Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting ('Part 1')

26 March 2020, 09:45 to 13:00
Virtual meeting, via Webex

Agenda

N.B. Following national guidance on social distancing, Trust Board meetings will not be held in public at present. Members of the public with queries should contact the Trust Secretary's office (please refer to the Trust website for contact details).

03-1
To receive apologies for absence

David Highton

03-2
To declare interests relevant to agenda items

David Highton

03-3
Minutes of the 'Part 1' meeting of 27th February 2020

David Highton

Board minutes 27.02.20 (Part 1).pdf (7 pages)

03-4
To note progress with previous actions

David Highton

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

03-5
Safety moment

Claire O'Brien / Peter Maskell

Safety Moment.pdf (7 pages)

03-6
Report from the Chair of the Trust Board

David Highton

Chair's Report.pdf (1 pages)

03-7
Report from the Chief Executive

Miles Scott

Chief Executive's report March 2020.pdf (2 pages)

03-8
Update on the Trust's response to COVID-19 (Incl. an update on the 2020/21 Operating Plan)

This will be a verbal item

Miles Scott

03-9
Outcome of the diagnostic phase of the Exceptional People Outstanding Care programme

A presentation will be given at the meeting

Rita Lawrence and Kathryn Brown

This item has been scheduled to start at 10.15am

03-10
Integrated Performance Report for February 2020

Miles Scott

IPR month 11.pdf (44 pages)

03-10.1
Safe (incl. update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for February 2020)

Claire O'Brien

03-10.2
Safe (infection control)

Sara Mumford

03-10.3
Effective

Sean Briggs

03-10.4
Caring

Claire O'Brien

03-10.5
Responsive

Sean Briggs

03-10.6
Well-Led (finance)

Steve Orpin

03-10.7
Well-Led (workforce)

Simon Hart

03-11
Review of Nurse staffing Ward and non-Ward areas (major review)

Claire O'Brien

Board Report Non ward and ward staffing reviews 2019 for March 2020 Board v1.2.pdf (36 pages)

Board Assurance Framework (BAF)

03-12
Review of the Board Assurance Framework 2019/20

David Morgan

Board Assurance Framework 2019-20 (at 20.03.20).pdf (16 pages)

Quality items

03-13
Quarterly mortality data

Peter Maskell

Mortality Report for Trust Board.pdf (9 pages)

Assurance and policy

03-14

To approve a proposal to temporarily extend the delegated expenditure limits for members of the Executive Team

Steve Orpin

Proposal to change authorisation limits during COVID-19.pdf (2 pages)

03-15

Update from the Senior Information Risk Owner (SIRO) (incl. approval of the Data Security and Protection Toolkit submission for 2019/20, and Trust Board annual refresher training on Information Governance)

Claire O'Brien

Update from the SIRO.pdf (5 pages)

03-16

Six-monthly update on Estates and Facilities

Miles Scott

Estates and Facilities March 2020 Board Report.pdf (4 pages)

Annual Report and Accounts

03-17

Confirmation of the outcome of the Trust's 'going concern' assessment

Steve Orpin

Going Concern approach Trust Board 17.3.20.doc.pdf (2 pages)

Reports from Trust Board sub-committees

03-18

Patient Experience Committee, 04/03/20

Maureen Choong

Patient Experience Cttee Trust Board Report, 04.03.20.pdf (1 pages)

03-19

Quality Committee, 11/03/20

Sarah Dunnett

Summary of Quality C'ttee, 11.03.20.pdf (1 pages)

03-20

Audit and Governance Committee, 19/03/20

This will be a verbal item

David Morgan

03-21

Finance and Performance Committee, 24/03/20

Please note that the report will be issued after the meeting

Neil Griffiths

03-22

Charitable Funds Committee, 24/03/20

This will be a verbal item

David Morgan

03-23

To consider any other business

David Highton

Date of next meeting: 30th April 2020, 9.45am

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 27TH FEBRUARY 2020, 1 P.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director (left during item 02-12 – refer to the specific minute for details)	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Simon Brooks-Sykes	Senior Strategic Development Manager & Programme Manager for the Kent and Medway Vascular Network (for item 02-14)	(SBS)
	David Sulch	Medical Director, Medway NHS Foundation Trust (for item 02-14)	(DS)

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

02-1 To receive apologies for absence

Apologies were received from Sean Briggs (SB), Chief Operating Officer.

02-2 To declare interests relevant to agenda items

DH declared that he remained the interim Chair of the Kent and Medway Sustainability and Transformation Partnership (STP).

