long term plan) Ensure diagnostics available for AEC in same timescale as ED to allow direct access to self presenters / GP referrals to AEC

WORKSTREAM	Best Patient Flow (elective and non elective)	BEST CARE BOARD DATE	Nov 2018
WORKSTREAM LEAD	Angela Gallagher	PMO SUPPORT	Fiona Redman / Sarah Smith

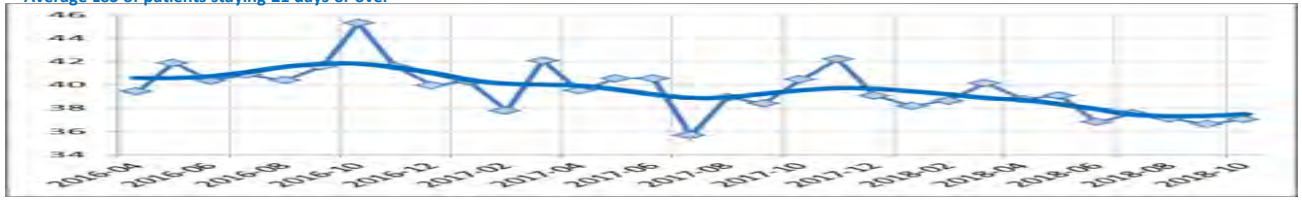
DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Non-Elective Surgical LOS	- Fine-tuning hot chole pathway including job planning. - Nurse Led Discharge the teams are linking in with the corporate nursing team project for a more robust embedment. - Reviewed BADS data for possible improvements to patient pathways. - Continue enhanced care pathways for TKR/THR patients on Ward 30 – commenced Sept 18. - Continue with red:green days to identify root causes of discharge delays - Virtual ward patient presentation list completed and sent to the project group. - Executive report completed on NEL LOS for surgery and submitted.			- Implement virtual ward as directed by the virtual ward project group. - Continue nurse endoscopy training programme. - Complete surgery/ T&O AEC actions as above. - MRCP pathway and comms strategy to be completed. - Undertake another audit for enhanced care pathway.
Increase in private activity	- Adverts for nursing staff have gone out and been shortlisted. Interview date is 16/11 and 19/11. - Business manager appointed. Starting date 15th December- - Finalised move including pharmacy and basic stock. - Identified feasibility of adding a kitchenette/shower facilities. - Have a discussion with Basildon re: NASH group to consider commercial support. - Feasibility paper drafted for inpatient rooms to be added in the PPDU			- Appoint nursing staff in order to commence day case activity - Hold an open day for consultants to visit the unit. - Clarify the ventilation levels in the ultrasound room to consider differing treatments that can be undertaken. - Submit paper to the executives on options for the PPDU. - Transform the PPDU into a more 'private experience' including décor/ furniture.
Prime Provider	- Clarified quality measures for outsourcing in relation to concerns raised at the steering group. - Held working groups to finalise operational plans and financial mitigations. - Meetings held to develop an electronic patient tracker. - Prepared for patients to be outsourced on 1st November – Prime provider business unit has been set up and notes pulled for the first patients. - Recruiting for prime provider general manager, interviews 16/11/18. - Identified estates location for business unit; equipment and IT installed ready for staff appointment.			- Financial and operational modelling of 'lot 2' - Alternative solution for electronic tracker identified and implemented by 1/12/2018 - Undertake deep dives into N:FU and RATC impact and include within the operational plan. - Continue through mobilisation plan.
Operational Productivity	- POA processes adapted to avoid unnecessary POA appointments. Being piloted in urology. - Phase 2 text messaging service has gone live - MRSA (extended screen) pilot has commenced. - Finalised the voice recognition business case in light of potential STP funding. - Transformation managers have commenced . - Theatre list sign offs have been brought forwards having a positive impact on theatre turnaround times. - Roll out of smartcard. - Identified a plan to take ophthalmology cases out of short stay theatres in order to further release dedicated capacity over winter for other elective cases.			- Approval of the GRS business case - Phase 2 text messaging service for admissions to go live - Approval of the voice recognition business case - Roll out a 6-week rolling meeting looking at outpatient and theatre scheduling. - Locum surgeon to undertake Monday am sessions to improve MOU utilisation - CAU effectiveness informal review by transformation managers to identify areas for improved productivity.
Outpatient Transformation	OPT - Benefit summary development for EAIC Group submission 8/11/18. H&N and T&O validation updates 5/11/18• E-Referral - 100% Paperless target Oct 2018 - NHS digital agreed as achieved and fax lines closed. ASI rate reduction recovery plan completed and target achieved - monitoring process in place. •2x Band 8a OPT Managers commence roles 29/10/18 and 2 x Band 7 OPT Managers commence roles from 8/11/18 •Pain Team noted 50% reduction achievement of activity due to MSK. •Initial Charcot pathway review held 17/10/18 with mapping cascaded to clinical leads for input. •W&C commenced a trial of triage system w/c 1/10/18 and Myosure meeting held 23/10/18 re: options to move from day case to outpatient. •H&N validation of waiting list and triage to Borough Green continued to plan. •Validation of waiting list by T@O department following implementation commenced. •Cardiology Kinesis service, TW had 20 referrals with 100% target responded within 2 working days; MS had 14 referrals with 93% responded with 2 working days. GPwSI expansion for TW patch agreed/anticipated start date after training 09/19. Expansion of TW Direct access subject to funding agreements agreed and next steps confirmed. •Opthal Failsafe Officer attended to validation of waiting list of 5534 patients. Currently 4000 patients reviewed with 350 patients so far discharged as of 17/10/18. Sample validation completed of patients seen in 07/18 within 25% of their target date, by taking 1/5 patients completed 17/10/18. BI team confirmed 82% (401) of patients were seen within 25% of their target date.			E-Referral - Continue internal validity audit of paper referrals + smartcard rollout/training. IT to establish/verify fax closure savings. Internal SOP sign off 13/11/18. Prepare for programme closure/ business as usual conversion end 11/18. Develop respiratory business case admin validator band 3/4. Review respiratory telephone triage service/next steps. Develop charcot pathway/next steps/project team creation 7/11/18. Scope skype use all specialities. Review outcome of triaging to reduce 2WW in W&C and Myosure outcome/next steps. Review UGI CNS validation re: impact on waiting list and 2WW. Review progress made on LGI and breast triage pathways. Cardiology Sprint - Kinesis data review/clinician work to improve % at MD and GPwSI training programme CCG agreement/implement by end 11/18. CCG develop expansion business case, MTW review current echo activity levels, agree echo clinic implementation date 20/11/18. Opthamology – Review patients from waiting list audit that require appointments then booking process.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Due to lack of confirmation of Prime Provider, it is likely that this route will not deliver the savings.	Exec level communication to push forward. Consideration of "black" schemes to fill gap.	9/3/18		
There is a risk that teams cannot recruit to posts due to national recruitment shortages and lead time.	Working with Best Workforce to develop smarter recruitment campaigns	9/3/18		
Releasing internal capacity to undertake additional Prime provider work.	Operational Productivity project underway. Theatre trans. Manager in post. Outpatient/CAU trans. Managers to commence Oct/Nov.	08/10/18		
Private patient service staff recruitment process causing delays In the opportunity and therefore impacting on overall financial contribution.	Management teams to approach the Housden group to help support the service in the interim.	16/10/18	NEW	
Clinical admin teams have some vacancies or training needs causing ineffective booking of inpatients/ day cases. This can affect operational productivity.	Repeated RTT training underway. Vacancies are being appointed to. Outpatient and CAU transformation managers commenced work in order to help processes to improve efficiencies.		NEW	
Internal standards for turnaround time for Diagnostics is different in ED to AEC which is stopping direct admission to AEC.	Working with Radiology to remedy.	6/11/18	NEW	
The financial plan is based upon assumptions that LOS will maintain its level and that AEC/frailty will be funded for 7 days.	A decision of what staff is going to be substantially funded for the frailty/ AEC 7 day service. Approval for funding for 7 day services at TWH for frailty / AEC			
Theatre transformation manager resource currently assisting the operational teams du e to staffing pressures.; potentially impacting transformational work.	There are weekly 1:1 meetings with the ADO to optimise the situation. Staff member is still in post.	09/11/18	NEW	
Completion of EDNS not completed as a day before action-impacting on LOS	Escalated to CD Laurence Maiden-for review of process		NEW	
The continued use of AFUs as escalation areas will impact on unit performance and flow	Monitor site performance and compare MH 5 day service to TWH 7 day service		NEW	

Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
Fit for purpose coding and data collection in place for AFUs	30/06/2018	75%		
Appoint staff and implement 8 – 8/ 7 days a week AEC unit at TW	01/12/2018		NEW	
Rollout of Red and Green days within CUR	31/08/18	75%		
Recruit to posts to support increased opening hours of TW AFU	13/11/18		NEW	
Hospital at Home (virtual ward) Go Live 1/12 with agreed bed base	13/11/18			
Commence PP additional activity in EGAU	15/08/2018	0% PPU acquired		
Award of CCG tender for prime provider	31/08/2018	50%		
Achieve 100% opportunity (c. 95% utilisation) within theatres creating capacity for prime provider (stepped increase)	01/10/2018	w/c 29.09.18: 85% all specialities. T&O 90%		
Receive income from Prime Provider (primarily from outsourcing) in August 2018	01/08/2018	0		
Creation of Therapies 3-6 month plan to support improved flow	13/11/2018		NEW	
CCG agreement of funding to support planned ambulatory hub at Tonbridge cottage	13/11/2018		NEW	

KPIS	Target	LAST MONTH	THIS MONTH
NE LOS Medical	7.6	7.3	7.7
NE LOS Surgery	5.5	5.2	5.2
NE LOS T&O	10.3	10.5	11.5
Achieve or exceed DTOC target (%) ***Estimate only as actual figure not yet available.** The counting methodology has changed which means the new & old figures are not entirely comparable.*	3.5	**5.9%***	4.5%*
Theatre Utilisation for Prime Provider (%) Step up KPI to 100 opportunity (95%) utilisation	95	82 T&O = 89	85 T&O= 90
Outpatients DNA Target (new)	5%	Aug: 6.1%	Sept 5.6%
Cancellations on the Day (theatres) 2 way SMS to be rolled out End Nov 18	5%	9.1	10.3

Average LoS of patients staying 21 days or over



2. Workstream Summary

Maidstone and Tunbridge Wells NHS Trust

2d.Best Quality

The Best Quality worksteam 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	November 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Roose /Hannah Pearson

PROJECT	MILESTONE ACTUAL	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Overarching	• Joint Best Safety and Best Quality Meeting to discuss key projects and issues which overlap both workstreams. • Addition of Patients' own drugs (time critical medicines) to be captured within this workstream following on from BS / BQ joint meeting			
Complex Needs	**Dementia** • Ongoing audit of patients admitted from Nursing and Residential Homes to ascertain any frequent admissions. • Proposal for nurse-led clinic presented at September Best Quality Board. • Attended Dementia Clinical Pathway review work-stream meeting 19/10/18. • Still awaiting information re executive lead. • Work pressures for emergency services representatives meant unable to attend meeting. • Awaiting date for AIC Show and Tell event.	A	A	**Dementia** • 2nd Emergency Services round table meeting 4/12/18.
	Transition • Job description for Transition Nurse going to Agenda for Change for banding, this will determine the length of time for which the nurse will be in post. • Business case for care of 16 & 17 years olds with diabetes within paediatrics rather than transferring to adult services (tariff available for care within paediatrics) in development. Work with Adult Diabetes services underway to identify feasibility and potential benefits –quality and financial. • Site office staff trained in Level 3 safeguarding Training to ensure that someone is on site at all times to provide support. • Numbers reviewed for 16/17 year olds in adult areas for August 18, training targeted to these areas.	A	A	**Transition** • Minor delay in recruiting to Transition Coordinator post -Post needing to be grade evaluated before recruitment. • Transition Coordinator post to be advertised and shortlisted • Level 3 Safeguarding Training continues to be delivered • Policy for care of 16&17 year olds on adults wards being drafted • Ramping up of awareness raising and relationship development with adult wards • November Meeting to focus on Diabetes and the Best Practice Tariff which could generate some income • Relaunch in January meeting – with Corporate Nursing representation to gain Adult nursing engagement
Experience and Engagement	**PPEE** • Planned engagement and listening event with patients and vol sector partners took place on 12th October at Camden Centre, Tunbridge Wells. Agreement to second co-design event in November • Insight gathered at events written up and shared with participants as drafts for wider discussion and development within networks. • Preparation for 2nd co design events in November • NHSi Always Events project being aligned with Patient and public engagement events	G	G	**PPEE** • Second engagement events take place on 24 and 29 November at Ditton Community Centre and Camden Centre. Focus on co designing improvements prioritised by patients , carers and vol sector participants. • Agreement about how continue working with patients, carers and vol sector partners in development of patient experience and engagement strategies and improvement programmes • Development of business plans for securing continuity and sustainability of patient engagement and experience activity.
	Staff Experience and Engagement • Difficulty with attendance for Staff Engagement events • 1st staff outreach engagemetn event took place 05/01/2018 –at TWH discharge lounge, radiology, outpatients and opthalmology • More outreach engagement dates to engage with staff in workplaces takes planned	G	G	**Staff Experience and Engagement** • Plans for other engagement outreach at other sites and dates agreed, plans to target areas such as CAU's, radiology • Bullying & Harassment Awareness sessions to be produced • Bullying & Harassment poster campaign to be produced • Medical Engagement to be reviewed and updated • LiA pulse check action plans to be created
Quality Improvement	**Quality Improvement Committee** • Majority of 2018 should do's now reporting as green as plans are in place to address issues • Some SD's also showing as 'blue' complete and embedded • Internal assurance inspections continue to provide focus for Quality improvement committee discussions • In progress Pulling together 'key areas of focus' aligned to KLOE's to move MTW to Good and Outstanding.	G	G	• November QIC provides detailed discussion on 4 SD actions which the team need • Detailed plan in place with Trust employees who have had experience as CQC Specialist Advisors and Corporate nursing team will pull together a paper to describe key focus for moving the organisation to 'good' and ultimately 'outstanding'. • Launch of Quality strategy along with QSIR Methodology for completeness • Unannounced inspection Cascade update • Emphasis on ensuring Lead attend or appoint a deputy so that all areas are represented at the QIC.

Effectiveness and Excellence	**Maternity Safer Births / CNST** • November BQ Board discussion about performance against existing criteria and proposed new stretch scheme delayed until November BQ Board • Assurance received that performance against existing 10 criteria has been maintained in first two quarters of 2018/19 . –one risk identified however maternity team aware and plans in place. • Still awaiting further information from NHS Resolution about detail of new scheme 'stretch criteria' and any further monies coming to MTW as a result of the conclusion of the maternity incentive scheme appeals.	G	G	**Maternity Safer Births / CNST** • Maintenance of performance against existing 10 criteria and preparation for publication of stretch criteria and development of action plan • Additional rebate received of £470k against the Better Births 10 step criteria
	Crowborough • Agreement reached regarding adjustments to planned building works • Sufficient funding obtained from additional monies from Friends of CBC and 10K MTW contribution. • Now able to award tender to contractor within next week • Further discussions re closure, this is unlikely to be the preferred option due to loss of momentum for activity • Marketing - Video clips of women have now been filmed and awaiting editing for website • Slight delay in awarding tender due to confirmation of finance agreement/decisions. -Awaiting written confirmation of additional funding prior to awarding the tender	A	A	**Crowborough** • Contractors to survey site and plan actual start date once tender awarded • Once plans available review feasibility of remaining open during entire project • Ascertain any potential disruption to services i.e. water being turned off • Communications- Preparation of information for women due to deliver regarding impact of building work on them • Ensure community midwives are well informed regarding plan • Video clips edited and placed on MTW Maternity website • Further comms meeting planned between potential for more use of social media in order to promote out of hospital births generally with a focus on Crowborough during refurbishment works • Consider additional fund raising for environment improvements not covered by refurbishment funds
	CQUINS: • Submission of CQUIN evidence for National & Specialist CQUINS for Quarter 2 • Pathways live for Smoking assessment	A	G	**CQUINS** • Alcohol pathway is yet to be finalised and launched. • Compliance and awareness of Sepsis pathway remains of concern with clinical teams. • Interface issues between MTW and CGL for alcohol referral • Rollout of Risky Behaviours pathway of referral • Development of CQUIN Dashboard for future submissions.
	#EndPJParalysis: • Tally chart devised to capture KPI's / engagement data • Ideas for competition's • Identified next PJ week & cake sale • Sustainability model sent out to all members of the group • W30/31 will roll out project during PJ week 10.12.18	G	G	**#EndPJParalysis** • Discuss project at NMAHPSG to gain ideas for dementia patients and going forward with project / new ideas • Signage / banners not obtained to promote the campaign • Next PJ w/c 10.12.18 all staff encouraged to come to work in xmas PJ's • Cake sale both sites on 27.11.18 to generate some monies towards activities for patients. • Christmas activities across all wards • Initiate gathering of engagement data / KPI's across the board • Introduce competitions for wards with published data – rewarded with tea party for winner • Red bag scheme initiative – to support project • Purchasing of items for volunteers to use with patients (xmas themed) • Asking larger supermarket chains if we can be considered for the green token scheme
	Criteria led discharge: • MTW has registered with NHSi to take part in the next cohort of the Criteria Led Discharge Improvement Collaborative. • Project team identified but to be finalised. • Gynae surgical clinical leads put forward by Sarah Flint as clinical leads – still to agree who will formally take on the role • Liaise with Jo Hockley who is working on nurse led discharge with diabetes team and hoping to trial it on 2 wards. Documentation has not yet been produced. • MTW attended first event which took place on 24th October to discuss data collection	A	A	**Criteria Led Discharge** • Inaugural project group meeting to be set up following inaugural NHSi Event.
	Pressure Sores: • Pressure Ulcer Policy under review to fit in line with new NHSi Definition and Measurement document • Dressing Formulary will be reviewed in line with new policy • Stop the Pressure day – 15th November to raise awareness • Pressure Ulcer Safety Calendar for month of November	G	G	**Pressure Sores and Falls :** • Implementation of new policy in line with new guidelines
	Falls: • Delivery of planned activity as per group workplans • 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.	G	G	**Falls:** • Members of the project team will be attended the 90 day event on 18th October 2018. • Plan for the pilot wards to sustain improvement made on lying and standing blood pressure and to progress on to another key indicator. • Project roll out discussed at Slips, Trips and Falls Group; plan for project to be rolled out to another 2 to 4 wards. • Ward 30 has been nominated by orthopaedic Matron and waiting for other wards to be identified.

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	November 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Roose / Hannah Pearson

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. 'Safeguarding Level 3 Champions' training being delivered but encouragement and support needed for adult ward take up.	24/05/18	A	G
Quality Improvement Losing momentum and key directorate representation as the process transforms to take a business as usual approach especially with winter capacity challenges	Actively engage with nominated leads and dissemination through appropriate forums	11/10/18	NEW	A
Data collection could mean PJ paralysis becomes and onerous on staff re data collection. Runs risk of staff resentment and disengagement	working closely with clinical areas and rolling out slowly at a local level to ensure engagement with teams and implementation in a way which works best with the staff undertaking the work	06/11/18	NEW	A

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
Recruitment to Transition Lead	30/08/18	Delayed	A	A
Transition – electronic solution to locate 16/17 year olds admitted to adult wards	28/06/18	Complete	C	C
Proposal for paediatrics diabetes care for 16 &17 year olds	30/10/18	Delayed	A	A
Engagement events to be set up off site during October & November	31/10/18	On target	G	G
Production of coproduced PPEE strategy	28/2/19	On target	G	G
Delivery of Criteria Led Discharge collaborative 30 day milestones	21/11/18	On target	G	G
Delivery of Criteria Led Discharge collaborative 120 day milestones	20/02/19	On target	G	G
NHSR submit decision on % rebate of CNST rebate (up to £908K)	30/08/18	Complete	C	C
Crowborough Out to Tender for works	16/07/18	Complete	C	C
Crowborough Practical Completion	21/12/18	At risk	A	A
Invitations sent for multi organisation Dementia Show and tell event	09/11/18	In progress	NEW	G
Plan for PJ Paralysis Xmas week w/c 10/12	10/12/18	On target	NEW	G
Engagement with wards to Collect PJ data	10/12/18	On target	NEW	G

KPIS	TARGET	Sept	Oct
Total Number of Labours commenced at Crowborough Birthing Centre	18	21	20
Number of Births at Crowborough Birthing Centre	14	18	16
Total Number of women receiving Ante Natal Care at Crowborough	200	213	198

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	November 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Roose / Hannah Pearson

FINANCE NARRATIVE

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

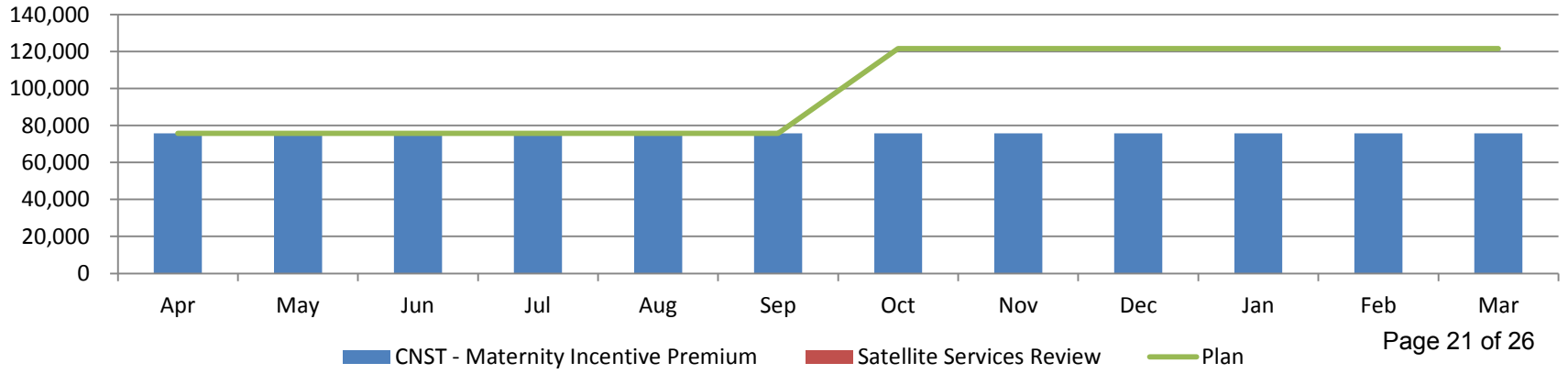
Safer Births / CNST:
NHS Resolution has confirmed achievement of all 10 safe births made rebate payment of 908k. Still awaiting confirmation and payment of additional rebate from unallocated maternity incentive scheme resource. Need to maintain delivery against safer births performance criteria in preparation for 'stretch' of refreshed maternity incentive scheme.

Crowborough Birthing Centre:
No change to KPI and profile of projected increases in no of births.

Women's and Children's Directorate identified a number of schemes to bridge the shortfall, schemes are being identified, assessed, developed and costed so that support can be targeted to those priority schemes that are 'high' value and considered to be more readily deliverable.