02-3 To approve the minutes of the 'Part 1' meeting on 30th January 2020

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

02-4 To note progress with previous actions

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

- **01-14b ("Ensure that all Trust Board Members received the report submitted for the "Update on IT strategy and related matters" item at the Finance and Performance Committee meeting on 25/02/20").** KR noted that the "Update on IT strategy…" report had been deferred from the Finance and Performance Committee meeting on 25/02/20 so the report would be circulated as soon as it was submitted to the Finance and Performance Committee.
- **02-21 ("Explore the feasibility of improving the sound quality in the room used for Trust Board meetings at Tunbridge Wells Hospital, to enable the proceedings to be properly heard in the "Public Gallery"").** KR confirmed that there was nothing further to add to the update provided in the "Progress" column.
- **01-14a ("Circulate the IT Strategy was approved by the Trust Board in July 2029").** KR reported that the correct version of the strategy had been circulated on the morning of 27/02/20,

as the version circulated on 19/02/20 contained some changes which had not been approved by the Trust Board.

02-5 Safety moment

COB referred to the relevant attachment and highlighted the key points therein, which included the focus on Urinary Tract Infections (UTIs), and the need to "skip the dip" i.e. not use urine dipsticks to diagnose UTIs in patients aged over 65. COB also explained the use of "catheter passports". SM added further details of the work to prevent the use of urine dipsticks and to use clinical acumen to identify Catheter-Associated UTIs (CAUTIs). SM also gave details of the work being done to reduce the incidence of e-coli bacteraemia.

PM then stated that if it was up to him, he would repeat the subject of that month's "Safety moment" each month. PM also gave his observations on the challenges involved ceasing the use of urine dipsticks. DH referred to PM's initial comment and queried whether it remained appropriate for the "Safety moment" to be a four-week programme with a different subject each month. DH also queried whether the effectiveness of the "Safety moment" had ever been tested. COB acknowledged that such effectiveness had not been tested but noted that staff were keen to use the "Safety moment", and the next one had already been scheduled to raise awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). SDu provided her own perspective on the "Safety moment" item. DH therefore asked COB, PM and SM to consider the future of the item, including whether the frequency should be reduced to quarterly. This was initially agreed, but MS cautioned against making any decision in the next month, as the future of the "Safety moment" would need to take into account the Trust's potential future improvement programme relationship with Western Sussex Hospitals NHS Foundation Trust (that had been discussed at the workshop with that Foundation Trust earlier that morning). The point was acknowledged. COB also asked for agreement that the MCA/DoLS "Safety moment" that was scheduled for March 2020 could continue and that was duly confirmed.

Action: Liaise to consider the future of the "Safety moment" item at the Trust Board (including the frequency of the item), taking into account the Trust's potential future improvement programme relationship with Western Sussex Hospitals NHS Foundation Trust (Chief Nurse / Medical Director / Director of Infection Prevention and Control, March 2020 onwards)

02-6 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted the key points therein. DH added that his term as the interim Chair of the STP would end at the end of March 2020, when the Chair of Kent Community Health NHS Foundation Trust's Board would take over for six months, to enable an independent Chair appointment to be made.

DH also noted that he had chaired the STP's Non-Executive Director oversight meeting, along with an extraordinary meeting of the STP Programme Board, on 24/02/20, and the principle of "system by default" within the NHS planning guidance for 2020/21 had been discussed. DH added that the principle had been incorporated into the financial system, in that 50% of individual organisations' Financial Recovery Fund (FRF) monies would be dependent on system-wide performance. DH added that he believed it was therefore inevitable that sovereign organisations, and Boards, would need to cede some authority to the wider system. DH proposed that the issue be discussed further, perhaps at a Trust Board 'Away Day'. DH then continued and noted that the FRF across Kent and Medway would be £110m for 2020/21 but the Trust had not been allocated any FRF monies. A discussion was then held on the issues raised by DH.

02-7 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the key points therein, which included the key themes for action that had emerged from the Trust's findings from the national NHS staff survey 2019. MS added that he would ensure that the raw data from the survey was circulated to Non-Executive Directors.

MS then deferred to SM who gave an update on the coronavirus situation. MS commended the efforts made by SM, the Director of Emergency Planning & Communications, and the Estates and Facilities Department. SDu asked what support was being provided to staff involved in the Trust's response and SM described the arrangements. JW then referred to recent media coverage relating to screening being extended and asked SM to comment. SM clarified that the system to which JW had referred was being piloted in a small number of Trusts, and the outcome of the pilot would inform the next steps involved in the containment.

Integrated Performance Report

02-8 Integrated Performance Report for December 2019

MS firstly asked SO to comment on the work being taken to develop the format of the Integrated Performance Report. SO explained that details of the new style report, which would focus on special cause variation, had been included in the Integrated Performance Report submitted to the January 2020 Trust Board meeting, and added that it was intended to introduce the new style report to cover the first month of 2020/21, which would mean the report submitted to the Trust Board meeting in May 2020. RF asked whether the new format would enable tracking of performance. SO replied that the underlying Statistical Process Control (SPC) charts would enable such tracking. A discussion was then held on the issues, during which SO emphasised that the format could be further developed and DM suggested the adoption of the convention whereby an upward trend in data always indicated a positive change.

DH therefore acknowledged that the new style performance report would be submitted to the Trust Board in May 2020, by which time the Trust Board would have agreed a new Board Assurance Framework (BAF), and stated that he would like those responsible to explore how the ratings within the BAF could be synchronised with the forecast ratings within the Integrated Performance Report. It was confirmed that this was a reasonable challenge.

Action: Liaise to explore how the ratings within the Board Assurance Framework could be synchronised with the forecast ratings within the Integrated Performance Report (Trust Secretary / Chief Finance Officer, February 2020 onwards)

02-8.1 Safe (incl. planned and actual ward staffing for January 2020)

COB referred to the relevant attachment and highlighted the key points therein, which included the work taking place on pressure ulcers, which would feature at the Quality Committee 'deep dive' meeting in June 2020.

COB also drew attention to the Never Event that had occurred recently and confirmed the incident was under investigation.

The planned and actual ward staffing data for January 2020 was then noted.

02-8.2 Safe (infection control)

This was covered under item 02-6.

02-8.3 Effective

PM referred to the relevant attachment, and the attachment that had been submitted under item 02-10, and highlighted the key points therein, which included the ruling from the Judicial Review into the future of stroke services in Kent and Medway, and the impact of that ruling. PM also highlighted the difficult circumstances under which the Trust's stroke staff were working. MS added that he had asked SB to revisit the planning timetable for the development of the Hyper Acute Stroke Unit (HASU), and particularly whether the design work could be expedited.

DH asked why the Trust's HASU could not be opened before the HASU had been established at Darent Valley Hospital. PM explained the situation, which noted the importance of the closure of the stroke unit at Medway NHS Foundation Trust (MFT) on the timing.

DH suggested that a follow-up report on the timetable for the development of the Trust's HASU be submitted to the Trust Board and proposed that this be scheduled for the Trust Board meeting in April 2020. This was agreed.

Action: Arrange for an "Update on the establishment of the Hyper Acute Stroke Unit at Maidstone Hospital" report to be submitted to the Trust Board in April 2020 (Medical Director / Chief Operating Officer, April 2020)

PM then elaborated on some of the clinical changes that would be made to the stroke service, including the new stroke assessment that would be introduced in 2021.

PM then concluded by reporting the current status of readmissions and the analysis he had undertaken as well as the health records review that he had requested be undertaken.

02-8.4 Caring

COB referred to the relevant attachment and highlighted the key points therein, which included the latest performance on complaints responses and the response rate to the Friends and Family Test (FFT) in the Emergency Department (ED). RF asked when and how patients were asked to complete the FFT. COB explained the process and the challenges faced. KC asked whether any other Trusts had achieved a high response rate. COB confirmed that the Trust had itself performed well in the past but its performance had varied recently.

02-8.5 Responsive

In SB's absence, MS referred to the relevant attachment and highlighted the key points therein, which included the latest performance on the ED 4-hour waiting time target and cancer access standards (all of which had been met for the month).

02-8.6 Well-Led (finance)

SO referred to the relevant attachment and highlighted the key points therein, which included that the Trust's performance for the year to date remained in accordance with its plan.

02-8.7 Well-Led (workforce)

SH referred to the relevant attachment and highlighted the key points therein, which included the latest position on sickness absence (which remained high) and the staff flu vaccination campaign, which would end on 29/02/20. SH stated that the Trust had achieved the Commissioning for Quality and Innovation (CQUIN) target for the latter, and would likely end with a final rate of 83%. SH added that that was an improvement on the 78% achieved the previous year and meant that the Trust was one of the best performing Trusts in the South region. SH also gave details of the latest vacancy rates.

Board Assurance Framework (BAF)

02-9 Proposed amendment to objective 6 in the Board Assurance Framework for 2019/20

KR referred to the relevant attachment and highlighted the decision that the Trust Board had been asked to take. DH added further context to the proposed change, which was approved as submitted.