FINANCES

	M1	M2	M3	M4	M5	M6	M7 – Reporting	M8	M9	M10	M11	M12	Sum of NHSI 1819 Non Risk Adjusted Plan
CNST - Maternity Incentive Premium													
Sum of NHSI 1819 Plan	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	908,500
Sum of 1819 Actual / Forecast	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	908,500
Variance	0	0	0	0	0	0	0	0	0	0	0	0	0
Crowborough Services Review													
Sum of NHSI 1819 Plan	0	0	0	0	0	0	45,833	45,833	45,833	45,833	45,833	45,833	275,000
Sum of 1819 Actual / Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0
Variance	0	0	0	0	0	0	-45,833	-45,833	-45,833	-45,833	-45,833	-45,833	-275,000



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	
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT)/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	
Preventing Harm	LEW Following a meeting with Peter Maskell and Angela Gallagher it was agreed to undertake a harm review of all patients that have waited longer than 52 week and a sample of patients that have waited longer than 44 weeks for elective treatment –either as an inpatient or daycase. The information team are reviewing the number of patients that fall into this category over the last few months and will advise on the specialities that this affects. The team will then work with the audit team to design the format for these reviews. Documentation and Record Keeping It has been agreed that this project will become a clinical audit process and revert to the original design for medical staff. The Trust-wide aspects (Nursing and AHP) will be incorporated in the EPR work. Consent: • Trust-wide email sent out requesting copies of all Consent forms currently being used within the trust to be forwarded to Wendy Bates. • Numerous documents received, many of which were not known to exist. • Lead for Consent working group has been identified and agreed to lead- Alistair Challiner. • Draft Consent Policy on target for release for consultation by 31.10.18. • Briefing of Alistair Challiner by Wendy Bates to discuss next steps.			LEW Finalise the plan for Long Elective Waits Audit Documentation and Record Keeping Redesign of audit process, reverting to original Medical Staff review. Drafting of presentation for Quality Committee (December deep dive) Consent: • Review of paperwork to take place with AC • Receipt and collation of comments from consultation of updated Consent policy • Next Steps to be discussed and agreed
Quality Mark	The Quality Mark project is currently under review. A meeting was held with Peter Maskell (PM) and Claire O'Brien (COB) (31/10/2018) to discuss the 6 options that have been put forward as proposals, (all with a number of pros and cons) to determine the way forward. The 6 options proposed to date are: • Full ward accreditation process (utilising key CQC CLOEs) • Smaller accreditation process (mixture of some CLOES and local standards) • An 'award' for Quality and Innovation • An amalgamation of ratings from existing measurement systems such as the monthly performance review, PLACE, Internal Assurance inspections to feed into an overall score. • An 'award' for contribution to/achievement of the Trust Quality Standard goal(s) • A 'Best Care Award' for achievement of any initiative that demonstrates improvement in quality of care, plus amalgamating the Trust Clinical Audit Awards and the Trust QIP Awards processes. There are three key questions that are hampering the progression of this project which are: • Timing: Review of the launch of the new Quality Mark process in light of the new Clinically Led structure that is shortly to be implemented and the involvement of the Chiefs of Service in the design and discussion. • Nature of the Design: There are two differing styles of proposal in the 6 options. One is a more formal, ward-accreditation based process and the other is a simpler 'award' style. The former will require significant resource and commitment to run, but is broadly felt to be more aligned to the nature of a 'Quality Mark', than an awards process. It will also support the CQC process. The latter is considered to be far less complex to administer but there is concern that it will not be respected as it is more informal and the criteria for decision could be subjective. It is also felt to potentially clash with the Trust Awards and other award-based processes in the Trust and become 'one of many'. • Driver for Project: It is noted that the project was initially proposed to support the Learning Lessons Project (to help create a culture which is receptive to learning). It has been noted that the driver is not being fully delivered through the design options proposed to date. PM and COB confirmed that the Quality Mark was required by the Trust but that the timing for implementation should be delayed until the next financial year. It was agreed that a presentation would be taken to the overarching Best Care Board for broad discussion to agree direction.			• Project In Review (Proposals to be presented to Best Care Board in April 2019). • LA and GC to meet to begin draft of presentation for Best Care Board (for the April 19 meeting). • Joint meeting of Best Safety and Best Quality to review above draft presentation and confirm content. • HP to schedule Quality Mark discussion for April Best Care Board.
GIRFT	The infrastructure for the new Internal Panel has been set up including Terms of Reference, process paper, standard agendas. A briefing sessions has been set for the 30th October and then these will be monthly thereafter. Membership includes the Project Team, Directors of Operations, Quality Team, GIRFT local implementation Team. The Speciality Clinical Lead and Lead manager will be invited for their action plan reviews. Action Plans. The PMO team are working with the Directorates to ensure the action plans are up to date. This is proving difficult in some instances where reviews were undertaken some time ago and personnel has changed during this period. However it is anticipated that this will be aided through implementing the panel. The Litigation action plan has yet to be updated. The GIRFT raised concerns regarding progress regarding this action plan at our last meeting. This has been escalated through Wendy Glazier. The SSIR report was released at the end of October. MTW's return only included Breast and General Surgical Infections rates. The Trust needs to resubmit the full data and develop an action plan. The Clinical Lead for this needs to be assigned, Following ED GIRFT review, the team have scheduled a meeting for the 1st November to review actions following the report being issued. This meeting will be to assign leads for action plan (Nick Baguley overall GIRFT ED Lead). The Radiology GIRFT Review is booked for February 2019. Endocrinology GIRFT visit was held on the 26th October. This was a largely positive visit. However it highlighted the demand and capacity issues. MTW will commence the action plan whist waiting for the report from GIRFT. Learning Lessons. The PMO Team will undertake a quick review of lessons learnt following the Endocrinology visit .			Litigation action plan has not been updated due to staff shortages and completing priorities. This has been escalated through to the Management Team. Action plans all updated by clinical leads Set up monthly meetings once corporate meeting set up Undertake Lesson learnt from Endocrinology review.

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

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		
Mortality: Business Case not approved for Funding for Mortality Module (Datix)	Continued use of manual process (not safe, but no alternative)	25.10.18		
Datix System Administrator Funding not approval (Secondment)	None – cannot implement new electronic version without in house Datix expertise	25.10.18		
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. Ongoing prospective Audit being designed.	08/03/18		
Medical Productivity: 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. This will now be escalated to the Best Care Programme Board	17/03/18		
Medical Productivity: Additional costs from the implementation of the PAAT	All CDs are aware of their responsibilities to remain within budget., and it will be the responsibility of the MJPCC to check for consistency across departments	01/09/17		
Significant cultural change required to obtain buy in to undertake and implement Best Value DCC and Personalised Metrics	AMD will work through DMD and CDs to resolve concerns. Project to be standard agenda item on CD meeting to keep Directorate Management Teams informed and updated. This will provide an opportunity to voice concerns and resolve issues arising.	12/09/18		
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. Clinical Leads are providing strong support.	25/10/18		
GIRFT: All action plans need to be fully updated with detailed evidence.	The PMO team are working with the Clinical Leads and Managers to ensure these are fully updated.	16/10/18		
GIRFT: Litigation action plan is not yet up to date	The team have provided assurance that work has commenced against the action plan but this still requires updating –with a clear plan for outstanding actions.	16/10/18		
Consent: Vacancies and workload within the Legal Services team is impacting on ability to focus on Next Steps	Weightmans have been approached to provide interim support	29/10/18		

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	Completed		
7DS – Challenge Event with Regional Team (NHSI/E) 18.10.18 to confirm compliance status	18.10.18	On target		
Learning Lessons: Delay to date for meeting with CG Leads (now 4.12.18).	Delayed	On target		
GIRFT: Ensure all Action Plans are up to date.	15/11/18	ongoing		
GIRFT: Set up the Internal Panel meetings	15/11/18	In progress		
Medical Productivity: MJPCC set up and first meeting held.	3/9/18	In Progress		
Medical Productivity: Personalised metrics to be developed	12/12/18	Yet to start		
Medical Productivity: All job plans on the system and signed off by directorate management teams.	3/09/18	In progress		

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	15th October 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Preventing Harm)

	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	105.8	
	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	76.6	
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 (see detail below)	329	304	
	Number of Job plans signed off on the e-job planning software (see detail below)	329	152	

Directorate	Total Job plans to be completed	Total on the system	% on the system	No in Discussion/ sign off by Dr	Awaiting Sign off by Management Team	Signed off	Signed off
Cancer and Haematology	58	56	97%	19	6	31	53%
Critical Care	59	56	95%	4	2	50	85%
General Surgery	36	31	86%	29	2	0	0%
Head and Neck	33	32	97%	16	5	11	33%
Pathology	25	25	100%	0	2	23	92%
Trauma and Ortho	19	19	100%	8	2	9	47%
Acute and Emergency Medicine	15	13	87%	8	5	0	0%
Speciality Medicine	45	42	93%	13	6	23	51%
W&C	39	30	77%	20	5	5	13%
	329	**304**	92%	**117**	**35**	**152**	46%

3a.Best Care Programme - Financial Summary

Comment

Original Plan Savings - £24.1m / Risk Adjusted - £13.3m

The Trust was £1.6m adverse to plan in the month and £2.9m adverse YTD, this is mainly due to slippage on STP Medical rate (£0.8m), Prime Provider (£1.3m), Private Patients (£0.3m) and Estates & Facilities (£0.2m)

Risk adjusted forecast is £10.8m adverse to plan, the main schemes forecasting slippage are:

- Estates & Facilities Subsidiary - £1.75m (reduced to £1.1m, due to £0.6m schemes added)
- Private Patients Income - £1.0m
- STP Medical Rates - £1.7m
- Medicine Management - £1.2m (Avastin - £0.7m)
- Prime Provider - £4.5m
- Urgent Care Centre - £0.4m
- Endoscopy Income - £0.2m
- Satellite Services - £0.3m
- Procurement - £0.5m

11-11 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	Amber
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 September 2018, it requested that the funding and implementation of the Virtual Ward initiative was reflected within the "What actions have been taken…" section of the BAF entry for objective 1. At the October 2018 Finance and Performance Committee meeting, it was also suggested that the other winter investments should be reflected, along with the additional winter social care funding. Both of the requests have tried to be addressed in the BAF entry for objective 1.

Review by the Trust Board

This is the third 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. 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

[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

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.

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, 20/11/18
- Trust Management Executive, 21/11/18
- Finance and Performance Committee (for objectives 1 to 4), 27/11/18

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 remaining 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 & capacity ((including winter resilience) planning for 2018/19 is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile & reason for admission as planning bases (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. 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)
d. GP streaming is now fully operational (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)
h. The Trust's 2018/19 winter plan includes a number of schemes that will improve patient flow, including a Virtual Ward and additional community capacity (Home Treatment Service & Rapid Response) (1, 6)
i. Social Care has had additional winter funding (4)

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 7, October 2018) was 90.75%
- The latest year to date performance (at month 7, October 2018) was 92.8%

[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 demand & capacity has been undertaken by the NHS Intensive Support Team (IST). The analysis has concurred with the Trust's understanding of the gap to be addressed
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 improvement (Cancer Transformation Manager & 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"

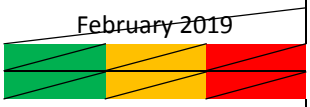
Risk owner:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Finance and Performance Committee / Trust Board

[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

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 6, 2018/19, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 62.2%. For MTW-only patients, performance was 65.7%

[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)
4. Workforce gaps in Consultants and particular Middle Grade doctors (surgery) which adversely affects the ability to deliver the activity

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, General Surgery, Ophthalmology and Urology) 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, has been completed (2)
g. There is a focus on recruitment & developing new roles in General Surgery, to expand capacity

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?

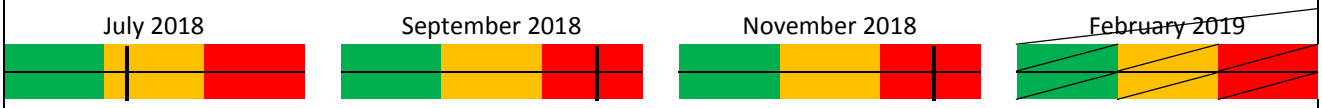
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

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]

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 available monthly performance (for month 6, September 2018) was 79.7%
- The latest available year to date (which equates to the quarter to date) performance (at month 6, September 2018) was also 79.7%

[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

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 Cost Improvement Programme (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)
i. Further additional actions are being developed in response to the month 7 forecast

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*

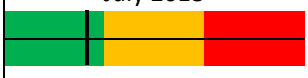
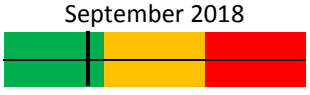
If "No", what other data is needed?

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 7 (October 2018), the Trust is at variance from its 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 completed the NHS Improvement (NHSI) Falls Prevention Collaborative, which included a specific focus on one action (lying & standing blood pressure) across all disciplines. Work is in progress to implement/embed the resulting actions (1 & 2)

b. Review and updating of relevant clinical systems to enable full recording and tracking of interventions via Nerve Centre IT system (3)

c. 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?

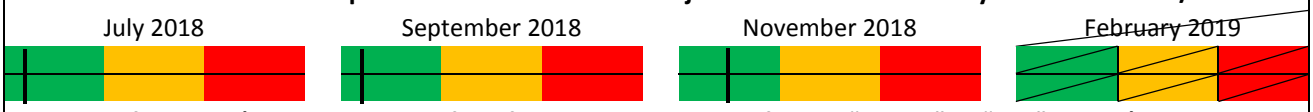
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

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 7, October 2018) is 5.81 (4.84 at Maidstone Hospital and 6.38 at Tunbridge Wells Hospital)
- The rate of falls for the year to date at month 7 (October 2018) is 6.08 (5.87 at Maidstone Hospital and 6.2 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

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 implement 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 Key Link Nurses & Ward Managers who can support locally for short periods of time (3)
h. There are links with Community TVNs for provision of clinical advice and assessment to telephone triage system (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 now complete and a Band 8a TVN Lead (to cover unscheduled absence within the TVN team) will commence (on secondment) in early December 2018 (3)
l. The worldwide 'Stop the Pressure' day was celebrated on 15th November 2018, which enabled the profile of pressure ulcer prevention to be raised

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 7, October 2018) is 0.98
- The rate of falls for the year to date at month 7 (October 2018) is 1.42

[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

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 due to upgrade requirements and system investment needed
2. The availability of funding for a Datix System Administrator resource to complete the internal Datix recovery requirements & install long overdue Datix upgrade(s) (& then maintain the system going forward)
3. Clinical Directorates not being able to release key staff to attend clinical governance meetings
4. The identification of meaningful/measurable metrics to assure learning is shared & 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 (Clinically Led) will need to be implemented before the revised meeting content and structure of the Clinical Governance process can be finalised

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 27/09/18 to discuss issues with functionality and press them for a solution/support to resolve (1)
b. Actions have been agreed and are being actioned and monitored via Best Safety.
c. A request for resource for a Datix System Administrator (initially for a 6 month secondment of an external experienced Datix System Administrator – individual sourced) has been sent approved by the Executive Team Meeting (2)
d. The Interim Director of Health Informatics is involved in discussions, and will oversee upgrades requests and allocate required resource once the Datix System Administrator is in post. Assurance has been received for the current upgrade and an IT project manager has been allocated (2)
e. A meeting has been arranged with all Directorate Clinical Governance Leads for 04/12/18 to review the content of the Clinical Governance meetings, Directorate attendance and the required and cascade strategy from clinical governance meetings This will be clinically-led by 2 senior clinicians (3, 4)
f. 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. The next meeting takes place on 28/11/18 (4)
g. 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

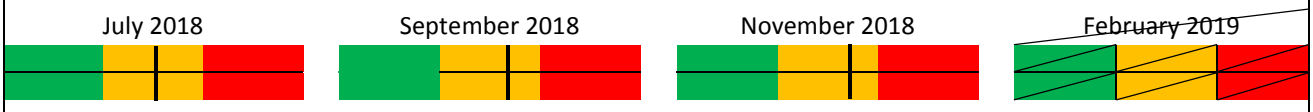
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

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 in staff time may be required from the Clinical Directorates
- There are known to be national-level difficulties in achieving clear metrics (including Human Factors benefits)
- The lack of a Datix System Administrator role has been identified as a significant rate-limiting step to stage 1 of the project and proposals are in place for this to be remedied (the funding of which confirmation of funding)

[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
8. Involvement in the National Wave 2 Medical Workforce project and consequent learning and peer benchmarking benefits

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, strong follow-up and delivery chasing with Directorate Teams and Associate Medical Director liaising directly with Clinical Directors – this has resulted in improvement in ratings on the Allocate system (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 and is working closely with the National Team (8)

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?

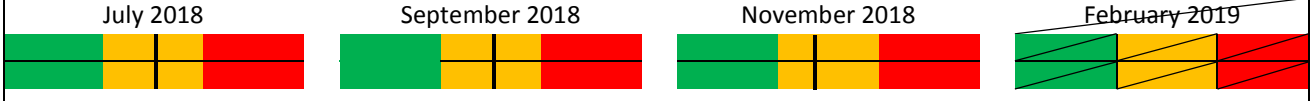
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

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 & sign off has delayed planned timescales but does not threaten the overall project. The MJPCC meetings schedule has been reviewed by the Core Team to

[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

accommodate

- 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 full year of operation.
- Demand and capacity training has taken place with NHSI for key Core Team members with respect to the Best Value aspect of the project.

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?

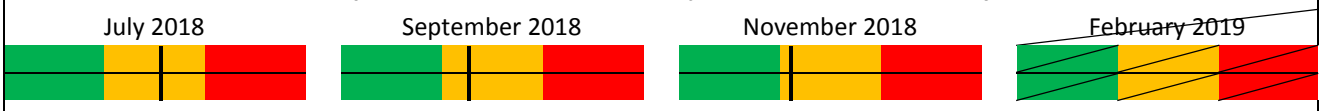
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

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 7, October 2018) was 8.6%
- The latest available vacancy rate for the year to date (at month 7, October 2018) was also 8.6%
- 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 7, October 2018) was 9.4%
- The turnover rate for the year to date (at month 7, October 2018) was 9.1%

[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 16/10/18, 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 21/11/18:

- 13 red-rated risks
- 58 amber-rated risks
- 24 green-rated risks
- 1 blue-rated risks

The issues covered by most of the 13 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
- Nursing staffing levels in Orthopaedics
- The governance arrangements for Point of Care testing
- Medical staffing shortage in Surgery impacting on inability to deliver emergency & elective care
- Risk associated with failing to learn from incidents
- Risk of no qualified Speech and Language Therapy service to non-Stroke neurology patients
- Lack of capacity to assess and treat within clinically recommended timeframes in the general Ophthalmic and Medical Retinal Service
- Turnaround backlogs in Histology due to Consultant reporting capacity
- Risk of absconding and violence and aggression due to delays in the assessment or admission of psychiatric patients in the Emergency Department (ED)
- Faulty telemedicine carts in Stroke Services resulting in lack of back up for out of hours stroke consultation
- Delay in follow-up treatment in Respiratory Services due to clinical capacity issues

It should also be noted that the last 2 bullet points relate to red-rated risks that have not yet been validated via Executive Team Meetings (which validates red-rated risks every quarter). It is therefore possible that either the RAG rating and/or the risk score of these risks will be amended.

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.

Trust Board meeting – November 2018

Maidstone and Tunbridge Wells NHS Trust

11-12	Closure report on the Clostridium difficile outbreak	Director of Infection, Prevention and Control

The enclosed report provides information on the Trust-wide outbreak of *C. difficile* declared on 12 September 2018.

During June, July and August a higher than expected number of hospital-attributable *C. difficile* infections were seen across the trust. The rate of infection year to the end of August is 10.37 per 100 000 bed days. For 2017/18 the rate was 9.5 per 100 000 bed days. This increase was mirrored by an increase in community acquired cases.

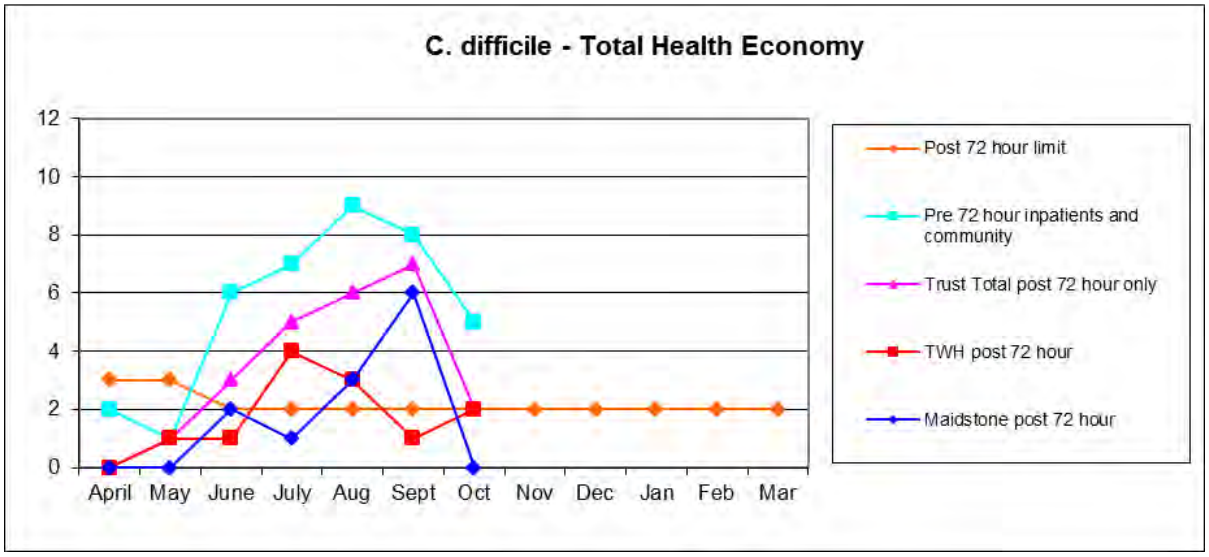
No evidence of cross infection had been found and cases had been seen on both sites and on multiple wards. In August, incident meetings were held for three wards where 2 or more cases were identified; Mercer, Ward 11 and John Day.

An outbreak was declared in order to highlight and prioritise the work needed to prevent further infections.

An outbreak management plan was developed and approved by the executives.

Four outbreak meetings were held on both sites over a four week period and a recovery plan was developed and implemented. Staff engagement was good and attendance at the outbreak meetings was high including representatives from NHSI, PHE and WKCCG. Trust wide communications were sent out and all doctors received emails from the Medical Director and the DIPC. Weekly infection control updates were sent to Board members, senior managers (managers, matrons and clinical directors) and other key staff.

Concern was raised regarding seven patients who died following their *C. difficile* diagnosis. The mortality lead undertook a review of these cases and concluded that in five cases there was no evidence that the infection influenced the patient's clinical course. In the remaining two cases, the conclusion was that although the infection complicated the management of the patients, both were seriously ill and the outcome was inevitable prior to the *C. difficile* diagnosis.



Further testing identified a single episode of cross infection on a ward at Maidstone hospital. A serious Incident has been declared and further investigation is ongoing for this case.

Root cause analysis was completed on all cases. 22 cases were seen in total from May to September. Three cases were found to have been avoidable. Root cause and lapses of care

identified are summarised below. Some cases had more than one lapse of care.

	Root Cause					Lapses of care			
	Appropriate antibiotics	Immuno-suppressed	Cross infection	CAHA	Inappropriate antibiotics	0	1	2	3
Avoidable			1		2			2	1
Unavoidable	16	2		1		9	9	1	

Lapses of care included delay in stool sampling, prescribing antibiotics inappropriately, delay in rapid risk assessment and hence isolation of the patient.

The infection prevention team have shared the lessons learned from the root cause analysis of the outbreak patients with staff on the wards and through NELF meetings. Findings have also been shared with doctors and will also be included in future teaching sessions for junior doctors.

The criteria for closing the outbreak were agreed as a month with *C. difficile* rates at or below baseline levels.

By the end of October both sites had had a period of over a month (37 days at TWH and 46 days at Maidstone) without a case of *C. difficile* and the rate returned to baseline for October.

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 - November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-13	Update on the project to create a single Pathology service for Kent & Medway	Chief Executive

Summary

The enclosed information has been produced by Medway NHS Foundation Trust (MNHSFT) and shared as a brief for all of the Trusts involved in consideration a single Pathology service for Kent & Medway.

The project to create a pathology single service is making good progress and following discussion with the national and regional teams the Strategic Outline Case (SOC) will be available for all four trusts in Kent in December. This will be for consideration to move to the Outline Business Case (OBC) phase which will require NHS Improvement approval.

The current long list of seven options will be reduced in the SOC stage and simplified into a delivery option of either one, two or the current three hubs and the commercial models which will apply to this delivery solution which will be in-house, strategic partner / in-house or outsourcing.

There has been reasonable engagement from the pathology leadership community and each trust is represented on the pathology steering group chaired by Lesley Dwyer. Miles Scott, Chief Executive of Maidstone and Tunbridge Wells NHS Trust, will be taking the responsibility for the group after Lesley moves to her new role in Australia at the end of November 2018.