Planning and strategy

02-10 Stroke service update

This was primarily covered under item 02-8.5, but DH noted that the construction work was scheduled to take place over the next winter, and such work may therefore be adversely affected by the potential need for an escalation ward. DH therefore proposed that Members of the Executive Team be asked to consider if that adverse outcome could be avoided. MS however confirmed that he had already asked SB to consider the issue.

02-11 Mid-winter review

In SB's absence, MS referred to the relevant attachment and highlighted the key points therein. COB pointed out that the impact of winter on paediatrics needed to be recognised, as she did not feel this had been adequately reflected in the report. The point was acknowledged.

02-12 Update on the Trust's 2020/21 plan (Incl. details of the first submission of the Trust's 2020/21 operating plan)

AJ referred to the relevant attachment and highlighted the key points therein, adding that the plan had been discussed in detail at the Finance and Performance Committee meeting on 25/02/20. AJ also emphasised that the aforementioned "system by default" principle in the planning guidance meant that the Trust was not required to submit a narrative document, but was required to produce trajectories and template submissions.

AJ then confirmed that he was seeking the Trust Board's approval of the content of the first draft submission to NHS England (NHSE)/NHS Improvement (NHSI), which was due on 05/03/20, but further reports on the 2020/21 plan would be submitted to the Trust Board meetings in March and April 2020, as the final submission was due to NHSE/I by 29/04/20, and a potential interim submission may be required by 09/04/20.

DH asked about the financial impact of the 26-week waiting time standard, in terms of a loss of revenue. AJ stated that the arrangements regarding the 26-week standard had not yet been finalised and MS added his perspective on the issue.

AJ then described the rationale for the proposed 88% trajectory for the ED 4-hour waiting time target and the trajectories for the cancer access targets. AJ also explained the proposed position in relation to the new 92% bed occupancy standard.

[N.B. KC left the meeting at this point]

SO then referred to the "2020/21 Financial Plan" section of the relevant attachment and highlighted the main points therein, which included the replacement of the Provider Sustainability Fund regime, which gave providers financial bonuses for delivery of their plans, with the FRF regime, which gave financial support to certain providers' underlying financial positions. SO then elaborated on the content of the "Movement between Long Term Financial Plan and Current Plan" section of the report and noted that it had been agreed at the Finance and Performance Committee meeting on 25/02/20 that the Trust would submit an unbalanced position in its first 2020/21 planning submission and highlight the various risks that the Trust faced.

The Trust Board confirmed it was content with the proposed submission.

02-13 The Kent and Medway Strategy Delivery Plan, 2019/20 to 2023/24

AJ referred to the relevant attachment and highlighted the key points therein, adding that the content of the document had previously been submitted to the Trust Board. DH commented further on the rationale for the document being submitted to provider Boards.

RF referred to objective 4 and remarked that it was very limited, and could benefit from considering wider Organisational Development issues. DH noted that various leads from within the STP had authored the strategy, although there had been some input from the leads within each organisation. SH explained the involvement he had had in the production of the document. MS stated that one way of addressing RF's point was to ensure that the Trust put forward the issues it wanted to be developed as part of the development of the Integrated Care System. The suggestion was acknowledged but RF reiterated that it was optimistic to refer to objective 4 as being "transformational".

02-14 Review of the Business Case for the Kent & Medway Vascular Programme

SBS and DS were welcomed by DH and introduced themselves. SBS then referred to the relevant attachment and highlighted the key points therein, which included that the proposals would not

affect the vascular service at Tunbridge Wells Hospital (TWH), but would affect the service at Maidstone Hospital (MH), as well as the services at MFT and East Kent Hospitals University NHS Foundation Trust. DS then added further details and confirmed that the proposals met the recommendations from the Vascular Society of Great Britain and Ireland and the Getting It Right First Time (GIRFT) Programme.

DH asked for clarification that there would be no substantial difference to the service provided at MH. DS confirmed that was correct.

EPM asked about the impact on patient travel times and DS elaborated on that impact and the mitigating actions being taken.

PM pointed out that there was a difference between the quality of vascular service provided at TWH and MH and noted that further work would be required in relation to rotas, but that could be agreed in due course. SBS concurred.

MS explained that the Trust had been keen to see its vascular services develop and asked for details of the demand and capacity planning, given the potential for higher than expected demand. SBS gave the requested details and gave assurance that there would be adequate capacity under the proposals.

DS then gave assurance that the provision of support services available at Kent and Canterbury Hospital site would meet the needs of a vascular service.

MS referred to PM's earlier point and noted that the Case did not contain any commitment to improve the service at MH. DS acknowledged the point and agreed to reflect on the challenge.

DM asked for confirmation that the proposed changes would result in a £850k loss to the combined entities. DS replied that it was likely that the costs in the submitted attachments did not accurately reflect the final financial position. SBS concurred and noted that more detailed work would be undertaken on the costs, which SBS offered to share. MS instead stated that he expected the opportunities provided by the new service would be able to address the cost issue, as well as improve the service. MS also emphasised that the Trust would not be paying any of the costs.

The Trust Board approved the Business Case for the Kent & Medway Vascular Programme as submitted.

Reports from Trust Board sub-committees

02-15 Workforce Committee, 30/01/20

EPM referred to the relevant attachment and highlighted the main points therein. EPM also noted that in future, support to the Committee would be provided by KR, and some changes were planned to make the agendas more focused. EPM duly thanked SH's Executive Assistant for the support she had previously given to the Committee.

02-16 Quality Committee, 06/02/20

SDu referred to the relevant attachment and highlighted the main points therein. Questions were invited. None were received.

02-17 Finance and Performance Committee, 25/02/20

NG referred to the relevant attachment and highlighted the main points therein. Questions were invited. None were received.

02-18 To consider any other business

There was no other business.

02-19 To receive any questions from members of the public (please note that questions should relate to one of the agenda items)

No questions were received.

02-20 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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]
01-9.6	Arrange for the revised Integrated Performance Report to be reviewed, in response to the comments made at the Trust Board meeting on 30/01/20 and to determine whether it was operating as effectively as intended	Chief Finance Officer	March 2020	It was instead confirmed at the Trust Board meeting on 27/02/20 that it was intended to introduce the new style report for the data for the first month of 2020/21, which would mean the report submitted to the Trust Board meeting in May 2020.
01-9.7	Ensure that the review of the revised Integrated Performance Report that was requested at the Trust Board meeting on 30/01/20 consider the appropriateness of the current workforce-related Key Performance Indicators in the "Well-Led" domain	Chief Finance Officer / Director of Workforce	March 2020	It was instead confirmed at the Trust Board meeting on 27/02/20 that it was intended to introduce the new style report for the data for the first month of 2020/21, which would mean the report submitted to the Trust Board meeting in May 2020.
01-14b	Ensure that all Trust Board Members received the report submitted for the "Update on IT strategy and related matters" item at the Finance and Performance Committee meeting on 25/02/20	Trust Secretary	March 2020	The report will likely not be available until 23/03/20, but it will be circulated as soon as it is provided.
02-5	Liaise to consider the future of the "Safety moment" item at the Trust Board (including the frequency of the item), taking into account the Trust's potential future improvement programme relationship with Western Sussex Hospitals NHS Foundation Trust	Chief Nurse / Medical Director / Director of Infection Prevention and Control	March 2020 onwards	Consideration has been given to the future learning events and how we can capture the evaluation and learning from the staff who attend and whether this could form the basis to replace the safety moment on a monthly basis.
02-8	Liaise to explore how the ratings within the Board Assurance Framework could be synchronised with the forecast ratings within the Integrated Performance Report	Trust Secretary / Chief Finance Officer	February 2020 onwards	Liaison has occurred and given the fact that the 2019/20 Board Assurance Framework (BAF) is nearing its conclusion, it is proposed to continue with

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

Ref.	Action	Person responsible	Original timescale	Progress[1]
				the current format (including the ratings process) for 2019/20, but to consider how the BAF needs to / should be amended for 2020/21 (noting that the format and operation of the BAF will be influenced by the Trust's proposed relationship with Western Sussex NHS Foundation Trust). In the meantime, the Chief Finance Officer will discuss the methodology involved in developing the forecast ratings within the Integrated Performance Report with the Associate Director of Business Intelligence

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
01-21	Explore the feasibility of improving the sound quality in the room used for Trust Board meetings at Tunbridge Wells Hospital, to enable the proceedings to be properly heard in the "Public Gallery"	Trust Secretary	March 2020	It has been agreed to purchase a portable sound system that can be used in the Education Centre at Tunbridge Wells Hospital, and the Academic Centre at Maidstone Hospital. The implementation of the system will be considered once the Trust Board resumes holding its meetings in public.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
01-15	Ensure that the recommendations from the Case Reviews published by the National Guardian's Office were included in future quarterly reports from the Freedom to Speak Up Guardian (along with the details of any action/s required by the Trust in response)	Freedom to Speak Up Guardian	April 2020	The request will be incorporated into the next quarterly report from the Freedom to Speak Up Guardian
02-8.3	Arrange for an "Update on the establishment of the Hyper Acute Stroke Unit at Maidstone Hospital" report to be submitted to the Trust Board in April 2020	Medical Director / Chief Operating Officer	April 2020	An item has been scheduled for the April 2020 Trust Board.