The initial financial analysis shows we have a reasonable chance of delivering the efficiency savings for the service identified by NHS Improvement nationally for the pathology networks, with the introduction of a common IT platform and common Managed Equipment Service (MES).

There remain further efficiencies from service and workforce redesign and commercial models which the OBC will need to pursue.

The possibility of partnering with South East London procurement has been raised. This is a complex, multi-site procurement and we have discussed this with them and agreed we will consider them as a strategic partner along with others at the OBC stage.

It is intended to circulate the SOC for consideration at the Trust Board meeting in December 2018.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-13	Update on the project to create a single Pathology service for Kent & Medway – update	Chief Executive

The purpose of this report is to provide a progress report on the development of the single pathology service across Kent and Medway.

There has been considerable progress on the development ion the single service during November 2018. The key developments are:

- The draft Strategic Outline Case (SOC) has been produced and is currently being commented on within the project team. It will go to the project steering group chaired by Miles Scott for approval on 6 December 2018, and onward for consideration by Trust Boards
- During December the case will be discussed with lead executives and the Non-Executive Directors of the Finance Committees and Quality Committees across the four acute trusts to ensure they are briefed on the SOC prior to consideration by Trust Boards. Mark Hackett as Programme Director will be discussing the case with each chief executive during December 2018
- There has been constructive and positive engagement with the pathology leadership community and there is clear, growing commitment to developing the single service, based on the goal and key principles and requirements that the trusts committed to in May 2018
- The SOC has developed a more simplified set of options which are based on three delivery options for the service – one, two or three hubs for direct access and for non-urgent hospital work and specialised testing. These will then be delivered through commercial models which are either in-house, working with a strategic partner or outsourcing. The SOC sets out the detailed timelines for reaching a delivery option by the end of February 2019. This will then be developed into three comparisons for in-house delivery, the strategic partner option or an outsourcing option. This will be finalised in July 2019 with the OBC being secured for Trust Board approval at the end of July 2019
- It is clear that the current work undertaken shows evidence that the single service will more than likely deliver the minimum productivity requirement set by NHS Improvement through harmonisation of skill mix , grades and productivity of services as well as a focus on harmonisation of LIMS and Medical equipment suppliers (MES) . This is after the investment in a common information platform. The re-organisation of the service into fewer hubs could drive further savings but there are capital investment requirements which need to be evaluated and there are certain workforce sustainability issues which may present a risk to service delivery. The OBC will test this in more detail and develop a preferred option
- A clinical visioning event was held across all laboratories on 23 November 2018 to set a compelling vision for the service with laboratory leaders and accredited trade unions. The workshop was very productive and will contribute to the SOC and deliver the goal of the service set by the chief executives
- The Human Resource directors are being engaged on the staff engagement strategy and key principles in December. There has been progress made on a future in-house management model if this is the preferred commercial option.

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 – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-14	Update on funding of replacement Linear Accelerator (LinAc) programme	Chief Finance Officer

NHS England (NHSE) has offered the Trust the possibility of being funded for another replacement Linear Accelerator (LinAc) machine this financial year, out of the surplus capital. A Business Case for proposed LinAc replacements covering 2017-2020 was approved by the Trust Board in May 2017 (having first been reviewed by the May 2017 Finance and Performance Committee). The report considered at the May 2017 Board meeting is enclosed in Appendix 2 for information (along with the extract from the minutes of the meeting, Appendix 3).

Although the number of LinAcs over the period matches what was approved (4), the sequencing in the years has varied slightly, in that funding was requested for 2 LinAcs in 2017/18 and 1 in 2018/19, when in fact the Trust was given funding for 1 in 2017/18 and what would now be 2 in 2018/19. Therefore, approval for the current Case is not required by either the Finance and Performance Committee or Board. However,

The LinAc would need to be delivered by 31/03/19 (into storage) and then be clinically operational by October/November 2019 and would be the replacement for LA6 at Maidstone Hospital.

Assuming the same process as the previous NHSE-fund LinAcs, the core machine will be financed by NHSE capital which will come to us as Public Dividend Capital (PDC) (circa £1.7m), but the ancillary equipment and enabling works will need to be met from the Trust's own internal capital resources. The current estimates of those costs are £370k for enabling, and £250k for equipment and commissioning costs, so a total of £620k.

The Director of Medical Physics has provided a briefing, which is enclosed below.

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

Update on the Business Case for the replacement of the Kent Oncology Centre LinAcs

Introduction

1. The original business case for the replacement of 4 linear accelerators at the Kent Oncology Centre over 2017-2020[2] was approved by the Trust Board on the 24th May 2017.

2. The business case called for the replacement of 4 end-of-life, obsolete, radiotherapy treatment units (linacs) by the end of 2020.

3. It was anticipated that the NHS England Modernising Radiotherapy program would fund 3 of these linacs (in addition to an earlier linac in 2016/17) and the Trust would fund the 4th replacement in the 2019/20 capital program.

4. The Modernising Radiotherapy services funding was anticipated to provide 2 linacs in 2017/18 and 1 in 2018/19. However only 1 linac was funded by NHS England in 2017/18 and initially 1 in 2018/19. The Trust has now been provisionally offered a further linac under the modernisation program for 2018/19 - which brings the replacement program back into line.

5. The advantage of the variation in provision of the modernisation funding is that we have reduced or eliminated the need to store the linacs for significant periods whilst the enabling works to upgrade the bunkers were completed.

6. We are, therefore, on track to return the modernisation linacs to clinical use either on or before the dates specified in the original business case.

7. Consequently we are also able to continue to plan for the proposed replacement linac scheduled for the 2019/20 capital program subject to agreement on the funding.

8. This briefing note summarises the current position regarding the profile of the linacs within the Kent Oncology Centre and identifies the next linacs for replacement.

Current position

Linac obsolescence

1. The Kent Oncology Centre has 2 linacs at Maidstone which NHS England considers to be obsolete because they are over 10 years old: LA6M, which was due for replacement in 2016, and LA3M, which was due for replacement in 2017.

2. On the Canterbury site 1 linac is obsolete: LA3C, which was due for replacement in 2012.

3. A further linac on the Maidstone site (LA2M) is obsolete from next year.

[2] The radiotherapy modernisation program – linac replacements in 2017 - 2020

The Canterbury unit

4. The business case identified that whilst LA3C at Canterbury is the oldest linac (16 years) in the fleet, the current uncertainties around the future of the Canterbury site, which is owned by EKHUFT, should be resolved before replacement.

5. The business case also demonstrated that delaying the replacement program whilst a decision was made about the future of the Canterbury site would put the remaining linacs within the KOC at risk because of the already aging profile across the fleet.

6. The Specialist Commissioners have indicated that they are supporting the replacement of the Maidstone linacs through the modernisation funding to avoid the inherent uncertainties around the Canterbury site.

7. It is our understanding that the Canterbury position remains unresolved and we anticipate that the earliest that a new facility would be available for the treatment of radiotherapy patients is September 2021.

8. We have discounted the replacement of the Canterbury linacs, therefore, in identifying the next linacs due for replacement.

The TWH satellite

9. The business case also discussed a satellite facility at Tunbridge Wells Hospital with the possibility of decanting a linac from Maidstone to Tunbridge Wells.

10. It is our understanding that this proposal has not progressed with the Specialist Commissioners and we have, therefore, discounted this option in identifying the next linacs for replacement.

Review of the business case assumptions

11. As outlined in the original business case, the replacement program is about maintaining current activity and is not a case for growth of the radiotherapy service.

12. We are not aware of any material changes in predicted radiotherapy activity or revenue costs that would affect the original case.

The next linacs due for replacement

1. Based on the current uncertainties around the Canterbury site and the age profile of the Maidstone linacs, the following linacs should be replaced in accordance with the approved business case:

Linac	Location	Funding	Age at replacement	Date of removal from clinical use	Enabling works completed and linac accepted	Date of return to clinical use
LA6M	Maidstone	Modernisation	13	10 May 2019	09 Aug 2019	04 Nov 2019
LA3M	Maidstone	Trust Capital	13	06 Dec 2019	23 Mar 2020	06 Jul 2020

2. For detailed costing for the replacement of these linacs please see appendix 1.

Stephen Duck
Director of Medical Physics.
23 November 2018.

Appendix 1: LinAc replacement costs

Replacement of LA6 at Maidstone with a Varian Truebeam		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£368,400[3]
Commissioning equipment	Verification phantoms	£30,000
	Verification film	£2,900
Dosimetry equipment	Dosimetry PC and Trust PC	£3,500
	Instrumentation cabling	£1,000
	Detectors	£10,500
	Instrumentation	£25,000
	MV QC Phantom(s)	£9,500
	Dosimetry Equipment (array)	£50,000
Patient equipment	Patient communications system	£2,400
	Additional CCTV cameras	£2,500
	Head and Neck overlay board	£7,000
	Gated and Short Arc CBCT package	£30,000
Treatment planning equipment	Citrix server	£7,000
	FAS Server	£8,000
	Aria Hardware	£20,000
	Trust PCs and 22" monitors x 5	£8,000
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7	£25,000
	Overtime to meet the commissioning program	£8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£618,700
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays and electrons	£1,719,150

[3] Subject to the design team inspecting the bunker

Revenue requirements		Costs (inc VAT)
Storage costs	The linac will not go into store in this program.	£0
Licenses for the new PCs	Basic software licenses are not capitalised.	£4,500
Licenses for Aria hardware	Basic software licenses are not capitalised.	£14,400
Linac training	Additional training for our linac engineering team to support the replacement Truebeam.	£51,860
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£99,010

Trust Board meeting – May 2017

Maidstone and Tunbridge Wells NHS Trust

5-15	**Finance Cttee, 22/05/17 (incl. approval of the Business Case to replace 2 Linear Accelerators)**	**Chair of Finance Committee / Director of Finance**

In the autumn of 2016 NHS England announced a capital fund of £130m had been made available to support replacement of ageing or technologically obsolescing linear accelerators. They identified a number of machines that fitted the criteria for MTW, and invited bids in the first place for capital PDC funding in 2016/17. The Trust was successful in its initial bid and purchased a replacement machine for LA1at Maidstone Hospital to be commissioned in 2017/18. The Trust has recently submitted its application to NHS England for the replacement of 3 further machines to be funded from central PDC capital in 2017/18 (2 machines) and 2018/19 (1 machine).

The enclosed Business Case sets out the preferred option for the linear accelerator replacement programme from 2017 to 2020 explaining the rationale for the selection of machines, the financial implications, the arrangements for ensuring that SLA patient activity is maintained during the replacement phase, and the overall project management.

The Trust's Reservation of Powers and Scheme of Delegation (2.6) stipulate that "Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of £1,000,000" is a function reserved for decision by the Trust Board. The Case has therefore been submitted for consideration by the Finance Committee on 22nd May 2017, before the Trust Board is asked to approve the Case. The outcome of the Finance Committee's consideration will be reported to the Trust Board as part of the summary report from that Committee (which will be issued after the meeting).

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 22/05/17

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

Business Case

The radiotherapy modernisation program – linac replacements in 2017-2020

Issue date	May 2017
Department	Kent Oncology Centre
Directorate	Cancer & Haematology
Author	Stephen Duck
Clinical lead	Dr Sharon Beesley
Executive Sponsor	Jim Lusby
ID reference	ID 490

Approved by	Name	Signature	Date
General Manager	David Fitzgerald		
Finance manager	Gemma Paling		
Clinical Director	Dr Sharon Beesley		
Executive sponsor	Jim Lusby		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	Jeanette Rooke		
Director of Informatics	Donna Jarrett		
HR Business Partner	Angie Collison		
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group	IAG		17.5.17
Finance Committee			
Trust Board			

Maidstone and Tunbridge Wells NHS Trust

The Business Case Summary

Strategic context

The Trust is falling behind with the radiotherapy linac replacement program which is pushing the projected age of the machines out to between 12-15 years on current timescales – well beyond the national recommendation that treatment units should be replaced once they reach 10 years[1].

Whilst benefiting from the NHS England Modernising Radiotherapy program to replace 1 linac in 2017, the Trust will still have a further 5 out of a complement of 9 linacs that will be obsolescent by the end of 2017.

NHS England commissioners have indicated that the Trust may be allocated access to the Modernising Radiotherapy fund[2] *to purchase 3 further linacs in 2018-2019.*

The Trust's capital program also schedules a further linac for 2019/2020.

This linac should be considered in conjunction with the 3 modernisation program linacs to close the gap on the obsolescence that the Kent Oncology Centre is facing by providing a robust replacement program for 2017-2020 that is responsive to the uncertainties in the timescales for the proposed TWH satellite radiotherapy centre and the future of the Kent and Canterbury Hospital site (both the subject of separate strategic cases).

The case recommends that the enabling works for the first linac should be undertaken in 2017/18 to minimise further delays to the overall replacement program and proposes how this could be achieved.

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

[1] NHS Standard Contract for Radiotherapy (all ages)
[2] Transforming Radiotherapy Services – letter from NHS England

Maidstone and Tunbridge Wells NHS Trust

Objectives of the investment and the problems with the status quo
1. *Continue with the linac replacement program outlined in the earlier agreed business case for the replacement of LA1M in 2016/17.* 2. *Replace four end-of-life, obsolete, radiotherapy linear accelerators (linacs) during 2017-2020 which are not compliant with the NHSE specification for the provision of radiotherapy, with modern units that provides a safer, higher-quality treatment that will deliver better patient outcomes and which meet the radiotherapy specification.* 3. *Take advantage of the Transforming Radiotherapy Services Capital Investment Programme's proposed allocation of two linacs to Maidstone and Tunbridge Wells NHS Trust for the financial years 2017/18 and one linac for 2018/19 to develop our services.* 4. *Continue with the Trust's capital replacement program for 2020.* 5. *Maintain existing radiotherapy activity during the replacement programme.* 6. *This is not a case for increasing radiotherapy activity.*
The main benefits expected from the investment
1. *Improve access to modern radiotherapy techniques for our patients – increasing access to dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT).* 2. *Provide continuity for the radiotherapy service, maintaining standards for patients living in Kent, Medway and parts of East Sussex.* 3. *Improve patient care through better treatment outcomes.* 4. *Improve capability for transferring patients between linacs during breakdowns and servicing which could otherwise result in patient delays and additional staff overtime.* 5. *Protect market share.*
The main risks associated with the investment
1. *The loss of 11% of linac capacity during the replacement of the treatment unit and the need to maintain business continuity.* 2. *The aging linac at Canterbury (LA3C) is prone to high failure rates that may result in extended down-times that would reduce linac capacity by a further 11%.* 3. *Knock-on delays (due to enabling works or equipment issues for example) may incur additional storage charges as the installations of subsequent linacs are delayed.* 4. *Funding may not be allocated if there is no agreement over the Trust's control target with NHS Improvement.* 5. *Funding may not be allocated if the Trust does not sign up to participate in the local radiotherapy network.*
Available options
A. *Do nothing – do not replace a linac at the KOC in 2017-2020.* B. *Replace 4 linacs in 2017-2020, identifying the priority as Maidstone but continuing to review both the strategic position at Canterbury and the TWH satellite, with a view to substituting LA3C at Canterbury for a scheduled Maidstone replacement as service/strategical reasons dictate.*

Maidstone and Tunbridge Wells NHS Trust

Preferred Option

Option B Replace 4 linacs in 2017-2020 according to operational and strategic demands

1. *Replace 4 obsolescent linacs with state-of-the-art Varian Truebeam linear accelerators similar to that which was installed at Canterbury in 2015 and which is currently being installed at Maidstone. The linacs will provide additional dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT) in accordance with modern radiotherapy delivery.*

2. *Identify the priority as the Maidstone linacs that are over 10 years old – subject to the outcome of the review on the strategic case for the disposition of linacs in east Kent.*

3. *Utilise access to the Modernising Radiotherapy PDC funding for 3 of these replacements, with the 4th funded in-line with the Trust's capital program.*

4. *Begin the enabling works for the first replacement in January 2018 to minimise potential delays in the linac replacement program.*

Funding, affordability

Revenue – net additional costs [no extra activity or income assumed)

Year	*Recurrent*	*Non-recurrent*	*Total net additional costs*
2017/18	*(£8.5k)*	*£90.3k*	*£81.8k*
2018/19	*£46.2k*	*£153.6k*	*£199.8k*
2019/20	*£302.8k*	*£102.7k*	*£405.5k*
2020/21	*£693.2k*	*£28.2k*	*£721.4k*
2021/22	*£888.9k*	*£0k*	*£888.9k*
2022/23	*£987.7k*	*£0k*	*£987.7k*

The additional revenue costs arising from the replacement of the linac machines relate to higher capital charges (new machines/enabling works approx. twice the cost of the predecessor machines) and the full preventative maintenance contracts after the 2yr warranty expires. The case does not assume additional activity or income changes.

Capital

Year	*Linac machines*	*Enabling works, commissioning & other equip*	*Total Capex*	*Bids for PDC funding*
2017/18	*£3.68m*	*£0.00m*	*£3.68m*	*£3.68m*
2018/19	*£1.84m*	*£1.10m*	*£2.94m*	*£1.84m*
2019/20	*£1.84m*	*£1.39m*	*£3.23m*	*£0.00m*

The Trust has submitted bids to the DH for 3 linac replacements funded from central PDC, 2 to be funded in 2017/18 and 1 in 2018/19. All other costs for enabling build works, commissioning and ancillary equipment are financed from Trust capital which is not available until 2018/19 onwards, which will mean the Trust will incur off site storage (as for the first funded linac in 2016/17). The 2019/20 linac is currently planned for replacement from Trust capital.

Management arrangements

The project will be managed by an internal MTW team from procurement, Estates & Facilities and Medical Physics. Work-streams to manage the various tasks will be formed under an umbrella Project Group that will report into the Maidstone Program Board and the Cancer and Haematology Directorate Board (see below for further details).

The Business Case

Strategic Context	*Strategic Case*

Current status

The Maidstone and Tunbridge Wells NHS Trust hosts the regional Kent Oncology Centre (KOC) that provides specialised cancer services – including radiotherapy – to the 1.9M population in Kent, Medway and parts of East Sussex.

The KOC radiotherapy service is based at Maidstone General Hospital (MGH) and the Kent and Canterbury Hospital (KCH). Delivering over 69,000 fractions/year, the service is one of the top 5 Cancer Centres in England for radiotherapy delivery.

The radiotherapy department at MH is relatively new and purpose built while the facilities at KCH are older and were not originally designed for linacs (being built in 1937), albeit the area has been recently refurbished.

NHSE have published, in conjunction with Cancer Research UK, a vision for radiotherapy services [3]where "All patients will receive advanced and innovative radiotherapy that has been shown to be clinically and cost effective" and that "aging equipment prevents centres from keeping pace with innovation and provide advanced techniques to agreed levels of good practice…Trusts should have appropriate replacement plans for these machines to ensure they continue to meet national standards[4]."

The NHS standard contract for radiotherapy recommends that treatment units should be replaced once they reach 10 years to ensure that the advanced and innovative radiotherapy technology present on modern treatment units is implemented in cancer centres to improve patient outcome[4].

The Kent Oncology Centre has a fleet of 9 linacs (6 at MGH and 3 at KCH). Of the 9 linacs, 5 are in need of replacement in 2017 because they are already at the end of their 10-year lifetime. Being older generation linear accelerators they are unable to meet the current minimum specification for radiotherapy treatment delivery and are not capable of meeting the future developments envisaged by the KOC in the 5 year plan.

There is a published linac replacement program for the Kent Oncology Centre that calls for a replacement of a linac every year (Appendix A) but this program has already been delayed with projected replacement ages now between 2 and 5 years higher than when the original business case to replace LA2C was written in 2013.

As a consequence, the replacement program now extends the lifetime of each linac significantly beyond the recommended 10 years– with planned replacement ages now upwards of 12- 15 years which are well beyond NHS England's recommended age for linacs .

Further delay in the replacement program would push all of the linear accelerators well beyond the recommended lifetime (unless there are options to replace 2 linacs in a single year over a number of years) and would, therefore, place significant strain on the KOC's ability to provide modern radiotherapy. Ultimately, this could challenge the viability of the KOC service as other providers seize the opportunity to enter the market, because the NHS radiotherapy contract specifies that commissioners are free to engage with other suppliers, who presumably are able to provide a modern radiotherapy service, where the provider has not agreed a timely replacement program, "Commissioners may divert activity where this is breached without agreement".

[3] Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014
[4] NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013

In 2016/2017, NHS England announced funding through the Modernising Radiotherapy program to support the replacement of obsolete and aged (10 years or older) linacs as a priority[5,6].The Trust was subsequently allocated access to this funding and is currently replacing a linac at Maidstone which is due to return to clinical use in October 2017.

Access to the recently announced second tranche of central funding would continue to allow the KOC to partially catch-up on a delayed replacement schedule and improve the Trust's position. NHS England commissioners have indicated that the Trust may be allocated two linac replacements in 2017/18 and one more in 2018/19.

Failure to take advantage of this funding to purchase the latest generation of radiotherapy treatment units into the Trust will significantly impact not only the potential outcomes for our patients but also the Kent Oncology Centre's radiotherapy income as commissioners choose to use those providers who are able to offer better access to modern treatments[1].

Regarding the proposed satellite centre at TWH, the Trust's capital program identifies that this may come on-line in 2020 with the TWH Radiotherapy Bunker Capacity Project Outline Business Case[7]identifying the diversion of a Maidstone replacement linac to equip the TWH facility. The replacement program needs to take this development into account and provide a solution should TWH be delayed.

The replacement program also needs to be able to respond to the current uncertainties around the future of the Kent and Canterbury Hospital site, which is owned by East Kent Hospitals University Foundation Trust (EKHUFT), and to manage the difficulties in installing replacement linacs on this site given the buildings are not purpose built for radiotherapy machines and suffer the inherent infrastructure issues often present in buildings which are over 80 years old. These considerations are particularly acute given the oldest linac in the KOC fleet, LA3C, is based at Canterbury.

The Trust is engaging at executive level with EKHUFT to understand their plans for the site and the future configuration of the KOC at Canterbury is the subject of a separate strategic case.

The NHS England commissioners are aware of the position regarding KCH and have indicated that the replacement of an obsolete linac at Maidstone instead of Canterbury is acceptable under the Modernising Radiotherapy program should this be necessary.

The Trust's capital program includes a linac replacement in 2020 (and further replacements in subsequent years). This linac should be considered in this business case in conjunction with the 3 Modernising Radiotherapy program linacs to demonstrate that the proposed replacement program is robust, achievable and able to respond to the uncertainties and risks described above.

This business case is, therefore, proposing to replace 4 linacs in 2017-2020 (3 under the Modernising Radiotherapy program and 1 from the capital program) to significantly address the current need to replace 5 obsolete linacs at the KOC.

This business case is about maintaining the capability of the KOC fleet and is not proposing growth in radiotherapy activity. There is, therefore, no need for recurrent staffing resources as a consequence of this replacement program (staffing for the TWH satellite facility is the subject of a separate case).

[5] Transforming Radiotherapy Services – letter from NHS England
[6] It should be noted that the funding is Public Dividend Capital for equipment only – monies for any bunker enabling works would need to be allocated from Trust capital.
[7] Outline Business Case: MTW Radiotherapy Bunker Capacity Project, 2015

Advances in radiotherapy technology

Significant technological progress has been made in both treatment unit design and radiotherapy techniques that have contributed to improved patient outcomes since the older generation units were installed over 10 years ago, including:

- *RapidArc for dose painting that concentrates the dose on the target lesion whilst minimising the dose to surrounding critical structures.*
- *On-board imaging that provides near diagnostic quality images with the patient in the treatment position on the linear accelerator to improve the accuracy of dose delivery,*
- *Image acquisition during treatment to monitor target position in real-time which is important when targeting lesions that can vary position throughout treatment,*
- *High-dose rate modes for stereotactic radiotherapy techniques to significantly reduce treatment times and improve accuracy when irradiating small, highly mobile, lesions.*

The first 2 of these advances opens the way for 4D image guided adaptive radiotherapy that should be the standard of care for many patients[8,9] and the last 2 would improve the accuracy of the techniques such as stereotactic ablative radiotherapy/stereotactic body radiotherapy (SABR/SBRT) which are in the KOC business plan and significantly reduce treatment delivery time and improve outcomes for some patients.

Current linac status

The table below lists the current location of the linac fleet within the Kent Oncology Centre and indicates whether they meet the NHS specification for maximum age (in 2017) and the ability to deliver modern radiotherapy, including 4D Adaptive and SABRE/SBRT.

The Kent Oncology Centre has 5 linacs that need immediate replacement if the Centre is comply with the NHS specification.

The table also indicates the anticipated replacement dates for the linacs, assuming access to the second tranche of the Modernising Radiotherapy fund (3 linacs) and the Trust's capital replacement program (see Appendix A).

Even with access to this funding, the KOC will not meet the NHS Specification for equipment replacement without additional investment in both linacs and decant bunker capacity (see Appendix B) for further details.

[8] NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013
[9] National Radiotherapy Implementation Group Report Image Guided Radiotherapy (IGRT) Guidance for implementation and use, 2012

Current status of the treatment units at the Kent Oncology Centre.

Location	Linac	Within 10y Age (2017)	Capable of modern RT	Replacement date		Anticipated age at replacement	Comments
				Due	Expected		
Canterbury	LA1C	Yes	Yes	2020	2023	13	
Canterbury	LA2C	Yes	Yes	2025	2025	10	
Canterbury	LA3C	No	No	2014	2019	15	Delayed due to uncertainty of the east Kent site.
Maidstone	LA1M	Currently being replaced					
Maidstone	LA2M	Yes	Yes	2019	2022	14	
Maidstone	LA3M	No	Yes	2017	2021	14	
Maidstone	LA4M	No	No	2015	2018	13	
Maidstone	LA5M	No	Yes	2016	2018	12	
Maidstone	LA6M	No	Yes	2016	2020	14	Upgraded to 4D adaptive in 2013 under government "Innovations" program.

The case for the replacement of a treatment unit

The drivers for replacing a radiotherapy treatment unit include: equitability of access to modern radiotherapy facilities for our patients, improving patient care through improved outcomes[10] and the protection of market share.

Providing the best care for our patients requires providers to keep up with technological advances that improve outcomes by replacing treatment units regularly. The NHS standard contract for radiotherapy states that "The provider should ensure that each Linear Accelerator is in operation for a maximum of 10 years and that the replacements are planned in a timely manner." This is echoed through the Modernisation of Radiotherapy Services Program[11] where priority is given to "Replacement of linacs that have reached or are reaching the age of ten years or older, as these are considered obsolete".

The NHS standard contract for radiotherapy also identifies "Access to technologies such as Image Guided Radiotherapy (IGRT), which together with intensity modulated therapy forms the basis of 4-D Adaptive Radiotherapy, should be the standard of care for many patients". These techniques require imaging equipment that is not available on older generation treatment units.

The delivery of the best care to our patients also requires providers to increase access to IMRT. The current national target of 24% has been achieved by the Kent Oncology Centre (currently access to IMRT at the KOC is around 34%), but the latest national guidance recommends 50% by 2020[12] and there is already an expectation that "incentives to

[10] Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014
[11] Specialised Services Circular, £130m capital fund to modernise radiotherapy services in England – Next Steps, 2016
[12] Radiotherapy Board – Intensity Modulated Radiotherapy (IMRT) in the UK: Current access and predictions of future access rates, 2015

promote IMRT being driven through tariff[13]. In order to meet future targets and increase income the Kent Oncology Centre will need the additional dose-painting and on-board imaging capability that comes as standard on modern units.

The proposed linac would be the make and model (Varian, Truebeam recently installed at Canterbury), with the same standard features necessary to deliver innovative radiotherapy including IMRT, IGRT and SABR/SBRT.

Case for Change - Business Needs

The objective/s of the proposed investment

- *To improve access to modern radiotherapy techniques and better outcomes for our patients,*
- *To provide continuity of the radiotherapy service,*
- *To protect income and market share.*

Case for change -Benefits

The Economic Case

The measurable benefits associated with the investment objectives listed above are summarised below.

To improve access to modern radiotherapy techniques and better outcomes for our patients

- *Provide additional capability to deliver more advanced radiotherapy so that more patients are offered innovative radiotherapy techniques that will contribute to better outcomes.*

To provide continuity of the radiotherapy service

- *Maintain the radiotherapy service activity during subsequent linac replacements and minimise patient delays and gaps in treatment by standardising linac energies (6MV and 10 MV) across the fleet so as to allow patients to be transferred seamlessly between linacs during failures and downtime.*

To protect income and market share

- *Provide additional capability to deliver advanced radiotherapy that meets the National Standard Contract for Radiotherapy, assuring commissioners and patients that the KOC should remain the Cancer Centre of choice within Kent.*

Case for change –Risks

The Economic Case

List and description (category and grading) of the potential risks associated with the investment

Risk	*Category*	*Grading (Consequence x Likelihood)*	*Mitigation*
Loss of linac capacity during the replacement resulting in loss of activity and patient delays.	*Financial, Clinical Outcome, Quality*	*4 x 2= 8 Green*	*The KOC has recently undertaken a similar project successfully with no loss of activity.* *Select an obsolescent linac for replacement that is least able to support the activity of the KOC during the replacement project (and not necessarily the oldest).* *Business continuity arrangements will be in place.* *Major servicing and quality assurance will be undertaken out of hours and, where possible, before the project starts.* *The number of linacs being replaced in any one year will not impact on activity or waiting times because only one unit is out for replacement at any one time.* *A delay in the completion of a linac replacement will impact on the program for a subsequent linac, which*

[13] Improving outcomes: a strategy for cancer, Department of Health, January 2011

			may result in additional storage charges & contractor costs (see "unforeseen occurrences" below).
Incomplete knowledge of bunker structure and supporting services resulting in additional costs and delay in the project.	*Financial* *Maidstone replacements*	*3 x 2 =6 Green*	*The bunker is a purpose built facility. Services/bunker inspected as part of developing the Contractor's proposals and contingency costs allocated where appropriate.* *Advice from the Estates Department is that HVAC is sufficient.* *Core samples (which are standard) will be required for additional assurance.*
	Financial *Canterbury replacement*	*3 x 4 =12 Amber*	*Whilst the existing bunker is relatively new, the surrounding infrastructure is poor and deteriorating.* *Early engagement with EKHUFT estates and the design team (with the support of the MTW estates team) is essential to formally agree and document roles and responsibilities, design derogations and timescales.* *LA3C is programmed for later in the program which will further minimise the risk to the overall replacement program.*
Unforeseen occurrences, including unavailability of contractors and equipment failures, resulting in delay in the overall program.	*Financial*	*3 x 3 = 9 Green*	*Early engagement with the Turn-key contractors to secure their commitment to the enabling works dates proposed in this business case.* *Major equipment failures resulting in long-term commissioning delays are rare. Overtime would be required to catch up where possible.* *Regular communication with the equipment suppliers and the Turn-key contractors would be required to manage additional knock-on effects and minimise costs (such as additional storage charges of contractor costs).*
Insufficient staffing or expertise to successfully commission the linac resulting in project delays.	*Workforce*	*4 x 2= 8 Green*	*The team have successfully commissioned a similar unit at Canterbury in 2015 and this expertise is still available within the centre.* *Maintenance of the routine service during the replacement may require staff to agree to work overtime.* *Commissioning times are expected to be shorter as the replacement linac will match the Canterbury linac and, therefore, data collection and analysis will be a sub-set of what is undertaken normally.*

Constraints

1. *To maintain activity during the replacement program any enabling works that may affect the operation of the other linacs will need to be carried out outside of the radiotherapy service working hours.*
2. *To meet our obligations under the Modernising Radiotherapy program, the Trust must take ownership of the 2 linacs by 31st March 2018 and 1 linac by 31st March 2019 – either delivered to site or to a bonded warehouse.*
3. *Availability of capital to fund the enabling works could restrict the program to the financial calendar introducing delay.*

Dependencies

1. *Timescales for the delivery of the project are dependent on the following external factors:*
   a. *Confirmation of allocation of funding for the linac from NHSE – so that an order can be provided for the enabling works and the linac.*
   b. *Availability of the Turn-key contractors to carry out the enabling works (the Modernisation Program has already significantly increased demand for their services).*

2. *Trust capital funding is required for the bunker enabling works, commissioning costs and additional equipment to support the clinical use of the linac.*

The short list of options *The Economic Case*

Option A. The do nothing option - **Discounted.**

Do not replace linacs in 2017-2020.

SWOT Analysis – Do minimum	
Strengths	*Lower capital costs in the short term.* *a. No loss of radiotherapy capacity during the linac replacement.* *b. Sweating high value capital assets.*
Weaknesses	*Increased failure rates on aging equipment will result in delays in patient treatments.* *a. Increase in revenue in the instance of major breakdown as staff will need to work overtime at weekends to meet demand.* *b. There is an increased risk that a catastrophic failure will remove an older unit from clinical use for an extended period at very short notice, resulting in significant disruption, local and national media interest and consequent loss of income and reputation.* *c. Managing capacity during unscheduled long-term catastrophic breakdowns will not always be possible without compromising the outcome of treatment for some patients.* *d. Increasing pressure on other IMRT capable units to meet demand – extended working days and weekend working to cope – increase in revenue.* *e. Recruitment difficulties as it would be more attractive to work at other centres providing better facilities, working hours and advanced treatment techniques.* *f. Higher staff turnover due to unsatisfied staff.* *g. Increased staff stress and poorer morale due to workload and overtime with the potential of increased clinical incidents.*
Opportunities	*None identified given the age profile of the linac fleet.*
Threats	*Increasing loss of MTW market share and income:* *a. Significant extension to the projected lifetime of the KOC linacs damaging local and national reputation and questioning the strategic and operational viability of the cancer centre,* *b. commissioners may choose to redirect patients to other centres who are able to meet the NHS standard contract for radiotherapy delivery,* *c. patients may choose to have their treatment elsewhere where the provider is able to offer a modern radiotherapy service, and,* *d. other providers may be encouraged to enter the market and secure the business having assessed the age of the KOC fleet as significantly outside the 10 years specified in the NHSE Radiotherapy standard contract.*

Option B Replace 4 linacs during 2017-2020 – **Preferred Option**

Replace 4 linacs in 2017-2020, starting the enabling works for the first linac in January 2018 to minimise delay to the overall linac replacement program.

Key assumptions

a. *There is currently no capital allocation for enabling works in 2017/18 (£373,600 inclusive of vat and Estates fees) but capital has been allocated for 2018/19.*
b. *Beginning the enabling works in January 2018 removes the bottleneck created by the Modernisation linacs on the Trust's capital plan that would have created further delay in the linac replacement program.*
c. *The enabling works proceed in January 2018 on the basis that the Turn-key contractor accepts the deferral of payment until the completion of the works in 2018/19 or capital is secured in year from slippage / reallocation of estates/equipment funding (see below for further details).*

Proposed replacement program 2017 – 2020

Linac	*Funding*	*Linac purchase date*	*Linac accepted*	*Project completed*	*Proposed installation site*	*Alternative site*
LA4	*Modernisation*	*Nov 2017*	*30 Apr 2018*	*27 Aug 2018*	*Maidstone*	*X (Canterbury not resolved, TWH not available.)*
LA5	*Modernisation*	*Nov 2017*	*10 Dec 2018*	*15 Apr 2019*	*Maidstone*	*X (Canterbury not resolved, TWH not available.)*
LA6 or LA3C	*Modernisation*	*Mar 2019*	*5 Aug 2019*	*4 Nov 2019*	*Maidstone (LA6)* *East Kent (LA3C) – subject to strategic case*	*X* *X*

And then one of the linacs below (depending on whether it was LA3C or LA6 replaced earlier in the program)

LA3 or LA3C or LA6	*Trust capital*	*Oct 2019*	*23 Mar 2020*	*6 Jul 2020*	*TWH (LA3)* *East Kent (LA3C) – subject to strategic case* *TWH (LA6)*	*Maidstone (LA3)* *X (LA3C - unless to TWH)* *Maidstone (LA6)*

Mitigating the financial risks in starting the enabling works in January 2018

1. *The proposal is to begin the enabling works in January 2018 upon agreement with the Turn-key contractors that the liability to pay the contractors is only triggered upon satisfactory completion of the building works in 2018/19.*

2. *If the contractors decline, then funding, or part funding if the contractors are prepared to accept some of the financial risk, could be secured in year from slippage / reallocation of estates/equipment funding.*

3. *If no slippage funding was forthcoming, then the start date would need to be renegotiated with the contractor. But there would be no guarantee that the contractors could commit to a new start date in early 2018 which would put*

the replacement program even further behind and the Trust would also incur penalty costs for the subsequent delay. 4. *The alternative approach is to de-risk the LA4 enabling works completely by planning them for 2018/19 when capital funding has been allocated. This will create its own risks, however, because the Modernisation linacs will be pushed up against the Trust capital linac scheduled for 2019/2020. This will put the capital plan under pressure as the enabling works and linac acceptance (5% of linac cost) move from 2019/20 to 2020/21 – for LA3C this could require around £1,000,000 of additional capital to be found in 2020/21 which could stall the replacement program.*

SWOT Analysis – Replace 4 linacs 2017-2020 with enabling works beginning January 2018	
Strengths	*Modernises the linac fleet, secures local and national confidence in the future of the KOC.* *Accommodates the uncertainties regarding the TWH satellite centre and the future of the Canterbury site, by prioritising the aged linacs at Maidstone - all of which are beyond the 10 year lifetime recommended by NHS England.* *Minimises bottlenecks in the capital program and potential delays by bringing forward the enabling works for the first linac replacement (LA4) into the 2017/18 financial year.* *Options for the future configuration of the KOC at Canterbury and the subsequent disposition of the LA3C replacement in east Kent are the subject of a separate strategic case.* *Should the TWH satellite centre be delayed, subsequent linac replacements scheduled under the Trust's capital program (and not covered by the modernisation program or this business case) could be diverted from Maidstone to TWH to complete the proposed satellite configuration and achieve the objectives of the TWH Radiotherapy Satellite Business Case.*
Weaknesses	*There is little room for slippage in the program.* *The Turn-key operator may decline to accept full payment at the completion of the works or slippage money is not available.* *If LA3C is not replaced in 2019 and the TWH satellite centre comes on-line in 2020 - taking a replacement from Maidstone - then LA3C will be at least 17 years old before it is replaced.* *Reduction in linac capacity of 11% during the commissioning program.*
Opportunities	*Provides additional capability to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT.*
Threats	*EKHUFT is currently undertaking a strategic review of the location of their hospital services and, therefore, the future of the Kent and Canterbury site is unclear which could impact on the future delivery of radiotherapy services and the disposition of linacs in east Kent.* *The lifetime of LA3C could as a consequence extend beyond 15 years which may encourage other providers to enter the east Kent market and secure business.* *MTW's strategy for the East Kent linacs needs to be resolved relatively quickly so as to facilitate the replacement of the oldest linac ASAP.*

Maintenance options – Truebeam Linac

Potential options for managing the maintenance of the Truebeam after the 2 year warranty include:

1. *No maintenance contract from the linac manufacturer – support is chargeable when required, spares not included.*
2. *Limited maintenance contract – telephone support and access to diagnostic tools but spare parts are not included.*
3. *Full-service maintenance contract, including all spares except "high-vacuum" items.*

The provision of manufacturer support and access to diagnostic tools is considered essential to ensuring that delays due to breakdowns are minimised. Proceeding without maintenance cover is, therefore, not recommended because the risks to the service are too high.

Selection of the most appropriate maintenance contract from the remaining options (limited cover and full-service cover) is essentially a question of the financial risk that the Trust wishes to take around the cost of the spare parts: all parts are chargeable under the limited contract but under a full-service contract spares are included – except items identified as "high vacuum" items which are typically x-ray tubes, and high energy valves etc.

Unfortunately, given that the Truebeam is a relatively new linac platform, with the Canterbury unit just out of warranty (early 2017), it is difficult to predict the spare-parts costs at this stage and therefore the relative merits of these options – except that the full-service contract places an upper limit on the likely spend on spare parts in a year.

We may be in a better positon to identify the best service contract option as theses linacs come out of warranty in 2 years because we will have several years of (non-warranty) maintenance experience on the Truebeam at Canterbury and Maidstone.

Summary of maintenance options.

Maintenance options	*Advice*	*Diagnostics*	*Spares*	*Service contract cost/year (£)*	*Comments*
No cover	*X*	*X*	*X*	*£0*	*Not recommended – business continuity risks are too high.*
Limited cover	*√*	*√*	*X*	*£18,500*	
Full-service	*√*	*√*	*√*	*£85,000*	*All spares covered excluding "high vacuum" items.*

The Preferred Option *The Economic Case*

Services and/or assets required

1. *This is a linac replacement into an existing bunker and will, therefore, connect into the existing services already being supplied to the current unit.*

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

1. *There are no anticipated implications on activity and SLAs because the service will maintain business as usual during the linac replacement by extending the service's operating hours.*

2. *The replacement is supported by NHSE through the Modernising Radiotherapy program.*

3. *Radiotherapy services are fully commissioned.*

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Workforce impact
1. *The service will extend operating hours during the replacement program which will require staff to work different shift patterns and some occasional weekend working and overtime –but additional staff will not be required to support the extended working day.* 2. *The linac commissioning will be undertaken utilising existing Radiotherapy Physics staff – this approach was successful when commissioning LA2 at Canterbury in 2015 and has been shown to be the most cost-effective approach[14]. These "business continuity" costs have been factored into the financial assessment.* 3. *Additional clinical staff will not be required to maintain existing activity once the linac facility has been returned to clinical use.*
Estates impact
1. *Enabling works are required within the bunker to increase the protection levels to meet the demands of the replacement machine and to bring the facility up to modern standards.* 2. *The enabling works and installation will be a turn-key project using the team that completed LA2 at Canterbury.* 3. *The Estates and Facilities team will be involved in the project management and delivery of the enabling works.* 4. *We are advised by Estates that there is sufficient power on-site to support the linac.* 5. *During the enabling works, noisy working and the movement of materials into and out of the work area will be undertaken out of hours to minimise any disruption.*
Impact on other directorates
1. *No impacts are anticipated on other directorates at any stage of the replacement process.* 2. *The Project Management arrangements described below will be used to manage communications should a problem arise that may impact on other directorates.*

Funding and affordability *The Financial Case*

[14] Business Case – Replacement linear accelerator at Canterbury (October 2014)

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Capital costs of preferred investment option

1. *The Trust has bid for 3 further Linac replacement machines from DH capital PDC, with a 4th replacement funded from Trust capital resource. This is in line with the Trust 5 year capital programme submitted to NHSI in the 2017/18 planning submissions.*

2. *Only the machines are funded from PDC; the other necessary costs for build enabling, associated equipment and commissioning of the machines has to be found from Trust capital. In most cases the timings in this case accord with the latest plan submission but there are some mismatches that will need to be managed. The main initial issue is the desirability of commencing the enabling works for LA4 replacement at Maidstone at the back end of 2017/18, although the funding is not at present available until 2018/19. The two options currently under consideration are:*
   a) *Identify sufficient funding from the 17/18 programme from either slippage during the year or by redirecting currently allocated budgets to other areas. This is being explored.*
   b) *Commence the work in 17/18 but ensuring that it is not completed, or contractually liable until 18/19.*

If neither of these options becomes available then the work will need to be delayed until the 2018/19 financial year.

3. *There are risks on the cost of the enabling works for LA3C at Kent and Canterbury hospital given the infrastructure challenges of that site. The base case proposal is to delay replacement of that machine until clarity on issues around the future of the site are resolved, so it is not an immediate risk to resource in the next two financial years.*

4. *The costs are based on latest quotes from NHS Supply Chain and updated estimates of internal works costs.*

Capex £m inc. VAT	Machine	2017/18	2018/19	2019/20	2020/21	Funding	Plan position
Linacs	LA4M	1,839				DH PDC bid	2017/18
	LA5M	1,839				DH PDC bid	2017/18
	LA6M		1,839			DH PDC bid	2018/19
	LA3C			1,839		Trust Capital	2019/20
Enabling works	LA4M		374			Trust Capital	2018/19
	LA5M		374			Trust Capital	2018/19
	LA6M			374		Trust Capital	2018/19 not 2019/20
	LA3C			910		Trust Capital	2019/20 but only £700k
Associated equipment	LA4M		74			Trust Capital	2018/19
	LA5M		142			Trust Capital	2018/19
	LA6M		72			Trust Capital	2018/19
	LA3C			75		Trust Capital	2019/20
Commissioning	LA4M		31			Trust Capital	2018/19
	LA5M		31			Trust Capital	2018/19
	LA6M			31		Trust Capital	2018/19 not 2019/20
	LA3C				32	Trust Capital	2020/21
Totals £m incl. VAT		**3,677**	**2,936**	**3,228**	**32**		

Revenue costs of the preferred option

1. *The linacs are replacements to existing capacity. No assumptions of additional growth in patient activity and corresponding income and marginal costs have been factored into the case. The change in recurrent costs begins to impact significantly in 2019/20 with c£303k additional cost, and rises to £988k by 2022/23 when all the machines are out of warranty. There are two main drivers for the change in recurrent cost levels:*
   a) *The replacement linacs plus enabling works and other costs are more than twice the cost of the predecessor machines and thus generate higher capital charges across the asset lives (13 years for linacs and 5 for other equipment). This accounts for over 70% of the change in cost by 2022/23.*

b) *The case assumes at present the highest level of maintenance cover once the 2 year warranty expires – the cost is £85k per machine against a current cost of around £15k per machine amounting to a net change of £280k per annum by 2022/23. As stated in the discussion on maintenance cover this choice is subject to review with the experience from the Truebeam machine installed at Canterbury. The Directorate will need to finance the additional costs of the maintenance cover from within its existing budget resource.*

2. *Non recurrent costs have been assessed for:*
   a) *Storage costs for the linac machines until the enabling works' completion permits their onsite installation;*
   b) *Business continuity costs for existing staffing working on other machines to maintain contractual capacity;*
   c) *Disposal/write off costs of the replaced machines. The Trust policy on linac asset lives is 13 years, recognising the reality of use beyond the recommended 10 year span; the advent of the national funding will enable earlier replacement than at the end of the 13 years for some of the current machines.*

The analysis of both new costs, and avoided costs, by machine and by year is set out in the following table.