NHS Maidstone and Tunbridge Wells NHS Trust

Safety Moment **Chief Nurse / Medical Director**

The Safety Moment for March has been focussed on MCA and DOLs.

The enclosed report contains a summary of the key messages that have been shared each week.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 25/02/20

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

Week One 06/03/2020

Assessing Mental Capacity

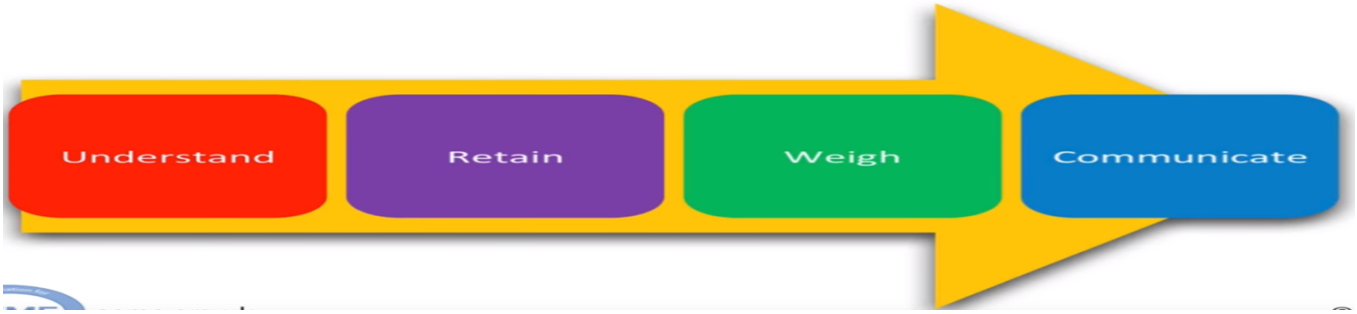
- Have you carefully considered the decision to be made?
- Document your reasoning for assessing capacity for this particular decision, at this time.
- Do you need any assistance to carry out this assessment of capacity such as:-
  - Speech and Language therapist
  - Someone who knows the person well
  - Learning Disability Liaison Nurse
  - Dementia Care Lead Nurse

Stage 1

Do they have an impairment or disturbance of the functioning of their mind or brain? If so name it
Confusion; delirium; anxiety; depression; phobia; learning disability; dementia; brain injury such as CVA, trauma; bi-polar: schizophrenia; delusional disorder; personality disorder; (not an exhaustive list)

Stage 2

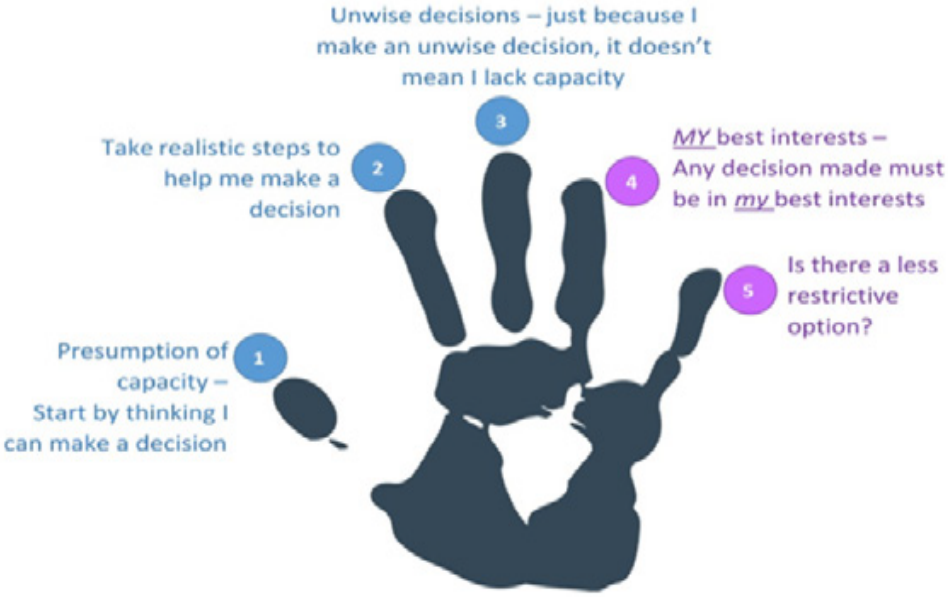
Consider if one of the following abilities is impaired or missing:-