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			2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
LA4M	Recurrent	New Depreciation		95,543	191,086	191,086	191,086	191,086	859,887
		New PDC	32,175	71,046	74,398	67,710	61,022	54,334	360,687
		Previous Depreciation		-79,097	-79,097	-79,097	-79,097	-79,097	-395,485
		Previous PDC (avg)		-18,263	-18,263	-18,263	-18,263	-18,263	-91,315
		Maintenance (Net)		-15,000	-15,000	70,000	70,000	70,000	180,000
		Total Recurrent	32,175	54,229	153,124	231,436	224,748	218,060	913,774
	Non Recurrent	Pay - Business Continuity	9,786	24,464					34,250
		Storage	1,411						1,411
		Asset Write off	79,098						79,098
		Total Non Recurrent	90,295	24,464	0	0	0	0	114,759
		Total Revenue	122,469	78,693	153,124	231,436	224,748	218,060	1,028,532
LA5M	Recurrent	New Depreciation			153,559	204,746	204,746	204,746	767,797
		New PDC	32,175	71,046	80,790	75,415	67,353	60,187	386,966
		Previous Depreciation		-35,871	-71,742	-71,742	-71,742	-71,742	-322,841
		Previous PDC			-19,649	-19,649	-19,649	-19,649	-78,598
		Maintenance (Net)		-3,750	-15,000	6,250	70,000	70,000	127,500
		Total Recurrent	32,175	31,425	127,957	195,019	250,707	243,541	880,824
	Non Recurrent	Pay - Business Continuity		28,250					28,250
		Storage		11,200	800				12,000
		Asset Write off		89,679					89,679
		Total Non Recurrent	0	129,129	800	0	0	0	129,929
		Total Revenue	32,175	160,553	128,757	195,019	250,707	243,541	1,010,753
LA6M	Recurrent	New Depreciation		0	47,711	190,846	190,846	190,846	620,249
		New PDC		33,442	73,129	76,035	69,355	62,676	314,636
		Previous Depreciation			-68,177	-90,903	-90,903	-90,903	-340,886
		Previous PDC				-20,110	-20,110	-20,110	-60,329
		Maintenance (Net)			-7,500	-15,000	27,500	70,000	75,000
		Total Recurrent		33,442	45,163	140,868	176,688	212,509	608,670
	Non Recurrent	Pay - Business Continuity			28,250				28,250
		Storage			5,500				5,500
		Asset Write off			68,178				68,178
		Total Non Recurrent	0	0	101,928	0	0	0	101,928
		Total Revenue	0	33,442	147,091	140,868	176,688	212,509	710,598
LA3C	Recurrent	New Depreciation				116,414	232,827	232,827	582,069
		New PDC			49,412	97,347	91,796	83,647	322,202
		Previous Depreciation	-59,380	-59,380	-59,380	-59,380	-59,380	-59,380	-356,283
		Previous PDC	-13,509	-13,509	-13,509	-13,509	-13,509	-13,509	-81,054
		Maintenance (Net)				-15,000	-15,000	70,000	40,000
		Total Recurrent	-72,890	-72,890	-23,477	125,871	236,733	313,584	506,933
	Non Recurrent	Pay - Business Continuity				28,250			28,250
		Storage							0
		Asset Write off							0
		Total Non Recurrent	0	0	0	28,250	0	0	28,250
		Total Revenue	-72,890	-72,890	-23,477	154,121	236,733	313,584	535,183
Total Revenue costs			81,755	199,799	405,496	721,445	888,878	987,695	3,285,067
Total Recurrent Revenue costs			*-8,540*	*46,206*	*302,768*	*693,195*	*888,878*	*987,695*	*2,910,201*
Total Non Recurrent Revenue costs			*90,295*	*153,593*	*102,728*	*28,250*	*0*	*0*	*374,866*

Procurement Route *The Commercial Case*

1. *The linacs and associated equipment will be procured through the DH approved NHS Supply Chain Framework with the supplier then providing a turn-key solution to the bunker upgrade and linac installation.*
2. *This approach has been implemented successfully on the previous linac replacements.*

Quality Impact Assessment *The Management Case*

Clinical Effectiveness

Have clinicians been involved in the service redesign? If yes, list who.

Dr Sharon Beesley, Clinical Director for Cancer and Haematology and Clinical Oncologist and Dr Mathilda Cominos, Lead Clinician for Radiotherapy and Clinical Oncologist.
Full discussion at the Cancer and Haematology Care Group meetings attended by all Consultants in oncology.
This has also been discussed at the Cancer and Haematology departmental governance meetings and is included in the Annual Business Plan.

Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)

Yes, the national predicted patient demand for radiotherapy activity levels (known as MALTHUS modelling
Actual activity levels achieved in the last 5 years.
National trends in growth in oncology patients from a variety of sources including Macmillan and the Royal Colleges.
MTW has been nationally benchmarked with other radiotherapy centres in the UK.

Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.

The radiotherapy department monitors a number of key performance indicators including efficacy of treatment, number of fractions of radiotherapy per patient, incidence of side effects (minimal).
The Directorate regularly audits radiotherapy practise and there are a number of regular annual clinical audits on radiotherapy treatments.
Complication rates are audited on a regular basis and discussed at the clinical governance meetings and monitored on the Trust Dashboards.
The directorate participates in Mortality and Morbidity meetings continually learn and improve on clinical outcomes.
Both the Radiotherapy and Physics departments are ISO 9001:2008 certified and CHKS accredited. Clinical Quality is a large part of the accreditation process.

Are there any risks to clinical effectiveness? If yes, list

Yes – 11% loss in capacity during the replacement program, potential failure of one of the remaining treatment units during this time – reducing capacity further.

Have the risks been mitigated?

Yes – there is a business continuity plan in place to manage the 11% loss in capacity during the linac replacement and to manage breakdowns during this period.

Have the risks been added to the departmental risk register and a review date set?

Yes.

Are there any benefits to clinical effectiveness? If yes, list

Yes – the replacement treatment unit will contribute to improved patient outcomes by supporting advanced radiotherapy

techniques, including dose painting of the target lesion and improved treatment accuracy through better image guidance.
Patient Safety
Has the impact of the change been considered in relation to:

Infection Prevention and Control?	Y/~~N~~
Safeguarding vulnerable adults/ children?	Y/~~N~~
Current quality indicators?	Y/~~N~~
Quality Account priorities?	Y/~~N~~
CQUINS?	Y/~~N~~

Are there any risks to patient safety? If yes, list
There are no known risks to patient safety at the time of writing as the radiotherapy service is highly governed and there are a number of inherent patient safety checks that are performed prior to administration of radiotherapy.
Have the risks been mitigated?
Yes, all of the existing risks have been mitigated appropriately.
Have the risks been added to the departmental risk register and a review date set?
Yes.
Are there any benefits to patient safety? If yes, list
Yes. Improved access to image guided, intensity modulated radiotherapy (IGRT/IMRT- dose painting) which may improve outcomes and reduce side-effects.
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Yes, the impact of the redesign has been assessed. There should be no impact on the patients/ carers or members of the public apart from the radiotherapy patients being offered a superior service to the one that is currently available within the existing resources.
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
Patients treated and consulted at the new radiotherapy centre will be managed by current MTW staff who will always promote self-care when applicable in addition to their treatment. **Tackling health inequalities?** *The radiotherapy department is open to all patients who access health services and can accommodate all types of patients as per the Trust's Access Policy.*
Does the redesign lead to improvements in the care pathway? If yes, identify
Yes, patients will be seen in a location closer to home and meet unmet patient need for treatment.
Are there any risks to the patient experience? If yes, list

No.
Have the risks been mitigated?
N/A.
Have the risks been added to the departmental risk register and a review date set?
N/A.
Are there any benefits to the patient experience? If yes, list
Yes – see above.
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes.
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No.
Has any negative impact been added to the departmental risk register and a review date set?
N/A.
Service
What is the overall impact on service quality? – please tick one box

Improves quality	✓	Maintains quality		Reduces quality	

Clinical lead comments

Management Arrangements

The Management Case

Project management arrangements

1. *The technical leadership and project management will be provided internally by MTW NHS Trust.*

2. *The project governance arrangements are covered by the Trust's Governance arrangements whereby the project group (see below) will report into the Cancer and Haematology Directorate Management Meeting which is chaired by the General Manager for the Directorate and the Maidstone Program Board which is chaired by the COO.*

   The main aims are to:

   - *Ensure the decision making can be integrated with MTW normal management processes as much as possible,*
   - *Clinical leadership and project management support can be targeted effectively and efficiently,*
   - *Best practice is applied in terms of project management and governance,*
   - *As part of the project, business assurance and benefits realisation key performance indicators along with risk and contingency plans have been developed and will be updated as the project develops.*

3. *The project group will ensure that the replacement of the linear accelerator is successfully delivered and the benefits realised and will oversee 4 work-streams that will manage contractor and site liaison, the team commissioning the unit and the associated treatment planning systems, the operational plan to maintain the service during the replacement period and the implementation of the new technology into routine clinical use.*

Group	*Role*	*Chair*	*Reporting to*
Project Group	*Oversee the implementation of the project, including the business planning process.*	*Director of Medical Physics*	*Cancer and Haematology Directorate Management Meeting* *Maidstone Program Board*
Operations work stream	*Implementation of the operational plan for maintaining business continuity during the replacement program*	*Cancer & Haematology Operations Manager*	*Project Group*
Contractor and site liaison team	*To ensure that the design meets the user's requirements and those of the wider Trust.* *To liaise with builders, Varian, MTW, operations and commissioning teams.*	*Estates Project Manager*	*Project Group*
Commissioning team	*To commission the treatment unit and the treatment planning systems*	*Lead Physicist*	*Project Group*
Radiotherapy Technique group	*To ensure that new treatment techniques/technology are introduced safely into clinical use.*	*Head of Radiotherapy Physics*	*Project Group*

Timetable

Milestone	*Indicative date*
Submission to Finance Committee.	*15th May 2017*
NHS England confirm award of PDC for 3 linacs	*15th May 2017*
Submission to the Trust Board.	
Linac ordered (minimum 12 week lead time)	*See table below for individual schedule for each linac.*
Formal instructions issued by the Trust to the Turn-key contractors	
Linac placed in storage until enabling works are completed.	
Close machine, move to business continuity arrangements.	
Enabling building works completed.	
Linac delivered, installation and acceptance commences.	
Treatment unit is accepted by the Trust and commissioning begins.	
Commissioning completed, staff training begins.	
Staff training completed and the treatment unit enters into clinical use. Centre returns to normal operating hours. Completion of the project.	

The timetable below shows the key installation and commissioning dates along with the key assumptions if the Trust is to install the 4 linacs in a timely manner.

Assuming that the enabling works for the first linac (LA4) start in January 2018

Linac	*Formal Instructions given to turn-key contractor*	*Linac purchased*	*Linac removed from clinical use*	*Storage (weeks)*	*Replacement linac installed/ enabling works complete*	*Replacement linac accepted*	*New linac Commissioned*	*Returned to clinical service*	*Comments*
LA4	*Jun 2017*	*Sep 2017*	*29 Jan 2018*	*2*	*02 Apr 2018*	*30 Apr 2018*	*20 Aug 2018*	*27 Aug 2018*	*Installation and acceptance timescales provided by Turn-key contractor and linac supplier. A 9 week build program (bunker shielding is up to specification), 4 week linac acceptance, a 16 week commissioning program (additional modalities require data collection) and 1 week of radiographer applications training.*
LA5	*Dec 2017*	*Sep 2017 (delivery Q4 2017/18)*	*10 Sep 2018*	*34*	*10 Nov 2018*	*10 Dec 2018*	*8 Apr 2019*	*15 Apr 2019*	*2 weeks to transfer patients onto the earlier replacement linac, 9 week build program (bunker shielding is up to specification), 4 week linac acceptance, a 16 week commissioning program, 1 week for public holidays, 1 week for radiographer applications training.*
LA6	*Aug 2018*	*Mar 2019 (delivery Q4 2018/19*	*6 May 2019*	*15*	*6 Jul 2019*	*5 Aug 2019*	*28 Oct 2019*	*4 Nov 2019*	*2 weeks to transfer patients onto the earlier replacement linac, 9 week build program, 4 week linac acceptance, a 12 week commissioning program (confirmatory measurements only and 1 week for radiographer applications training.*
LA3C	*Mar 2019*	*Jul 2019*	*18 Nov 2019*	*0*	*22 Feb 2020*	*23 Mar 2020*	*29 Jun 2020*	*6 Jul 2020*	*2 weeks to transfer patients onto the earlier replacement linac, 13 weeks build program, 1 week for public holidays, 4 week linac acceptance, a 14 week commissioning program and 1 week for radiographer applications training.*

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Business assurance and benefits realisation arrangements
1. *The business benefits that will be realised upon the installation of the Truebeam linear accelerator include:* • *improved access for patients to modern radiotherapy techniques,* • *no additional loss in market share,* • *replacement linacs within recommended lifetime.* 2. *The benefits will be realised as soon as the replacement treatment unit is fully commissioned and put into routine clinical use.*
Training arrangements
1. *A Truebeam linear accelerator has been commissioned by the Medical Physics team and introduced into clinical use within the KOC at Canterbury. There is, therefore, scientific, clinical and technical expertise within the centre to successfully commission, operate and maintain the replacement Truebeam unit.* 2. *Additionally, to ensure that expertise is developed within the teams, Varian will provide on-site clinical training in the week leading up to go live and a radiotherapy engineer will attend the appropriate maintenance training courses.*
Risk Management and Contingency plans
1. *The Centre will maintain activity throughout the replacement program following the business continuity arrangements that were implemented successfully during the replacement of LA2 at Canterbury and which have now been implemented at Maidstone for the replacement of LA1.* 2. *The plan was developed by a multi-disciplinary team from the Kent Oncology Centre to ensure that it is robust and the necessary infrastructure will be in place to support the continuity arrangements.* 3. *The workload will be redistributed across the remaining Maidstone linacs by starting the treatment day a little earlier and continuing through until 8pm. To ensure that there are sufficient resources to meet the requirements for RapidArc and to deal with the inevitable fluctuations in patient numbers, some patients in the Ashford corridor may be transferred to Canterbury when there is spare capacity.* 4. *To manage the extended working days, some servicing and quality assurance of the treatment units will move to the weekends for which the costs have been readily identified because these are scheduled tasks that are normally completed regularly throughout the year.* 5. *It is likely that a treatment unit will break down occasionally during the replacement program. If the breakdown exceeds 1 hour (breakdowns totalling 1 hour is the most that can be tacked onto an already extended day) then patients may need to be treated during the weekends to catch up (for many patients a gap in radiotherapy must be avoided). Weekend planned maintenance and quality assurance programs may need to be moved to a subsequent weekend when a breakdown necessitates weekend working.* 6. *The business continuity planning team have estimated a contingency element to cover the staffing costs required to cover unscheduled weekend working using the current breakdown statistics for the units that will be treating during the replacement. These costs are obviously subject to variability because breakdowns can be unpredictable.* 7. *To mitigate the requirements for extended servicing on the linacs, the engineering team will arrange for the OEM servicing on the Maidstone linacs to be completed before the replacement program gets*

underway.

8. *The contingency plan assumes that radiotherapy activity will not increase significantly during the replacement period – this assumption is supported by the activity data from previous years and there being no evidence to suggest that a significant increase is anticipated.*

9. *The business continuity plan does not provide a model for managing activity across the Kent Oncology Centre on fewer linacs in the longer term because the extended working day is not sustainable (patient acceptance, staff good-will, recruitment and retention, over-reliance on equipment and staff support), the Centre will not be able to replace future linacs because capacity will be insufficient, limited access to IMRT, IGRT and SABR/SBRT will affect patient outcomes and choice which could impact on the Trust's market share.*

Arrangements for post project evaluation

1. *Post project evaluation will be monitored through the Cancer and Haematology Directorate Management Meeting and include;*
   a. *RPA reports from a critical examination of the radiation facility,*
   b. *Linac acceptance and commissioning reports,*
   c. *Treatment planning system commissioning reports,*
   d. *External dose audit reports,*
   e. *Monitoring of activity, including patient delays and IMRT uptake.*

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Version history

Version	Issue date	Brief Summary of Change	Owner's Name

Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes/no
Revenue breakdown completed	Yes/no
Capital breakdown completed	Yes/no
Supporting statements from stakeholders attached	Yes/no
Quality impact assessment completed	Yes/no
Commissioner support agreed	Yes/no
Appendices attached	Yes/no
	Yes/no

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Appendix A
Trust capital program

Capital Programme

Capital Spend	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Estates					
Estates Projects - Backlog maintenance	1,300	900	900	850	850
Ward refurbishment/Decant ward	0	0	0	1,000	2,300
Estates Projects - other renewals	500	400	400	400	400
Electrical Substation/generator M	2,500				
Linac estates work	573	1,719	700	700	700
Subtotal - internally generated funds	**4,873**	**3,019**	**2,000**	**2,950**	**4,250**
ICT					
ICT - Infrastructure	1100	900	700	650	650
ICT - Clinical System	204				
ICT - Non-clinical systems	160	103	26	26	26
Core IT System Upgrade PAS (SaCP)	200				
Subtotal - internally generated funds	**1,664**	**1,003**	**726**	**676**	**676**
Equipment					
Linac replacement programme	207	621	1,900	1,900	1,900
Trustwide equipment	1,687	1,775	1,485	1,516	1,369
TWH closed theatre equipment	410				
Subtotal - internally generated funds	**2,304**	**2,396**	**3,385**	**3,416**	**3,269**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	495	457	575	939	1,186
Linac replacement programme	3,612	1,806			
New MRI Maidstone - build & equip		2,500			
Energy infrastructure/EPC	4,000				
TWH Satellite Radiotherapy Bunkers		4,056	3,244		
Maidstone Hospital Theatres' Renewal		3,000	12,000		
Subtotal - external finance	**8,107**	**11,819**	**15,819**	**939**	**1,186**
Total Capital Spend Plans	**16,948**	**18,237**	**21,930**	**7,981**	**9,381**

Comments:

The Trust is planning a rolling five year capital programme of £74m. This is inclusive of:

- £10m essential improvements in backlog estates
- Electrical substation at Maidstone to support future developments (£2.5m)
- Energy Performance capital of £4m from Salix loan application to support boiler, lighting and controls replacements
- Replacement equipment programme of £20m, including linear accelerators with 3 assumed from central DH PDC in addition to the one agreed for 2016/17
- £4.7m IM&T modernisation programme

The Trust is planning for capital investment loans to support the scale of the required estate renewal. The loans will support delivery of:

- Increase diagnostic capacity (£2.5m)
- Development of a satellite TWH radiotherapy facility (£7.3m)
- Theatre modernisation at Maidstone site (£15m)
- Salix loan application for an Energy Performance contract

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Appendix B

Linac replacement program

1. *The table below outlines the revised current proposed linac replacement program, taking into account potential funding from the Modernisation of Radiotherapy Services program and the Trust capital program (and assumes a LA3C replacement in 2019).*

2. *The table shows that even with access to central funding, the majority of the linacs are scheduled to be replaced between 12- 15 years - which is significantly beyond the 10 years recommended in the NHS specification.*

Linac replacement programme

Site	*Equipment*	*2015/16*	*2016/17*	*2017/18*	*2018/19*	*2019/20*	*2020/21*	*2021/22*	*2022/23*	*2023/24*	*2024/25*	*Age replaced*	*Note*
Canterbury	*LA1*									*R*		*12*	*1*
Canterbury	*LA2*										*R*	*10*	*2*
Canterbury	*LA3*					*R*						*15*	*3*
Maidstone	*LA1*		*R*		*Currently being replaced*							*--*	*4*
Maidstone	*LA2*								*R*			*14*	*5*
Maidstone	*LA3*							*R*				*14*	*6*
Maidstone	*LA4*				*R*							*13*	*7*
Maidstone	*LA5*				*R*							*12*	*8*
Maidstone	*LA6*						*R*					*14*	*9*
TWH	*Build bunker/s*						✓						*10*

Notes relating to linac replacement programme

Note 1: Canterbury LA1 10 years old in 2020
Note 2: Last replaced in 2015.
Note 3: LA3 moved back from 14/15 as a consequence of earlier LA2 delay (completed 11/2015) and now delayed due to discussions over the future of the KCH site.
Note 4: Currently being replaced
Note 5: 10 years old in 2019/20
Note 6: 10 years old in 2017/18
Note 7: 10 years old in 2015/16
Note 8: Delayed, due to knock-on from Canterbury. 10 years old 2016/17
Note 9: Extended replacement from 2016 due to Innovations upgrade.
Note 10: Option for bunker development at TWH which would allow the replacement program at Maidstone to continue whilst maintaining a full complement of treatment units in west Kent.

3. *There are a number of complexities with this replacement program that need to be managed:*

   a. *There is no bunker in which to house a replacement unit (at Maidstone or Canterbury) -which*

means that an existing linac would need to be removed from clinical use, reducing capacity by 11%.

b. *There is currently significant uncertainty within EKHUFT and the local healthcare economy regarding the future of the Kent & Canterbury site that houses the KOC at Canterbury – closure of the KCH site appears to be a real possibility.*

c. *Significant additional investment is required on the KOC at Canterbury site because the KCH is not designed to provide the infrastructure and shielding requirements of modern linear accelerator and the fabric of the building is also deteriorating, with water leaks throughout the department becoming common.*

d. *Each linac replacement is time-consuming, taking around 6-12 months to complete depending on the complexities of the estate (and involves removing the existing linac, upgrading the bunker, installing and commissioning the replacement unit and training the staff).*

e. *There is very little slack in the program which means that a delay in one replacement (due to funding or technical reasons) has a knock-on effect on the whole replacement program, pushing the age of the linacs ever upwards. The projected replacement age of the KOC linacs has already moved upwards by 2-5 years since the original business case was written to replace LA2C in 2013.*

Appendix C

Linac costs

The specification for all linacs is the same.

Truebeam Deal 3 specification.xlsx

NHS SC Quote - Varian Linac - Maidsto

Appendix D

Cost proposal – enabling works

The replacements of the Maidstone linacs (LA3, LA4, 5 and 6) are anticipated to require similar enabling works (and therefore costs) because these bunkers were designed and built to a similar specification.

Maidstone LA4 Proposed dwg for CP.

Maidstone LA4 Draft CP for budget.pdf

The enabling works for the Canterbury linac (LA3C) are much more complex given the age of the building and the additional shielding required bringing the bunker up to standard.


2186-215 LA3 Scheme plan revF.pdf


Canterbury LA3 Contractors Proposals

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Appendix E

Cost pro-formas for each linac replacement

Replacement of LA4 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Ionisation chambers Verification phantoms Verification film Winston Lutz kit OBI dosimetry equipment	£14,000 £20,000 £2,400 £2,700 £20,000
Dosimetry equipment	Dosimetry PC Instrumentation cabling	£1,600 £1,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license Upgrade to Advanced planner desktop	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£478,200
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage and insurance costs	NHS England is proposing to allocate funding for the Trust to acquire the linac in Q4 of the 2017/18 financial year. The Trust will be able to install the linac early April if the enabling works begin in January 2018.	£700
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £16,500 £4,000 £4,000
TOTAL		£34,250

Replacement of LA5 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Verification film	£2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Replacement monitor unit checking software IMRT QA upgrade	£1,600 £1,000 £50,000 £75,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license Upgrade to Advanced planner desktop	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£546,500
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage and insurance costs	NHS England is proposing to allocate funding for the Trust to acquire the linac in Q4 of the 2017/18 financial year. The Trust will be unable to install the linac at this point because capacity will already be restricted by the on-going replacement of LA4 at this juncture. Based on the proposed timescales storage is estimated as 34 weeks.	£12,000
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£40,250

Replacement of LA3 or LA6 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Verification phantoms Verification film	£20,000 £2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Detectors Instrumentation	£1,600 £1,000 £10,500 £25,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£477,000
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA3C	£5,500
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£33,750

Replacement of LA3C at Canterbury		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA6.	£5,500
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac. (includes an estimated uplift for inflation)	£910,000
Commissioning equipment	Verification phantoms Verification film	£20,000 £2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Detectors Instrumentation	£1,600 £1,000 £15,000 £35,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £9,000
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£1,007,000
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA6.	£5,500
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£33,750

EXTRACT OF THE MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 24TH MAY 2017, 10.30A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention & Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Gemma Craig	Assistant Deputy Chief Nurse	(GC)
	Darren Yates	Head of Communications	(DY)
	Ian Courtney	EMIS Health	(IC)
	Pam Croucher	Healthwatch Kent Representative	(PC)
	David East	Member of the public	(DE)
	Ali Nobakht	Member of the public	(AN)

5-15 Finance Cttee, 22/05/17 (incl. approval of the Business Case to replace 2 Linear Accelerators; and quarterly progress update on Procurement Transformation Plan)

SDu referred to the circulated report (Attachment 11) and highlighted the following points:

- The meeting was not quorate, which was regrettable given the amount of work involved
- The Committee agreed that the scope of Finance Committee should be extended to include performance, and therefore that a review should be undertaken to consider including this
- The recent increase in the use of Agency staffing and non-framework Agencies in particular had been noted, and it was agreed that the Workforce Committee should be asked to review this at its meeting w/c 29/05/17
- The Business Case for proposed LinAc replacements in 2017-2020 was reviewed and recommended for approval by the Trust Board

AK endorsed SDu's remarks regarding extending the role of the Finance Committee, on the basis that this would ensure the focus on performance was maintained after the Trust exited FSM. DH asked KT for his thoughts. KT stated that he agreed. DH then confirmed that he also concurred. It was therefore agreed that revised Terms of Reference (including membership) would be drafted, and submitted for approval to the Trust Board in June 2017, having first been agreed by the Finance Committee.

Action: Liaise with the relevant Trust Board Members and draft revised Terms of Reference (including membership) for the Finance Committee, to enable these to be submitted for agreement at the Finance Committee on 26/06/17, and approval at the Trust Board on 28/06/17 (Trust Secretary, May 2017 onwards)

DH then referred to the circulated Business Case for replacement LinAcs (Attachment 12). SO clarified that the despite the title on page 1 of the report ("…replace 2 Linear Accelerators), the Case was in fact to replace 3 LinAcs. DH acknowledged that the Finance Committee had reviewed the Case and invited questions or comments. GD remarked that he agreed with the approach being taken with East Kent Hospitals University NHS Foundation Trust.

SDu asked that the authors of the Case be commended, as it was very well written.

The Business Case for proposed LinAc replacements in 2017-2020 was approved as circulated.

SO then referred to the circulated quarterly progress update on the Procurement Transformation Plan (Attachment 13) and invited questions. DH pointed out that the “% of spend on a contract” of 43.91% in March 2017 was poor, when compared to the target of 90%, and asked for a comment. SO acknowledged the point, and gave assurance that actions would be taken to address this.

Trust Board meeting - November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-15	**Emergency Planning update (annual report to Board) (incl. "When tragedy strikes" briefing from NHS Confederation)**	**Chief Operating Officer / Head of Emergency Planning & Response**

Summary

Enclosed is the Emergency Planning update (annual report to Board). A supplementary presentation will also be given by the Head of Emergency Planning & Response at the meeting.

The Trust Board is asked to consider whether it is satisfied with the current arrangements for the oversight of Business Continuity (or whether it feels it appropriate for one of the Trust Board's sub-committees to provide more specific oversight).

Which Committees have reviewed the information prior to Board submission?

- TME, 21/11/18

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

Information, assurance and to consider if the Board considers that more specific oversight is required of Business Continuity arrangements

[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

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Emergency Planning and Response

Maidstone and Tunbridge Wells NHS Trust

Emergency Planning, Response & Recovery Annual Report to Trust Board 2017/2018

taking pride

Patient First · Respect · Innovation · Delivery · Excellence

1 Introduction

1.1 The Trust is a Category One responder as defined by the Civil Contingencies Act 2004 which imposes clear duties on the organisation in relation to emergency planning and response. In addition NHs England and the CCG through contracts also impose a number of duties and requirements in relation to resilience.

1.2 This report summarises the work of the Emergency Planning & Response Team over the year since the last report was presented to Trust Board and highlights the outcome of the recent NHS Emergency Planning Assurance process.

1.3 In March 2018 the NHS confederation published its report "When tragedy strikes" looking at some key learning from the incidents around the UK in the previous year. It made a number of observations on the response for NHs trusts. The team would bring to the attention of the Board the following points from this document in considering the Annual Report.

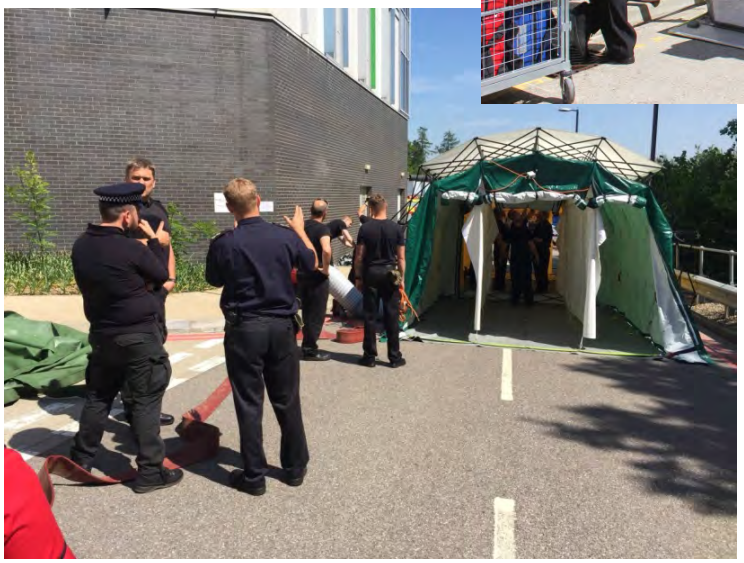
- **The overarching message is simple: planning and rehearsal, multi-agency collaboration, and support for both patients and staff are vital to providing the best possible care when tragedy strikes**
- **Individual hospitals must rehearse for mass casualty events: practise with desktop exercises, going through what would happen on the day, and practise a real-life simulation**
- **When planning for a major incident, plan with all the agencies that might be involved**
- **Understand the full range of colleagues with which you could collaborate**
- **Consider a way of managing the outside environment of the hospital with the press.**
- **Major incident exercises are vital**

2. Emergency Response

2.1 During the year the Trust has mounted a number of emergency responses including the response to winter weather at the start of the year. The Trust response ensured the safety of patients and the continuity of all critical services. The reliability of severe weather warnings this year enabled the pre cancellation of non-critical activity which assisted greatly in maintaining all our critical services. Our partnership with South East 4x4 worked well but our internal 4x4 arrangements also worked well and enhanced resilience. A debrief and further winter exercise have been carried out to refine plans for this winter. During the winter the benefits of our helicopter landing sites were proved especially in terms of transferring patients out to specialist centres.

2.2 A major incident standby was activated on May 5th in relation to an incident on Detling Hill involving firearms. The incident provided a good test of communications and review of plans at Maidstone.

2.3 The Heatwave in the summer tested various parts of our heatwave planning and provided a good test of the trust response to high temperatures. The Tunbridge wells Hospital stood up



Partnership Day for Business Continuity Awareness Week 2018

well with its modern design with very few issues around high temperatures. At Maidstone some areas required portable air conditioning to be provided. A separate report was compiled to look at how we manage responses to a heatwave in the future in the light of the report from the Parliamentary Select Committee on heatwave resilience.

2.4 On August 13th a Coach Crash occurred on the M25 resulting in the Ambulance Service declaring major incidents at TWH and MGH in addition to other hospitals. This provided a good test of procedures and a focussed debrief was held to look at amendments to plans.

2.5 Throughout the year there have been various highways issues affecting the Trust including the sinkhole opening on the A26 and various long term roadworks and closures on the motorway network. The team have worked with Kent Highways and Highways England to mitigate some of the adverse effects on the organisation.

3 Partnership Working

3.1 During the year the team have forged new partnerships in the community and reinforced others. Working with the Kent Association for the Blind the team have developed skills to be able to ensure those who are blind or partially sighted can be safely treated in chemical or radiation incidents where decontamination is required. Practical training with guide dogs that would also require decontamination has been beneficial. Helen Grant MP dropped into Maidstone Hospital to see the training first hand after the Salisbury Attacks and was very complimentary about the partnership she saw.

3.2 During Business Continuity Awareness Week we organised a partnership day where responders could meet each bother and their opposite numbers in the hospital. Kent Fire & Rescue Service, South East Coast Ambulance Service, Kent Police and HM Coastguard attended including the Coastguard Helicopter along with SERV Bloodrunners, South East 4 x4 and the Salvation Army. Hospital staff and other services were able to familiarise themselves with procedures and terminology. The event was attended by the Assistant Chief Constable from Kent Police and other senior officers. New technology including the Kent Fire Brigade Drone and Detection Identification and monitoring equipment used in Chemical Incidents was in use.

3.3 At the event the Resilience Awards were presented to South East 4 x4 and SERV Blood Runners for their assistance in the recent snow.

3.4 During July we celebrated the NHS 70th birthday. To cement our relationship the emergency services chose MTW to present a giant birthday card to the Trust.

3.5 During the year several other trusts have visited to see what MTW do and take away new ways of working.

3.6 The team are part of the South East London Kent & Medway Trauma Network Emergency Planning group and have worked with other trusts to consider a network approach to incidents involving the Trauma Network.

MP Helen Grant visits Kent Association for the Blind Training with staff at Maidstone

CBRN Training

4 Safety Advisory Groups and Public Events

4.1 During the year the team are members of local authority safety advisory group which consider all large events and disruptions. The team have been working to reduce hospital attendances even further with excellent results. The recent Little Mix Concert at the County Showground. Kent's largest event last year - was a good example of multi-agency planning where the team was part of the onsite control room with the Ambulance Service.

5 Next generation

5.1 The Trust have worked for several years to help develop the next generation of emergency planning professionals and develop NHS Emergency Planning as a career choice amongst new graduate emergency planners. The first student is now working for the Department for International Development and had a key role in the Ebola response. Sherena Evans joined the Trust for her year in July – a post shared with East Kent Hospitals and Dartford & Gravesham NHS Trust.

6 Helicopters

6.1 During the year the team continued excellent working with all helicopter providers and were invited by the RAF to a dedicated training day at RAF Benson working with Chinooks and larger aircraft to develop safety awareness.

6.2 The new HM coastguard helicopter has made a number of landings including during the snow.

6.3 The team successfully received funding to enable the Trust to start the process of building a new all-weather 24/7 pad at Maidstone Hospital to secure air access to the this site.

6.4 Relationships with all air providers using our sites have been enhanced this year with joint training and exercising.

7 Exercises & Training

7.1 Exercise Vanguard held in March at the Kent Event Centre enabled organisations across the county to review mass casualty preparedness.

7.2 Exercise Shakespeare held in April in North Kent enabled staff to play the part of casualties and bystanders to test emergency service responses to a firearms incident. This was very positive in considering the hospital response.

7.3 Exercise Nightingale was held in May at the Tunbridge Wells Hospital to test radiation emergency arrangements with Dungeness Nuclear Power Station, Kent Fire & Rescue Service and South East Coast Ambulance Service. It allowed ED staff, incident commanders and Medical Physics staff to respond to a live simulated nuclear incident. It also provided a full communications test.

Team member working with multi agency partners at Little Mix Concert 2018

Snow 2018

7.4 In June staff at TWH ED were able to test out through a live run through of moving Minor injuries to a major incident location. This was a good test of this important contingency.

7.5 The Trust annual table top exercise in June this year was held at the Kent Event Centre where over 60 Trust staff including the Medical Director and Chief Nurse worked with colleagues from SECAMB and the Independent Sector to respond to a large train crash.

7.6 The Trust annual winter exercise, Exercise Polar is now in is fifteenth year and saw over 60 staff with partner agencies including West Kent CCG, South East Coast Ambulance Service, Kent Community Health and Kent County Council work through winter contingencies.

7.7 In June Exercise Ragdoll enabled staff to work with Kent Police to respond to a simulated missing child allowing both Police and hospital staff chance to consider all the key issues in working together including investigation, warning and informing, communications and searching of the site.

7.8 In May staff at Tunbridge Wells Hospital were able to work with Kent Fire & Rescue Service when they practiced the use of specialist equipment to respond to emergencies where bariatric patients require rescue.

7.9 A number of Business Continuity Exercises took place with individual departments and services during the year across the Trust.

7.10 During the year a full programme of training has taken place including Command Accreditation Courses, CBRN, loggists and Command Support Team. New video packages and a new e learning package are being rolled out.

7.11 The team designed CBRN team training in a new format this year at the Kent Event Centre training over three days. Using the Exhibition Halls we were able to use all the equipment indoors including emergency services that were able to drive inside the halls and give staff a full understanding of the equipment and resources in use. This training experience was shared across the Kent trusts making it economic as well.

7.12 In the future the team will consider more challenging exercises for staff to ensure our procedures are as resilient as possible.

8 Kent Resilience Forum

8.1 The Trust is part of the Kent Resilience Forum bringing together all responders across the County including local authorities, military, utilities and emergency services.

8.2 The team sit on key sub groups including Exercises & Training, New Threats, Mass Fatalities and evacuation.

8.3 The team continue to work with partners on the forum to emerging and changing risks such as the planning for BREXIT and climate change.

NHS 70 – Emergency Services celebrate in partnership with MTW

Helicopter Training at Tunbridge Wells Hospital with MTW Staff

Exercise Nightingale in conjunction with SECAMB and Dungeness Nuclear Power Station

9. Team

9.1 This year the team have continued to work with East Kent University Hospitals Foundation NHS Trust and Dartford & Gravesham NHS Trust using the experience of the team to good effect across the patch. The huge benefits in having some of a Band 7 from ED in the team have been very evident.

10. Assurance

10.1 The NHS England EPRR assurance assessment was undertaken in the summer and the Trust found itself substantially compliant. There were two areas short of full compliance and these relate to areas where it is not possible to gain compliance until later in the year when NHS England release new guidance. All trusts in the region are in the same position.

11. Conclusion

11.1 The Trust remains well prepared with a good work programme going forward into next year. The team continue to look for new and innovative ways to train and prepare the organisation working in partnership where possible. Continued resourcing of the EPRR function is important in a challenging and changing world with the risks and hazards that it brings. It can be seen that the Trust already meets the challenges set out in “When tragedy strikes” however in order to be thoroughly prepared all parts of the organisation need to ensure they demonstrate resilience especially during service or staff changes.

11.2 The team continue to embed lessons identified from incidents across the UK and to ensure the right plans are in place. However there is no substitute for ensuring training is up to date and regular attendance at exercises. Resilience should be part of culture in every step of the business of the Trust and in every part of the Trust.

11.3 The continued resourcing of emergency planning and response activities at the current level is crucial to ensuring that the organisation remains well prepared.

11.3 Finally the team would like to thank the Chief Operating Officer who as Accountable Emergency Officer is retiring this year and the Executive Team for the environment to allow the team to push boundaries in Emergency Planning & Response again over the year.

Trust Board Meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-16 Summary report from Quality Committee, 14/11/18	**Committee Chair (Non-Executive Director)**

The Quality Committee met on 14th November (a 'main' meeting).

1. The key matters considered were as follows:

- The Medical Director reported on the **actions planned to reduce requests for Radiology investigations** and it was agreed that a further update should be submitted in January 2019
- The Clinical Director for Trauma and Orthopaedics reported on the **further outcomes data from the various procedure/sub-specialties** within the Directorate and it was agreed that the Clinical Director should provide the final report of the current 'deep dive' review of infected total hip replacements, to enable this to be submitted as part of a future 'key issues from Clinical Directorates' item at the 'main' Quality Committee. It was also agreed that the Clinical Director should check whether the reviews that were undertaken prior to data being submitted to the National Joint Registry were sufficiently robust in preventing the submission of inaccurate data (in relation to the presence of surgical site infections)
- The Medical Director reported on the process for **the prospective review of patients experiencing a long waiting time**
- The Associate Director, Quality Governance reported on the **findings / conclusions from the 3 Never Events Review Panels** held in September and October 2018
- The reports from the rolling programme of **Directorate-based clinical outcome reports** were reviewed for Surgery, Urology and Gynae Oncology and Women's and Sexual Health, and both reports contained much assurance
- The report of recent **Trust Clinical Governance Committee** meetings was discussed, and each Directorate then highlighted their key issues. The following key points arose:
  - Theatre utilisation was discussed and the Chair of the Trust Board agreed to discuss the proposal to establish a pilot scheme in which Consultant surgeons were given the responsibility to book their Theatre lists (to improve utilisation) with the Chief Executive
  - The Clinical Director for Cancer, Haematology & Radiology alerted the Committee to the time being taken to type Outpatient clinic letters, which was currently at several weeks. It was agreed that the issue should be drawn to the attention of the Trust Board
  - A discussion on inpatient Paediatric capacity led to an action for the Clinical Director for Paediatrics to provide an update on the Directorate's proposal/s regarding such capacity (& the consideration of the proposals by the Executive Team) to the Jan. 2019 Committee
- The summary report from the **Patient Experience Committee**, 05/09/18, was noted
- The Medical Director gave an **update on the Virtual Ward service** & the Chief Nurse reported the outcome of the **Quality Risk Tool review** undertaken by West Kent CCG
- The Medical Director and Chief Nurse presented an update on the **general review of Trust quality** that is currently taking place and it was noted that the finalised report would be presented at the next 'main' Quality Committee
- The Complaints and PALS Manager reported on the latest **complaints response performance** and the standing update on **mortality** was given by the Medical Director
- The latest **Serious Incidents** were reported and the report of the **Quality Committee 'deep dive' meeting** held on 15/10/18 was noted
- The method of the **Quality Committee's evaluation** for 2018 was agreed (which involved the completion of a brief survey by all Committee members)

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

3. The issues from the meeting that need to be drawn to the Board's attention are:

- The Clinical Director for Cancer, Haematology and Radiology raised concerns regarding the delays in Outpatient clinic letters being typed

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

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

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

Trust Board Meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-17	Summary report from the Trust Management Executive (TME), 21/11/18	Committee Chair (Chief Executive)

The TME met on 21st November. **The key matters considered at the meeting were as follows:**

- Under the **Safety Moment**, the Chief Nurse reported that the theme was the prevention of pressure ulcers
- Amendments to the **Terms of Reference** (to reflect the new clinical management structure) were approved. The main change was to change the frequency of meetings from monthly to quarterly. The amended Terms of Reference are enclosed in Appendix 1 for information.
- An update was given on the work regarding the **oversight of Cancer patients who were not part of a Cancer access target pathway**. This prompted a discussion on the paper-based process for requesting Radiology investigations in Outpatients, and the Chief Clinical Information Officer (CCIO) agreed to consider whether any practical steps could be taken to address the concerns that were reported regarding that process
- The **2018/19 winter plan** was again discussed in detail, with the discussions focusing on the use of the Hospital at Home service (which was formerly called the Virtual Ward)
- The Director of Strategy, Planning and Partnerships gave an **update on the Trust's 2019/20 plan** and the work being undertaken in relation to the **Trust's clinical strategy**
- A discussion was held regarding the future of **Listening into Action (LiA)**. As had been the case at the Executive Team Meeting (ETM) the day before, support was give continue with LiA, but it was recognised that work was need to review and refresh the Trust's approach
- The Head of Emergency Planning & Response attended to give the **annual Emergency Planning update**. The ensuing discussion led to an action for communication to be issued to key Divisional/Directorate staff offering to respond to any identified gaps in their Major Incident preparedness
- The key aspects of the **monthly performance for month 7** were highlighted (which included the continued challenges regarding the 62-day Cancer waiting time and Referral to Treatment (RTT) targets), whilst the latest **infection control performance** was reported. The 4 clinical Divisions also reported on their key issues
- Updates were given on the key issues from the **Clinical Directors' Committee** and the **national 7 day service programme**
- Reports on the recently-approved Business Cases; the Board Assurance Framework; an update on the update on 2018/19 Internal Audit plan; and the key issues from ETMs were received for information and/or assurance
- Updates were also noted on some of the TME's sub-committees (the Trust Clinical Governance Committee, Clinical Operations & Delivery Committee and Policy Ratification Committee)
- The Committee expressed its gratitude to a number of individuals who were attending their last TME meeting, including the Chief Operating Officer

In addition to any agreements referred to above, the Committee agreed that: N/A

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

Appendix 1: Amended Terms of Reference

TRUST MANAGEMENT EXECUTIVE (TME)

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

1.1. The Trust Management Executive (TME) forms, with the Trust Board and Executive Team Meeting, one of the central spine forums through which the Trust conducts its formal business.

2. Membership

2.1. The membership of the TME is as follows:
- 2.1.1. Chief Executive (Chair)
- 2.1.2. Chief Nurse
- 2.1.3. Chief Finance Officer
- 2.1.4. Chief Operating Officer
- 2.1.5. Director of Strategy, Planning and Partnerships
- 2.1.6. Director of Workforce
- 2.1.7. Medical Director
- 2.1.8. Chiefs of Service for each Clinical Division (x 5)
- 2.1.9. Divisional Directors of Operations (x 5)
- 2.1.10. Divisional Directors of Nursing & Quality (x 5)
- 2.1.11. Clinical Directors (x 18)
- 2.1.12. Director of Infection Prevention and Control (if not already represented under 2.1.8 or 2.1.11)
- 2.1.13. Trust Lead Cancer Clinician
- 2.1.14. Deputy Medical Director
- 2.1.15. Director of Medical Education (DME)
- 2.1.16. Clinical Lead for Research
- 2.1.17. Chief Clinical Information Officer (CCIO)
- 2.1.18. Head of Midwifery
- 2.1.19. Director, Estates and Facilities Management

2.2. Any other member of the Executive Team (2.1.2 to 2.1.7 above) can act as Vice Chair

2.3. Members should send appropriate deputies, when they are unable to attend in person

3. Attendance and quorum

3.1. Others may attend by the invitation of the Chair for specific agenda items.

3.2. Meetings will be quorate when attended by no less than 8 members which includes a minimum of 3 members of the Executive Team (i.e. 2.1.1 to 2.1.7 above, one of whom will Chair the meeting), 2 Chiefs of Service, 6 Clinical Directors, and 1 Divisional Director of Operations.

4. Frequency of meetings

4.1. Meetings will be generally held quarterly

4.2. Additional meetings will be scheduled as necessary at the request of the Chair.

4.3. The Trust Secretary will ensure that appropriate secretarial support is provided. This will include agreement of the agenda with the Chair, collation of reports, taking meeting minutes and keeping a record of agreed actions.

5. Sub-committees and reporting procedure

5.1. The following sub-committees report to the TME through their respective Chairs or representatives following each of their meetings. The frequency and format of reporting (i.e. whether written or verbal) will depend on the frequency of each sub-committee meeting, and the requirement of the TME. However, all of the TME's sub-committees should submit a written report to TME at least once per year:

5.1.1. Health & Safety Committee
5.1.2. Information Governance Committee
5.1.3. Informatics Steering Group
5.1.4. Nursing, Midwifery and AHP Committee
5.1.5. PLACE Action Group
5.1.6. Policy Ratification Committee
5.1.7. Private Patient Committee
5.1.8. Procurement Strategy Committee
5.1.9. Sustainable Development & Environment Committee
5.1.10. Trust Cancer Committee
5.1.11. Trust Clinical Governance Committee

The Terms of Reference of TME sub-committees are required to be approved by the TME, having first been agreed by the sub-committee. Sub-committee Terms of Reference should also be subject to an annual review (although approval should be sought within the year for any significant proposed amendments)

6. Parent Committee and reporting procedure

6.1 The TME has no parent committee, but will provide a summary report on its activities/decisions to the Trust Board (and to appropriate Trust Board sub-committees where required/requested)

7. Duties

Strategy and plans

7.1 Develop and discuss proposals for submission to the Executive Team Meeting and/or Trust Board on the Trust's strategy, vision, aims, objectives and values

7.2 Discuss proposals for submission to the Executive Team Meeting and/or Trust Board and/or Finance and Performance Committee on the Trust's annual plan/s, including the revenue and capital budgets / plans.

Finance

7.3 Contribute to the development of the annual planning process

7.4 To support the delivery of the Trust's annual financial plan by helping to overcome barriers

Performance

7.5 Support action in relation to key performance issues

Risk management and internal control

7.6 Supporting the delivery of robust risk management policies and processes

7.7 Supporting the identification and addressing of all key risk issues

7.8 To review and endorse the Trust's Annual Governance Statement, prior to this being considered at the Audit and Governance Committee and Trust Board

Quality

7.9 To support compliance with the national "fundamental standards", and contribute to action to address weaknesses in compliance or assurance

7.10 To support delivery of the Trust's Quality Accounts priorities, including remedial actions

IT and Information Governance

7.11 Support the resolution of any IT-related operational issues. This will mainly be achieved through exception reporting from the Informatics Steering Group, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

7.12 Review and endorse the draft Information Governance Toolkit year-end return for submission to the Trust Board

7.13 Support the implementation of effective arrangements for information governance. This will mainly be achieved through exception reporting from the Information Governance

Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

Estates

7.14 Support the implementation of strategic estates issues

Workforce

7.15 Support efforts to ensure that workforce projections meet current and future service delivery requirements

7.16 Support the actions developed in response to the annual national (and local) staff satisfaction surveys

Business cases

7.17 To note Business Cases approved by the Executive Team and/or the Investment Appraisal Group (IAG)

7.18 To discuss, and contribute to the development of Business Cases (prior to such Cases being considered for approval by the relevant forum) that, in the judgement of the Chair of TME, involve significant operational impact, and support / make recommendations as required

8. Emergency powers and urgent decisions

8.1 The powers and authority of the TME may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least 2 members of the Executive Team (2.1.1 to 2.1.7 above), 1 Chief of Service and 1 Clinical Director. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the TME, for noting.