If one of these is lacking for this decision or impaired, then the patient will not have the mental capacity for this *particular decision*. Document how you have worked this out in the healthcare records using the assessment of capacity form available

Week Two 13/03/2020

Mental Capacity Act (2005) Five Statutory Principles



This Act refers to the ability to make ***a decision, at the time*** it needs to be made.
Consider if you need to assess someone's capacity for a decision. If you do, how have you supported them to make their own decision.
Are they making a decision with capacity that you simply think is unwise?
Document your reasoning for assessing capacity for this decision and demonstrate the working out of your capacity assessment.
Most of this Act applies to 16 and 17 year olds with the exception of:-

1. Only people over the age of 18 years can make a Lasting Power of Attorney
2. Only people over the age of 18 years can make an Advance Decision
3. The Court of Protection may only make a statutory will for a person aged 18 years or over.

Week Three 20/03/2020

Best interest discussions and meetings

Any action taken on behalf of someone who lacks mental capacity, must be in the best interests (as defined by the Act) of the person. Consider anything relevant and particular to that person.

- Past and present wishes and feelings of the person
- Any beliefs and values of the person that may influence the decision
- Has a written statement of wishes and feelings been made?
- Has a valid and applicable advance decision been made?
- Is the act or decision the least restrictive of basic rights and freedoms?

Talk to people who know the person well to find these things out. This Act asks you to talk to all relevant people which can include:- Friends, family, carers, etc.
Consider the decision to be made – how important or serious is the decision?
Does the decision need to be made right now?
Is there time to hold a Best Interest Meeting?
If you need to discuss the decisions to be made, rather than have a meeting, document in the healthcare record:-

The decision to be made
Your assessment of mental capacity for this particular decision and outcome of this assessment
Who have you spoken to?
Have you discussed all relevant and available options?
What is the outcome of those discussions?
Has consensus of opinion been gained?
Proceed with the decision made.

What is classed as a **"serious medical decision",** where it is more likely that a Best Interest Meeting will be required?
Serious medical treatment is defined in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 as treatment which involves providing, withdrawing or withholding treatment in circumstances where one or more of the following apply:

- In a case where a single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail
- In a case where there is a choice of treatments, a decision as to which one to use is finely balanced
- What is proposed would be likely to involve serious consequences for the patient.

The MCA Code of Practice says that 'serious consequences' may include treatment options which:

- Cause serious and prolonged pain, distress or side effects
- Have potentially major consequences for the patient (for example, major surgery or stopping life-sustaining treatment)
- Have a serious impact on the patient's future life choices.

The Code of Practice lists the following examples of possible serious medical treatments (this list is not exhaustive):

- Chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation

- Major surgery (such as open-heart surgery or brain/neurosurgery)
- Major amputations (for example, loss of an arm or leg)
- Treatments that will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy.

Any decision not to offer the above treatments would similarly be classed as a serious medical decision.