8.2 If the Chair agrees, a decision on an item can be made via 'virtual' means. In such circumstances, all TME members will be emailed the details of the proposed decision, and offered the opportunity to object, by a given date (this should be at least 2 working days from the date of issue of the email). If no objections are received, the proposal will be considered to be approved. If objections are received, the Chair will determine whether to a) defer the decision to a formal meeting (to enable discussion to occur) or b) overrule the objection/s. If the latter is determined, an explanation will be provided to the next formal meeting.

9. Review

9.1 The TME will review (and approve) its Terms of Reference at least annually

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History

- Agreed by the Trust Management Executive, 22/01/14
- Approved by Trust Board, January 2014
- Amendments agreed by the Trust Management Executive, 23/04/14
- Approved by Trust Board, May 2014
- Amended following decision by Trust Board, November 2014 that the Trust Management Executive should no longer be a sub-committee of the Trust Board
- Amendments approved by the Trust Management Executive, 15/04/15 (annual review)
- Approval of addition of "Procurement Strategy Committee" as a formal sub-committee, November 2015
- Amendments approved by the Trust Management Executive, 17/02/16 (addition of several sub-committees, and refining of described processes to match actual practices)
- Amendments approved by the Trust Management Executive, 16/11/16 (to reflect new Divisional structure and changes to TME's functioning)
- Amendment approved by the Trust Management Executive, 18/01/17 (to change the role in reviewing Business Cases)
- Amendment approved by the Trust Management Executive, 21/06/17 (to add the new Deputy Medical Director and Associate Medical Director positions to the membership)
- Amendments approved by the Trust Management Executive, 20/09/17 (to add the Trust Cancer Committee as a sub-committee; to require the Terms of Reference of sub-committees to be approved by TME; and to require the sub-committees to undertake an annual review of their Terms of Reference

- Amendment approved by the Trust Management Executive, 17/10/17, to reinstate the Chief Executive as the Chair, and enable any member of the Executive Team to act as Vice Chair (as well as some minor 'housekeeping' changes)
- Amendment approved by the Trust Management Executive, 21/02/18, to add the Director of Medical Education (DME) to the membership
- Amendment approved by the Trust Management Executive, 21/03/18, to add the Clinical Lead for Research to the membership
- Amendment approved by the Trust Management Executive, 25/04/18, to add the Chief Clinical Information Officer (CCIO) to the membership
- Amendment approved by the Trust Management Executive, 20/06/18, to add the Chair of the MTW AHP Leads Forum, and remove the Deputy Chief Executive post from the membership
- Amendments approved by the Trust Management Executive, 19/09/18 (annual review)
- Amendments approved by the Trust Management Executive, 21/11/18, in relation to the changes promoted by the new clinical management structure

Trust Board meeting – November 2018

Maidstone and Tunbridge Wells NHS Trust

11-18 Quarterly progress update on Procurement Transformation Plan — Chief Finance Officer

The Procurement Transformation Plan (PTP) was originally approved by the Trust Board on the 19th October 2016 and then submitted to NHSI by the 31st October, which was the deadline for Board approved submissions.

It was a requirement that every trust should have a Procurement Transformation Plan. The PTP is a document which outlines the procurement function within the trust and the key actions and activity within the trust to deliver the Lord Carter targets set within the document.

Each PTP must have an action plan at the end of the report and it is the expectation that PTPs are agreed, and signed off, by the Trust Board.

This report sets out the latest performance against the updated Maidstone and Tunbridge Wells NHS Trust PTP including the revised Carter metrics. NHSI have indicated these metrics are likely to change within the year but this will be in consultation with NHS Heads of Procurement.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 27/11/18

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

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

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 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

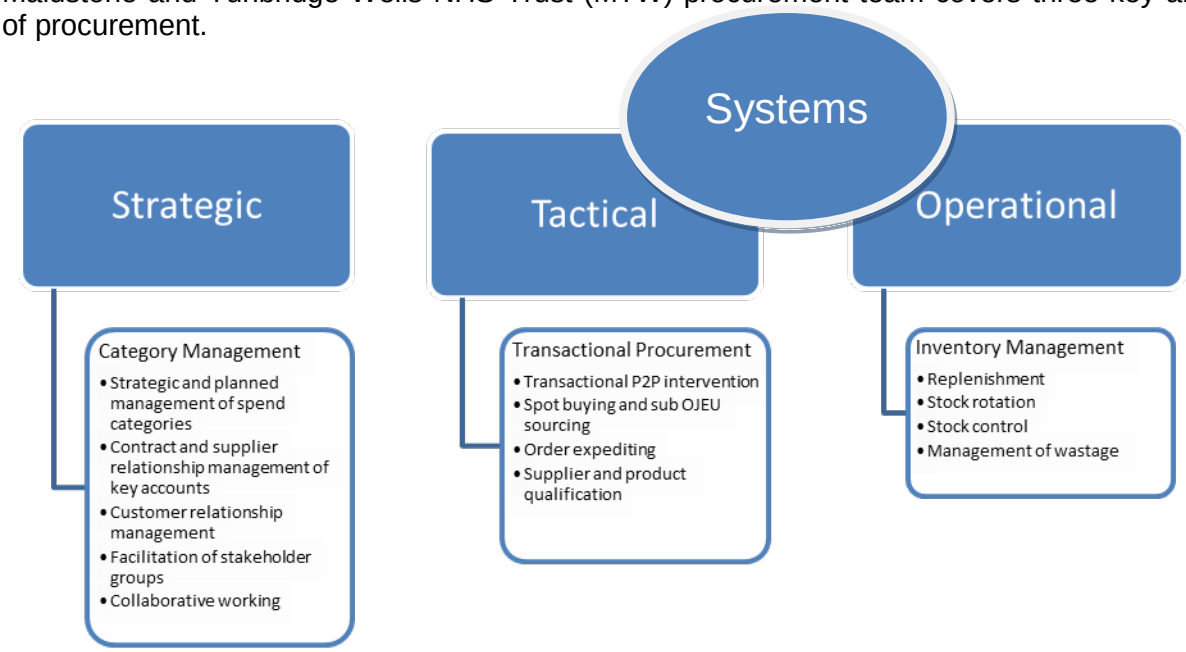
Background

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 reviews performance against 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 expects to attend all CIP meetings and be involved in 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 & Agency.

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 is currently 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. Some members have had to deal with internal factors that have diverted their focus away from the STP work. Therefore the onus for delivering this number has fallen back on the internal team and is no longer expected to be delivered through the 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 of October 2018 we were tracking to deliver £3.9m in year, with a carry-over of £1.3m into 19/20. In addition to this we have delivered £225k of non-cash releasing savings that are not included in the performance against target. This figure includes projects such as securing £100k of additional funding for Stoma care nurses and support, identifying £30k of PBR excluded devices which are not being reclaimed, adjusting Par levels to reduce the level of stock on-hand and negotiating Tariff + 0% MFF for outsourced elective surgery which provides an 11% benefit to the NHS. As stated the STP savings have not materialised as expected and so the £1m projection has been added to the internal plan. Therefore the internal team is tracking to deliver £700k above the original target, but with the addition of the STP target we are seeking to close the gap of £300k internally.

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. The system is now embedded so we will be looking at maximising its additional functionality and controls to drive quality data and opportunities.

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 high level review of the way we use this system has been undertaken. This has identified that we are not realising the full benefits of an automated inventory management system. An options appraisal will now be undertaken to establish what needs to be done to improve the system and whether the mixed model is appropriate e.g. would closed systems be better than a mix of closed and open. It has already been established that a small restructure of roles in the department is likely to be required to allow for the dedicated and effective management of this system.

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%**	**96.8%**	The Trust has fully implemented an electronic P2P system integrated with finance. This includes a catalogue which enables end user ordering. Focus will now be given to how we can convert non PO spend and bring areas outside of Integra on board (such as Estates)
3a	% of invoice value matched to an electronic purchase order	**90%**	**75.5%**	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. This metric is lower than expected. However, we have identified a number of large invoices that were processed without a PO for Imaging maintenance. They were procured through a compliant route and so we are investigating these were not flagged-up sooner. When these invoices are factored back-in, the metric increases to 90.7%.
3b	% by count of invoices matched to an electronically generated purchase order	**90%**	**87.4%**	As with 3a, if we factor in the missing imaging maintenance invoices, this metric increases to 89.9%. Currently, the Estates orders are processed through a different system (Shires) which has made it difficult to calculate and include against this metric. As of 1st December we will be working with Estates to start putting their spend through Integra which will give us a better overall output.
4	% of spend on a contract	**90%**	**Not yet reported**	A review of how we record Contracted and Quoted spend through Integra will allow us to start measuring and reporting on this metric.

5	Inventory Stock Turns	**NA**	**70.5 Days**	This number has come down for the second quarter running, but is still too high (our aim is to get down to 45 days). The reduction shows the increased focus on the efficient use of Omnicell.
6	NHS Standards Self-Assessment Score (average total score out of max 3)	**Appendix 3 includes the metric breakdown**		Level 1 standard assessment was completed in December 2017. MTW are still awaiting the formal ratification of the assessment. MTW understandings that a recommendation of level 1 achievement has been made. We are expecting this to go to the South west Board in December for review. See comment against People & Organisation in Appendix 1.
7	Purchase Price Benchmarking Tool Performance	**NA**	**£102,277**	Previous variance to Median for Q1 was showing on PPIB as £120,320. There is no specific target for this but a reduction from the previous quarter shows it is going in the

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 a development role and recruited to. The Apprenticeship scheme was not appropriate for this.

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 and intend to continue with this.

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. All members of the team have been offered the opportunity to study for their Level 4 CIPS through the Apprenticeship scheme. Three members of the team are currently studying for it. We will continue to offer this opportunity and will actively encourage staff members to develop via this route.

The quarter reported on has seen the departure of the Associate Director of Procurement with the Head of Category Management successfully applying to fill the role from 1st July. The vacant HoCM role has now been recruited to but this appointee will not be in post until Feb 2019. We had difficulty finding an interim of sufficient quality to temporarily fill this post but a suitable candidate has now been found and was employed from 1st October.

Appendix 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 have now started internal team development sessions to provide practical & bespoke support in areas such as strategy, specification development, key performance indicators, contract writing & contract management.

Internal movements, long term sickness and resignations have left a shortfall in the Inventory Management team which we have had difficulty recruiting to. We have explored how we might

be able to further utilise the Apprenticeship scheme to bring in some school leavers and develop the skills we need internally, but an appropriate qualification has yet to be identified that can support this. A revision of the part-time role into a full time post has been agreed and recruited to in order to provide a floating resource between the 2 sites. This has also helped to support the increased workload.

An initial review of the Purchase to Pay (P2P) process has identified a number of areas for improvement, for instance in the process for receipting goods. The responsibility for this step lies within the Portering team under Estates. This creates a structural disconnect with the Inventory Management team. A high level discussion has been had with EFM on the potential issues 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 have a significant impact on the audit trail. This will now form part of a wider P2P review to be conducted as a Finance Improvement Plan project with Accounts Payable.

Measures Implemented (200 words max)	All staff appraisals identify training needs and KPIs monitored on numbers of staff qualified. Three 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. A development role has been created for 2018/19. This post will be trained in Systems, Operations and Category Management for succession planning. A university graduate was 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 Bespoke internal training has started.
Impediments and support (200 words max)	The Category Management 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 has now started. 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. We do not have an appropriate staffing structure to support the effective management of the Omnicell system. A re-structure of roles in the team is required in the first instance and possibly additional resource required (although only temporary).

2) Processes, Policies & Systems :

The Procurement Strategy has been reviewed in November 2018. The strategy had been amended to take into consideration the impact of the significant changes to national policy and approach since it was agreed, and the effect on the regional STP and aligning the Trust

objectives to support the changes in the national landscape.

Processes & Policies
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 FT, Darenth Valley & East Kent FT, and the Community and Mental Health Trusts). The Productivity workstream for the STP is led by the Medway FT Head of Procurement 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 work-streams for MTW has had to be brought back in-house for this financial year.

NHSSC have been approached to undertake the analysis on behalf of the STP to identify quick wins through commonality of product that could generate better pricing in the short term when our volumes are aggregated, or changes in supply route. However, the benefit of this may only be short term with the introduction of national pricing on 1st April 2019. 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 national "Future Operating Model" went live in May 2018. As yet we have seen no direct impact as there are considerable issues in novating existing framework contracts across to the category towers. We do not expect to see any significant advantages or changes from this restructure until 1st April 2019. We have received the initial detail on how this will be funded via top-slicing of Trust's income. Our impact statement identified a top-slice figure of £1,794,230 which is planned to deliver a net positive impact of £42,483 in year one. It is not clear how this will work beyond the first year. The approach to the calculation has been challenged by the national Director of Finance group and a revision of this calculation is expected at the end of November.

As of 1st April 2019, NHSSC will become NHS SCCL which will be the vehicle for delivering the new category tower pricing. This will work on a buy price=sell price model so the opportunity for obtaining improved pricing through greater volume at a regional or local level is significantly reduced. This will have an impact on the areas of focus for the STP.

Systems

The implementation of the Inventory management system (Omnicell) and the integrated procurement and finance system (Integra) has given the Trust the facility 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 manual intervention and review to resolve invoice mismatches. A review of the whole Purchase to Pay process with Accounts Payable has therefore been established which will include the inputs from purchasing (price control), finance (invoice

processing) & estates (receipting).

The Purchase Price Index and Benchmarking (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. Whilst this is a useful tool for like for like benchmarking of catalogue items, the Trust has also recently invested in an 'intelligent' analytical tool called Procurement Dashboard. This takes all of our spend data (not just that on PO) and reports opportunities for product switches. It also benchmarks the cost of services against our peers.

NHSI have published the latest league table which now reports on Procurement quality metrics as well as price performance against our peers from PPIB. The full league table is provided in Appendix 4 but at a high level summary we are 25th out of 136 Trusts on price and 35th overall. We are also the leading Trust within the STP with East Kent at 74, Medway at 78 and Dartford & Gravesham at 80.

Measures Implemented (200 words max)	A Finance Improvement Project on the P2P process has started which will incorporate improvements in the use of Integra2. The STP has refocused its purpose. NHSSC have been retained to take on the day to day analysis of opportunity in view of the new national pricing model and the members have switched focus to the benefits of shared services. A high level review of the Inventory Management system has been undertaken which has identified a number of historical set-up issues which need resolving and some work required on the governance of its use. The Procurement Dashboard tool has been purchased and currently being implemented.
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 stakeholder engagement across the whole STP to deliver true collaborative working will be challenging. We need to leverage the support of the DDOF's when we experience resistance.

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 now been rejected.

The SE regionals Heads of Procurement from Medway Foundation Trust, Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Kent

Community Foundation Trust and Medway Community Healthcare, and Kent & Medway Social Care Partnership Trust have sought to work together as a region. East Kent have had to step back from engaging with the STP as it has focussed on setting up its arms-length wholly owned subsidiary which includes the Procurement service. The other Heads of Procurement meet every month to discuss opportunities for collaboration and have shared their procurement work plans.

The Heads of Procurement have shared 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 failed to get off the ground due to lack of resource and the internal pressures that have impacted East Kent and at different times each of the Trusts .The drive towards national pricing predominantly on clinical products now means that the focus of the STP will need to switch towards the benefits of shared services rather than leveraging aggregated volume on common products.

Next Steps

MFT, MTW, DGT, 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 in the short term and any areas where aggregated volume can still drive better pricing (such as Orthopaedics and Cardiology).

A number of areas that may benefit from a shared services model have been drawn up and these will be scoped further in the forthcoming HOP's meetings.

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 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) The Trust led on the procurement for the Kent-wide HSCN network which delivered a 60% saving of circa £4m over 5 years across the patch.
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 category towers will implement the national pricing (buy price = sell price) model with effect from 1st April 2019, so opportunities for benefitting from aggregated volumes will be limited. Whilst the focus changes towards shared services, these will typically be large and complex projects. The number of procurement staff who have the skills to run these is limited.

7. Risks and issues

The main risk to the procurement department 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

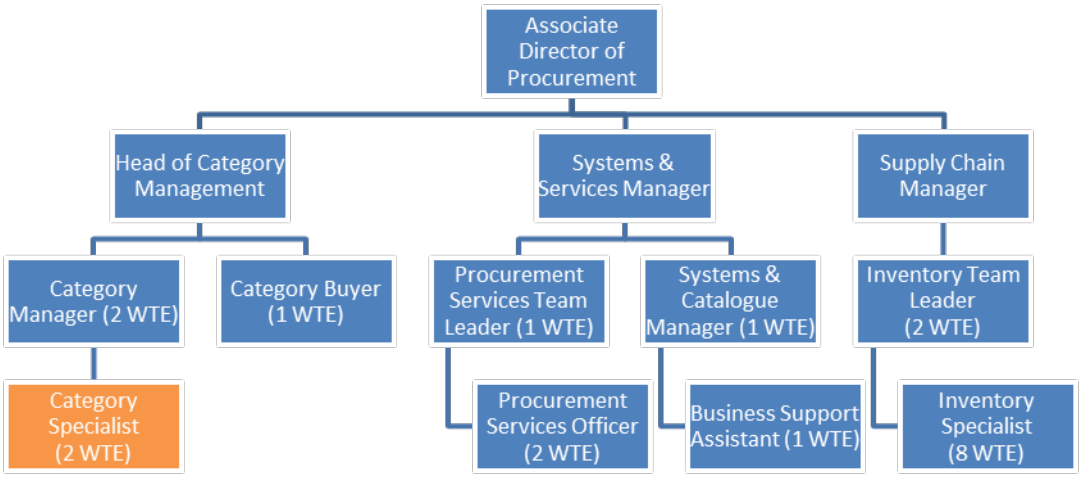
Trust and the whole STP region, requires staff with good procurement knowledge and the ability to negotiate in the market. Maidstone and Tunbridge Wells is very fortunate to have a Category Management team who are all MCIPS qualified but there is always the risk of losing staff to London where salaries are more attractive.

Having the Head of Category Management post vacant for 3 months has had an impact on driving the delivery of the work-plan forward at the pace planned, and has impacted on full CIP delivery.

Appendix 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 three members of the team training for the CIPS level 4 and this development opportunity remains open to all staff. 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. Bespoke internal training sessions have been developed to provide focused development of the Category Management team.
Procurement workplan	Delivery of 2018/19 procurement workplan. This workplan covers tail spend and improvement of the trust position on contract spend. Work has now started on the 2019/20 plan.
Procurement Savings	Achievement of agreed 2018/19 £4.2million – currently tracking £300k behind target
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. Increase number of quarterly contract review meetings with key suppliers. Re-introduce the Procurement Strategy Committee to drive the strategy with the new Chiefs of Service
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 yet to receive a response from Jane 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. We have received confirmation that another formal peer review will not be required, but we still haven't received our official accreditation. Once we have received this we have 12 months to work towards level 2. That work will therefore start as soon as we have sign-off.
Collaboration	Alignment of procurement work plans across the region
	Pre-market engagement with suppliers now the norm.
	Discussions with private sector on ways in which we can work in partnership

Appendix 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.

Appendix 3 – Procurement standards

NHS Procurement & Commercial Standards : Procurement Transformation Plan re-fresh Nov 2018

Area	Standard	*Level 1 Position at November 2018. If achieved then indicate below (you are not required to insert scores if achieved)	Level 2 Position at November 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-18	
	If not achieved then input self-assessment scores against each area and insert date of peer review to the right		Dec-19
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

Area	Standard			*Level 1 Position at November 2018. If achieved then indicate below (you are not required to insert scores if achieved)	Level 2 Position at November 2018. If achieved then indicate below (you are not required to insert scores if achieved)
4. Supply Chain	4.1 - Inventory Management & Stock Control				2
	4.2 - Logistics				2
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 Appendix 1 above

Appendix 4 – NHSi Acute Provider Trusts Procurement League Table

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
RW3	Central Manchester University Hospitals NHS Foundation Trust	North	100.0	1	100.0	44.2	79.5	34.6
RRF	Wrightington, Wigan & Leigh NHS Foundation Trust	North	94.8	2	87.9	39.2	84.3	36.3
RM3	Salford Royal NHS Foundation Trust	North	94.7	3	86.4	38.6	85.9	36.8
RJE	University Hospitals of North Midlands NHS Trust	Midlands And East	94.7	4	83.5	37.4	89.4	38.0
RTD	Newcastle Upon Tyne Hospitals NHS Foundation Trust	North	90.6	5	78.3	35.3	87.8	37.5
RNS	Northampton General Hospital NHS Trust	Midlands And East	88.5	6	70.2	31.9	93.7	39.5
RK9	Plymouth Hospitals NHS Trust	South	83.3	7	73.8	33.4	79.7	34.7
RAS	Hillingdon Hospitals NHS Foundation Trust	London	83.2	8	79.9	35.9	72.1	32.1
RGT	Cambridge University Hospitals NHS Foundation Trust	Midlands And East	82.8	9	65.6	30.0	88.6	37.7
RDZ	Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust	South	82.5	10	55.7	25.9	100.0	41.6
RA4	Yeovil District Hospital NHS Foundation Trust	South	82.0	11	68.5	31.2	83.6	36.0
RXR	East Lancashire Hospitals NHS Trust	North	81.2	12	81.2	36.4	66.7	30.3
RGP	James Paget University Hospitals NHS Foundation Trust	Midlands And East	81.1	13	69.6	31.6	80.6	35.0
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	North	81.0	14	78.7	35.4	69.3	31.1
RWE	University Hospitals of Leicester NHS Trust	Midlands And East	80.9	15	83.0	37.2	64.0	29.3
RXW	Shrewsbury & Telford Hospital NHS Trust	Midlands And East	80.4	16	73.6	33.3	74.4	32.9
RVJ	North Bristol NHS Trust	South	79.5	17	58.9	27.2	90.4	38.3
RJ1	Guy's & St Thomas' NHS Foundation Trust	London	78.3	18	53.5	25.0	94.8	39.8
RTF	Northumbria Healthcare NHS Foundation Trust	North	77.3	19	64.1	29.4	80.0	34.8

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
RHM	University Hospital Southampton NHS Foundation Trust	South	76.7	**20**	58.3	27.0	85.9	36.8
R1H	Barts Health NHS Trust	London	74.0	**21**	57.4	26.6	81.8	35.4
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	Midlands And East	74.0	**22**	65.6	30.0	71.9	32.0
RTE	Gloucestershire Hospitals NHS Foundation Trust	South	73.7	**23**	65.4	29.9	71.7	32.0
RBL	Wirral University Teaching Hospital NHS Foundation Trust	North	73.6	**24**	67.4	30.8	69.0	31.1
RWG	West Hertfordshire Hospitals NHS Trust	Midlands And East	72.3	**25**	71.5	32.4	61.7	28.6
RBN	St Helens & Knowsley Hospital Services NHS Trust	North	72.0	**26**	72.3	32.8	60.1	28.0
RJZ	King's College Hospital NHS Foundation Trust	London	71.3	**27**	64.7	29.7	67.9	30.7
RP5	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	North	71.0	**28**	65.5	30.0	66.4	30.2
RTG	Derby Teaching Hospitals NHS Foundation Trust	Midlands And East	70.7	**29**	73.3	33.2	56.4	26.8
RN5	Hampshire Hospitals NHS Foundation Trust	South	70.6	**30**	63.8	29.3	67.6	30.6
RRV	University College London Hospitals NHS Foundation Trust	London	70.5	**31**	49.5	23.4	84.8	36.5
RJL	Northern Lincolnshire & Goole NHS Foundation Trust	North	69.5	**32**	65.7	30.1	63.3	29.1
RNZ	Salisbury NHS Foundation Trust	South	69.4	**33**	69.7	31.7	58.2	27.4
RCF	Airedale NHS Foundation Trust	North	69.0	**34**	77.7	35.0	47.8	23.8
RWF	Maidstone & Tunbridge Wells NHS Trust	South	69.0	**35**	51.5	24.2	79.4	34.6
RYJ	Imperial College Healthcare NHS Trust	London	68.9	**36**	49.7	23.5	81.6	35.3
RFF	Barnsley Hospital NHS Foundation Trust	North	68.9	**37**	64.9	29.7	63.1	29.1
RVW	North Tees & Hartlepool NHS Foundation Trust	North	67.8	**38**	73.2	33.1	51.1	24.9
RR8	Leeds Teaching Hospitals NHS Trust	North	67.7	**39**	58.5	27.1	68.7	31.0
RAE	Bradford Teaching Hospitals NHS Foundation Trust	North	67.5	**40**	59.7	27.6	66.9	30.3

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
REF	Royal Cornwall Hospitals NHS Trust	South	67.5	**41**	55.7	25.9	71.5	31.9
RN3	Great Western Hospitals NHS Foundation Trust	South	67.4	**42**	59.8	27.6	66.4	30.2
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	North	66.8	**43**	54.5	25.4	71.8	32.0
RK5	Sherwood Forest Hospitals NHS Foundation Trust	Midlands And East	65.5	**44**	56.7	26.4	66.6	30.3
RM2	University Hospital of South Manchester NHS Foundation Trust	North	65.4	**45**	58.4	27.0	64.4	29.5
RTH	Oxford University Hospitals NHS Foundation Trust	South	65.2	**46**	58.8	27.2	63.5	29.2
RNA	Dudley Group NHS Foundation Trust	Midlands And East	65.2	**47**	58.6	27.1	63.7	29.2
RJ7	St George's University Hospitals NHS Foundation Trust	London	64.7	**48**	45.7	21.8	78.4	34.3
RVY	Southport & Ormskirk Hospital NHS Trust	North	63.7	**49**	50.5	23.8	70.8	31.7
RXP	County Durham & Darlington NHS Foundation Trust	North	63.6	**50**	65.8	30.1	52.0	25.3
RWY	Calderdale & Huddersfield NHS Foundation Trust	North	63.3	**51**	57.6	26.7	61.4	28.5
RL4	Royal Wolverhampton NHS Trust	Midlands And East	63.1	**52**	51.8	24.3	68.0	30.7
RBA	Taunton & Somerset NHS Foundation Trust	South	63.1	**53**	38.6	18.9	83.9	36.1
RCB	York Teaching Hospital NHS Foundation Trust	North	62.2	**54**	66.7	30.5	48.2	24.0
RKB	University Hospitals Coventry & Warwickshire NHS Trust	Midlands And East	62.1	**55**	50.9	24.0	67.2	30.4
RWW	Warrington & Halton Hospitals NHS Foundation Trust	North	61.5	**56**	65.1	29.8	49.0	24.2
RBK	Walsall Healthcare NHS Trust	Midlands And East	61.5	**57**	60.1	27.7	54.9	26.3
RDU	Frimley Health NHS Foundation Trust	South	61.1	**58**	64.0	29.3	49.4	24.4
RA9	Torbay & South Devon NHS Foundation Trust	South	60.9	**59**	36.0	17.8	83.0	35.8
RJR	Countess of Chester Hospital NHS Foundation Trust	North	60.7	**60**	54.5	25.4	60.2	28.1

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	**Score scaled 0 to 100**	**Rank**	**Process Efficiency scaled 0 to 100**	**Process Efficiency Score**	**Price Performance scaled 0 to 100**	**Price Performance Score**
RQ8	Mid Essex Hospital Services NHS Trust	Midlands And East	60.1	**61**	51.3	24.1	63.0	29.0
RWH	East & North Hertfordshire NHS Trust	Midlands And East	59.7	**62**	66.3	30.3	44.1	22.6
RXH	Brighton & Sussex University Hospitals NHS Trust	South	59.7	**63**	61.3	28.2	50.1	24.6
RF4	Barking, Havering & Redbridge University Hospitals NHS Trust	London	58.8	**64**	62.4	28.7	47.1	23.6
RA7	University Hospitals Bristol NHS Foundation Trust	South	58.6	**65**	44.0	21.1	68.9	31.0
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	Midlands And East	58.4	**66**	60.6	27.9	48.4	24.0
RC1	Bedford Hospital NHS Trust	Midlands And East	57.8	**67**	35.6	17.6	77.5	34.0
RJF	Burton Hospitals NHS Foundation Trust	Midlands And East	57.4	**68**	54.4	25.4	54.1	26.0
RBD	Dorset County Hospital NHS Foundation Trust	South	57.4	**69**	64.3	29.5	42.1	21.9
R1K	London North West Healthcare NHS Trust	London	57.3	**70**	42.5	20.5	68.4	30.8
RHU	Portsmouth Hospitals NHS Trust	South	57.3	**71**	51.0	24.0	58.0	27.3
RE9	South Tyneside NHS Foundation Trust	North	57.2	**72**	62.2	28.6	44.4	22.7
RW6	Pennine Acute Hospitals NHS Trust	North	57.2	**73**	49.8	23.5	59.2	27.7
RVV	East Kent Hospitals University NHS Foundation Trust	South	57.0	**74**	38.7	18.9	72.4	32.2
RVR	Epsom & St Helier University Hospitals NHS Trust	London	56.9	**75**	54.9	25.6	52.6	25.5
RCD	Harrogate & District NHS Foundation Trust	North	56.7	**76**	54.7	25.5	52.5	25.4
RDE	Colchester Hospital University NHS Foundation Trust	Midlands And East	56.6	**77**	39.4	19.2	70.7	31.6
RPA	Medway NHS Foundation Trust	South	56.4	**78**	36.2	17.9	74.3	32.9
RNL	North Cumbria University Hospitals NHS Trust	North	56.0	**79**	55.9	26.0	49.7	24.5
RN7	Dartford & Gravesham NHS Trust	South	55.1	**80**	43.2	20.8	63.3	29.1
RAJ	Southend University Hospital NHS Foundation Trust	Midlands And East	54.6	**81**	28.0	14.5	80.8	35.1

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
RAX	Kingston Hospital NHS Foundation Trust	London	53.1	**82**	49.8	23.5	51.5	25.1
RWJ	Stockport NHS Foundation Trust	North	53.0	**83**	48.2	22.8	53.3	25.7
RTK	Ashford & St Peter's Hospitals NHS Foundation Trust	South	52.7	**84**	40.2	19.5	62.5	28.8
RD8	Milton Keynes University Hospital NHS Foundation Trust	Midlands And East	52.3	**85**	55.6	25.9	43.1	22.2
RGQ	Ipswich Hospital NHS Trust	Midlands And East	52.3	**86**	65.5	30.0	31.1	18.1
RWA	Hull & East Yorkshire Hospitals NHS Trust	North	51.6	**87**	63.6	29.2	32.0	18.4
RCX	Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Midlands And East	51.3	**88**	50.9	24.0	46.8	23.5
RFR	Rotherham NHS Foundation Trust	North	51.2	**89**	38.6	18.9	61.6	28.5
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	North	51.0	**90**	89.1	39.7	0.0	7.5
RKE	Whittington Health NHS Trust	London	50.5	**91**	40.3	19.6	58.1	27.3
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	Midlands And East	49.8	**92**	30.1	15.4	69.1	31.1
RQQ	Hinchingbrooke Health Care NHS Trust	Midlands And East	49.8	**93**	30.1	15.4	69.1	31.1
R1F	Isle of Wight NHS Trust	South	48.9	**94**	57.3	26.6	34.5	19.3
RMC	Bolton NHS Foundation Trust	North	48.6	**95**	20.2	11.3	78.8	34.4
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	North	48.3	**96**	38.5	18.8	56.1	26.7
RYR	Western Sussex Hospitals NHS Foundation Trust	South	47.8	**97**	53.4	25.0	37.2	20.2
RD1	Royal United Hospitals Bath NHS Foundation Trust	South	47.4	**98**	44.5	21.3	47.2	23.6
RXC	East Sussex Healthcare NHS Trust	South	46.7	**99**	44.6	21.3	45.7	23.1
RXF	Mid Yorkshire Hospitals NHS Trust	North	46.4	**100**	47.2	22.4	42.0	21.8
RH8	Royal Devon & Exeter NHS Foundation Trust	South	46.3	**101**	23.0	12.4	71.1	31.8
RQM	Chelsea & Westminster Hospital NHS Foundation Trust	London	44.9	**102**	41.9	20.2	45.7	23.1
RGR	West Suffolk NHS Foundation Trust	Midlands And	44.9	**103**	50.1	23.6	35.8	19.7

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
		East						
RNQ	Kettering General Hospital NHS Foundation Trust	Midlands And East	44.8	**104**	10.8	7.4	83.1	35.9
RLQ	Wye Valley NHS Trust	Midlands And East	44.2	**105**	59.4	27.4	23.2	15.4
RA3	Weston Area Health NHS Trust	South	44.1	**106**	37.0	18.2	50.0	24.6
RJN	East Cheshire NHS Trust	North	43.8	**107**	50.8	23.9	32.7	18.7
RAP	North Middlesex University Hospital NHS Trust	London	43.8	**108**	32.2	16.2	55.1	26.3
RRK	University Hospitals Birmingham NHS Foundation Trust	Midlands And East	43.7	**109**	9.2	6.8	82.8	35.7
RAL	Royal Free London NHS Foundation Trust	London	43.7	**110**	37.0	18.2	49.1	24.3
RX1	Nottingham University Hospitals NHS Trust	Midlands And East	43.0	**111**	32.1	16.2	53.9	25.9
RBT	Mid Cheshire Hospitals NHS Foundation Trust	North	40.6	**112**	53.6	25.0	23.4	15.5
RJ6	Croydon Health Services NHS Trust	London	40.5	**113**	38.5	18.8	41.3	21.6
RXQ	Buckinghamshire Healthcare NHS Trust	South	40.0	**114**	60.4	27.9	14.0	12.3
RBZ	Northern Devon Healthcare NHS Trust	South	39.0	**115**	12.7	8.2	69.9	31.3
RR7	Gateshead Health NHS Foundation Trust	North	38.6	**116**	11.5	7.7	70.4	31.5
RXK	Sandwell & West Birmingham Hospitals NHS Trust	Midlands And East	38.3	**117**	6.9	5.8	75.3	33.2
RA2	Royal Surrey County Hospital NHS Foundation Trust	South	36.9	**118**	0.7	3.2	80.3	34.9
RWP	Worcestershire Acute Hospitals NHS Trust	Midlands And East	36.0	**119**	45.9	21.9	23.9	15.7
RD3	Poole Hospital NHS Foundation Trust	South	35.5	**120**	7.7	6.1	69.2	31.1
RC9	Luton & Dunstable University Hospital NHS Foundation Trust	Midlands And East	34.1	**121**	6.2	5.5	68.5	30.9
RJC	South Warwickshire NHS Foundation Trust	Midlands And East	33.4	**122**	21.3	11.7	48.9	24.2
RWD	United Lincolnshire Hospitals NHS Trust	Midlands And	33.4	**123**	25.6	13.5	43.6	22.4

			Overall		Process Efficiency		Price Performance	
Trust Code	Trust Name	Region	Score scaled 0 to 100	Rank	Process Efficiency scaled 0 to 100	Process Efficiency Score	Price Performance scaled 0 to 100	Price Performance Score
		East						
RR1	Heart of England NHS Foundation Trust	Midlands And East	32.8	**124**	7.6	6.1	64.3	29.4
RQX	Homerton University Hospital NHS Foundation Trust	London	31.7	**125**	31.5	15.9	33.3	18.9
RTP	Surrey & Sussex Healthcare NHS Trust	South	31.6	**126**	28.3	14.6	36.9	20.1
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust	North	31.4	**127**	15.5	9.3	52.0	25.3
RTR	South Tees Hospitals NHS Foundation Trust	North	25.1	**128**	13.6	8.6	42.4	22.0
RQW	Princess Alexandra Hospital NHS Trust	Midlands And East	22.7	**129**	9.8	7.0	42.4	22.0
REM	Aintree University Hospital NHS Foundation Trust	North	22.2	**130**	10.3	7.2	41.0	21.5
RQ6	Royal Liverpool & Broadgreen University Hospitals NHS Trust	North	20.3	**131**	7.2	5.9	41.1	21.5
RFS	Chesterfield Royal Hospital NHS Foundation Trust	Midlands And East	17.7	**132**	1.7	3.7	42.7	22.1
RJ2	Lewisham & Greenwich NHS Trust	London	16.8	**133**	3.2	4.3	39.3	20.9
RLN	City Hospitals Sunderland NHS Foundation Trust	North	14.3	**134**	0.2	3.0	38.1	20.5
RHW	Royal Berkshire NHS Foundation Trust	South	8.2	**135**	0.0	3.0	26.9	16.7
RLT	George Eliot Hospital NHS Trust	Midlands And East	0.0	**136**	1.4	3.5	9.7	10.8

11-18 Approval of request for an uncommitted loan facility (in advance of PSF payments) — Chief Finance Officer

At its meeting in November 2018, the Finance and Performance Committee will be asked to agree to recommend the approval by the Trust Board of a proposed advance funding application for Quarter 2 Provider Sustainability Fund (PSF) payment in 2018/19 (£2.544m) and to an approach that requests the Trust Board (at its meeting on 29/11/18) to approve the recommendations set out at the end of this report.

In 2016/17, the Department of Health and Social Care (DHSC) agreed that providers could apply for financing to advance the cash for expected PSF payments, given the significant time lag between accrual and actual cash settlement. The Trust has used this option for both 2016/17 and 2017/18. Once the PSF is paid to the Trust, the Trust repays the loan.

The Trust's financial plan for 2018/19 included assumptions about the payment of PSF funding comprising:

Quarter 1 PSF	£1.908m (this was received in September 2018)
Quarter 2 PSF	£2.544m (that has been agreed but the Trust is awaiting the cash settlement)
Quarter 3 PSF	£3.815m (the cash is expected in March 2019 if the PSF payment is earned in full)
Quarter 4 PSF	£4.451m (the cash is expected in 2019/20 if the PSF payment is earned in full)
Total	£12.718m

The Trust has achieved the Quarter 1 PSF and received the cash funding of £1.908m on 04/09/18; the Trust has also achieved the Quarter 2 targets and expects a PSF payment of £2.544m in line with plan for the second quarter of 2018/19. This payment will require authorisation through the NHS England / DHSC process and is therefore not likely to be cash settled until January 2019 at the earliest. NHS Improvement (NHSI) have sent out guidance indicating that Trusts who have signed up to their control totals are able to access financing to advance the PSF payments where there is a cash lag, in order to support operational liquidity.

The next drawdown date for financing is 17/12/18. The Trust has submitted a cash flow on 14/11/18 to NHSI supporting the advance of the PSF funding in December. Appendix 1 contains a blank loan template for information - once NHSI has approved that the Trust can receive the advance of PSF funding a completed loan form will be issued to the Trust for signing.

The Trust is assuming that it will receive the loan of £2.544m in December, with the cash funding relating to PSF being paid in January 2019 at earliest. Once the PSF payment is received the Trust will repay the loan received in December. The interest rate will be 3.5% on a daily basis, so if the Trust repays the loan on the key date in January (14th), the total interest would be £7,074.

DHSC will review the request for financing through their monthly interim financing meeting that takes place a minimum of a week ahead of the draw date. Therefore there is a quick turnaround required between the DHSC decision and the requirement on the Trust to complete the necessary documentation for the agreement. This includes a Board resolution to support the loan facility.

In order to avoid repeating this approach for future potential advances of PSF in the year, NHSI have recommended that a Trust Board resolution is obtained to cover the maximum amount of PSF funding likely to be advanced in the year in cash terms of £10.81m (for Quarters 2, 3 & 4) and then arrange the individual uncommitted loans on the authority of the overarching Board resolution. If the subsequent quarter PSF payments are not earned through meeting the relevant criteria, the advances in the form of the loans will not be sought or approved by NHSI.

The agreement document includes the "additional terms and conditions" in schedule 8 which have been common to all the financing agreements in the last 4 years, and to which the Trust has already signed up on each previous financing loan agreement.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 27/11/18

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

This report is therefore seeking from the Trust Board:

1. Approval of the financing proposed in the loan agreement template and the Board Resolution as set out below, in line with the "Conditions Precedent" of the Loan facility documentation (Schedule 1 of Appendix 1)
2. Approval that the loan facility can be signed by the Chief Finance Officer under delegated authority
3. To resolve to approve the applications for loan facilities to advance against PSF payments to a maximum value of £10.810m, being the total of Quarters 2, 3 and 4 in 2018/19, actual and planned
4. Agreement to the terms of and the transactions contemplated by the enclosed loan subject to DHSC (Appendix 1)
5. Authorisation of the Chief Finance Officer as the nominated officer to execute the agreement ("the Finance Documents")
6. Authorisation of the Chief Finance Officer to manage the agreement i.e. to sign and/or despatch all documents and notices including any Utilisation Requests required under the agreement
7. Agreement to the additional terms and conditions set out in the relevant schedule the facility agreement (schedule 8 of Appendix 1)

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

Appendix 1

DATED 2016

[ ]
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£[ ]

UNCOMMITTED SINGLE CURRENCY INTERIM REVENUE SUPPORT FACILITY AGREEMENT

REF NO: DHPF/ISUCL/]

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LOAN REF: DHPF/ISUCL/XXX/XXXX-XX-XX/X

THIS AGREEMENT is dated 2016 and made between:

(1) **[ ]** of**, XXX** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Limit" means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Limit" means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the uncommitted interim support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £[ ] at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

"Final Repayment Date" means [ ].

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

"Government Banking Service" means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 1.5% per annum, or other applicable interest rate that shall be notified by the Lender to the Borrower in respect of each Loan upon Utilisation.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Limits" means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"Minimum Cash Balance" means £[ ];

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"NHS Body" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Improvement" means the body incorporating the roles of Monitor and the NHS Trust Development Authority and acting as the health sector regulator providing healthcare transformation, regulatory and patient safety expertise.

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2015.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Dates" means the repayment dates set out in the Schedule 6 (Repayment Schedule).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means NHS Improvement, incorporating and representing both of the bodies previously known as the NHS Trust Development Authority and Monitor..

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower an uncommitted sterling interim support facility in an aggregate amount equal to the Facility Amount under the terms of which the Lender may, in its sole and absolute discretion, provide Loans to the Borrower from time to time, unless the Lender, in its sole and absolute discretion, has previously notified the Borrower of the termination of the Facility.

2.2 This agreement is not, nor shall it be deemed to constitute, a commitment on the part of the Lender to make any extension of credit to or for the account of the borrower and may not be relied upon by the Borrower for any financing.

2.3 The Lender reserves the right to revoke or withdraw this agreement and the facility in its sole and absolute discretion at any time.

2.4 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 ***(Purpose)***, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2

5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:

(A) Such agreement is granted by the Lender;

(B) any request is included in the Cashflow Forecast; and

(C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 Completion of a Utilisation Request

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 Currency and amount

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 **Payments**

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 **Repayment**

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 ***(Repayment Schedule)***.

6.3 **Reborrowing**

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 **Illegality**

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 **Voluntary cancellation**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest

accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 Interest Payment Dates

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 Shortening Interest Periods

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A Payment Start Date

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 Non-Business Days

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 Consolidation of Loans

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 Currency indemnity

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1

(Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 Financial statements

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 Requirements as to financial statements

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 Information: miscellaneous

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 **Notification of default**

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

(A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

(B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (***Loans***) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 **Non-payment**

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 **Compliance Framework and Negative Pledge**

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 **Other obligations**

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 **Misrepresentation**

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 **Cross default**

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of

making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary

at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 **Electronic communication**

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 **Accounts**

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 **Certificates and Determinations**

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 **Day count convention**

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial

exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

[ ] – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
[ ]

SCHEDULE 3: NOT USED

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

NOT USED.

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s**)") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 **Without Prejudice/Confidentiality**

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18th July 2020	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.

1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:

2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.

2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.

2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services ("CCS")

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of [ ]

By:

Name:

Position:

Address:

Email:

Attention:

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
2nd Floor
Quarry House,
Quarry Hill,
Leeds, LS2 7UE

Email: dhloanscentralinbox@dh.gsi.gov.uk

Trust Board Meeting – November 2018

NHS Maidstone and Tunbridge Wells NHS Trust

11-18	Summary report from Finance and Performance Committee, 27/11/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 27th November 2018.

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

- The actions from previous meetings were reviewed and under the "Safety Moment", it was reported that November's theme was pressure ulcer prevention and measurement
- The month 7 financial performance was reviewed in brief, on the basis that an extraordinary Committee meeting had been scheduled for 12th December, and financial performance (including the year-end forecast) would be discussed in detail then. It was however noted that the financial performance was currently in line with the plan, but required the release of reserves to achieve that outcome
- The Committee was given an update on the funding of the replacement Linear Accelerator programme (the same update has been submitted to the Trust Board)
- An update was given on the actions to recover the planned delivery of the "Medical Productivity" project (which is part of the Best Care programme)
- The latest position on private patient income was reported, which noted that a contribution of £400k for the remainder of the year was expected (compared to the £1m planned)
- The month 7 non-finance related performance was discussed, which included a detailed review of the 62-day Cancer waiting time and Referral to Treatment targets. It was agreed that the Chief Finance Officer and Chief Operating Officer should arrange for the Committee meeting on 12/12/18 to a) identify the costs of achieving green RAG ratings on the "Improvement" actions included in the revised 62-day Cancer waiting time target trajectory b) consider whether any additional actions could be taken to reduce the time taken to achieve the target c) consider whether the conclusion of the Intensive Support Team's work resulted in the need for additional actions and d) confirm any 'technical' improvements such as validation or including skin cancer in the Trust's denominator It was also agreed that the Chief Operating Officer should Provide the Committee with assurance that the Cancer patients that had waited over 104 days for treatment had done so because of a clinical decision (and not because of any delays in administrative and/or treatment pathways), and also confirm action plan and trajectory to eliminate all 104 day waits (other than genuine clinical exceptions)
- The Committee supported the Trust's request for an uncommitted loan facility (in advance of Provider Sustainability Fund payments (the Trust Board will be asked to approve that request at its meeting on 29/11/18)
- The usual update on the Lord Carter efficiency review (incl. SLR) was given, and it was agreed that the accuracy of the "Estimated Trust figure 2017-18" and "Estimated Trust figure Oct 2018" for the "Estates & Facilities Cost (£ per m2)" and "Estates & Facilities cost (£ per WAU)" data reported to the Committee, should be checked, to confirm whether the circa 50% reduction from the "Trust Model Hospital 2016-17" data was correct
- The Associate Director of Procurement attended to present the "Quarterly progress update on Procurement Transformation Plan" and "Annual Review of the Procurement Strategy" items, and the Committee commended the improvements that had been made to the procurement function over the recent past (both reports have also been provided in full to the Board in separate Attachments)
- The Committee approved a Business Case to fund the Frailty Service and Ambulatory Emergency Care (AEC) service at Tunbridge Wells Hospital for 7 days a week, 12 hours per day (8am to 8pm) for the period 01/11/18 to 31/03/19. It was also agreed that a post-implementation review of the Business Cases should be scheduled for a future meeting
- The Committee also approved a Business Case for renewal of equipment in the Cardiac Catheter Laboratory at Tunbridge Wells Hospital
- A report of the relevant aspects of the Board Assurance Framework was noted
- The Interim Director of Health Informatics and Chief Clinical Information Officer attended to present the proposed revised IT Strategy. The Strategy, which had been amended to reflect

the comments received when a previous draft had been discussed at an earlier Committee meeting, was well-received, but some further suggested improvements were made. It was confirmed that the Strategy would be submitted to the Board for approval in January 2019
- A report of the market concerns of Interserve was noted, as was briefing on the proposed changes to the Standing Financial Instructions, Standing Orders and Scheme of Delegation
- The standing "breaches of the external cap on Agency staff pay rate" report was noted
- The approach to the Committee's 2018 evaluation was agreed (and a brief survey will now be issued to Committee members and routine attendees)

2. In addition the agreements referred to above, the Committee agreed that:
- The Chief Finance Officer should relay the Committee's request that the numbering/labelling of the Trust's Linear Accelerators be amended to more clearly distinguish between those at Kent and Canterbury Hospital and those at Maidstone Hospital
- The Chief Operating Officer should confirm the definition/s used for theatre utilisation and provide benchmarking with other hospitals

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