Week Four 27/03/2020

Assessing capacity – some examples of completed documents

The Good

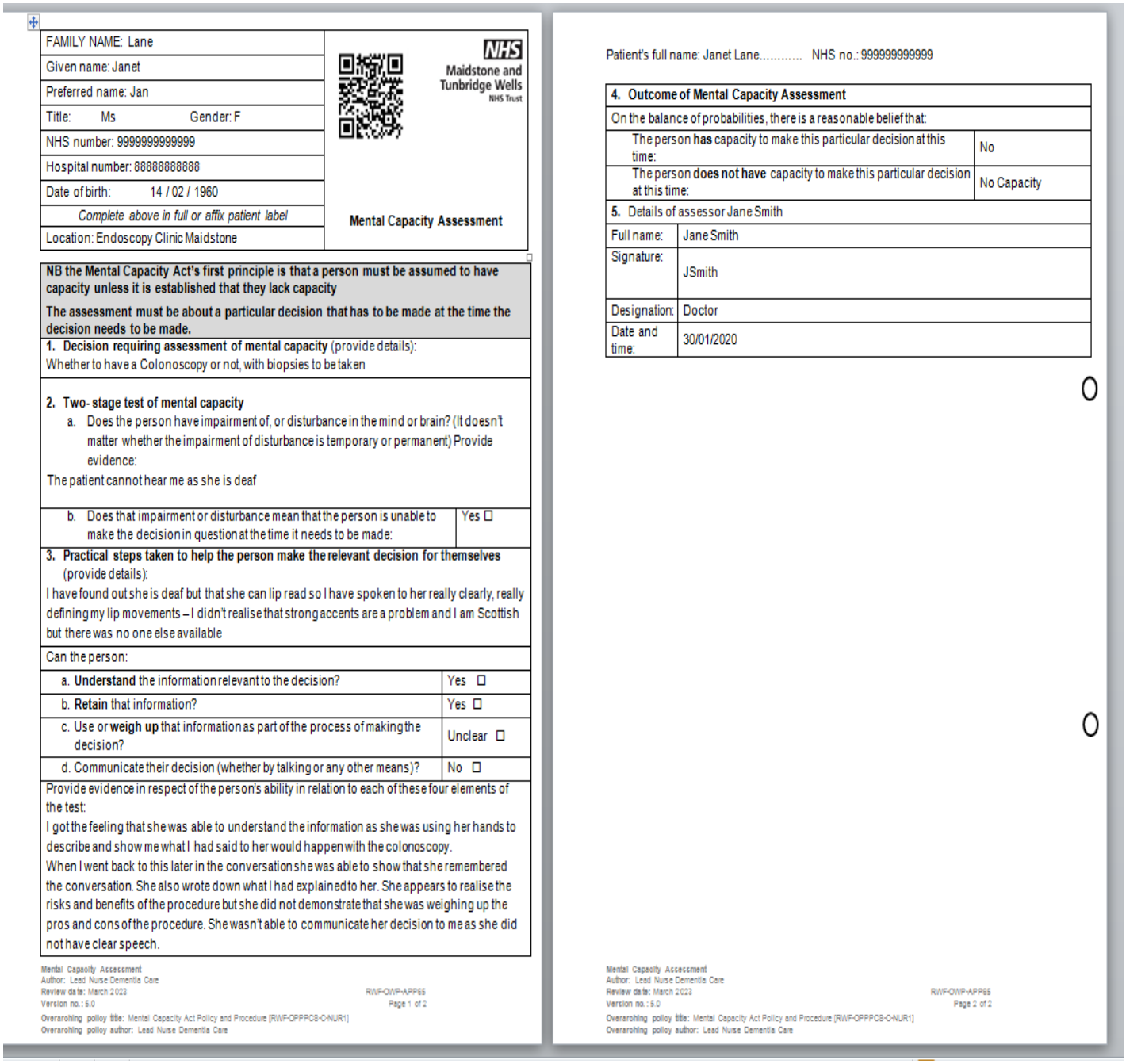
FAMILY NAME: Jenson	NHS Maidstone and Tunbridge Wells NHS Trust
Given name: Gabriella	
Preferred name: Gabby	
Title: Mr Gender: Female	
NHS number: 000 000 0000	
Hospital number: L0000000	
Date of birth: 30/12/1990	
Complete above in full or affix patient label	**Mental Capacity Assessment**
Location: Ward 62	

NB the Mental Capacity Act's first principle is that a person must be assumed to have capacity unless it is established that they lack capacity **The assessment must be about a particular decision that has to be made at the time the decision needs to be made.**	
1. Decision requiring assessment of mental capacity (provide details): Importance of using the Miami J Collar and of not loosening the collar and not removing collar due to unstable neck fracture.	
2. Two- stage test of mental capacity a. Does the person have impairment of, or disturbance in the mind or brain? (It doesn't matter whether the impairment of disturbance is temporary or permanent) Provide evidence: Yes – Brain injury due to trauma – fell from height	
b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made:	Yes
3. Practical steps taken to help the person make the relevant decision for themselves (provide details): Made sure Gabby was comfortable, introduced ourselves and ensured that she was in agreeement to talking to us about her ability to make her own decisions. S&LT has been approached to assist but their assessment was that Gabby has good cognitive functioning at the moment and is able to express herself so they did not feel it was necessary for them to be present.	
Can the person:	
a. **Understand** the information relevant to the decision?	Yes
b. **Retain** that information?	Yes
c. Use or **weigh up** that information as part of the process of making the decision?	Yes
d. Communicate their decision (whether by talking or any other means)?	Yes
Provide evidence in respect of the person's ability in relation to each of these four elements of the test: As Gabby has on a number of occassions been spoken to about the importance of keeping her	

Comment

In this assessment it is clear that the assessors engaged with the patient and ensured she was comfortable prior to starting the assessment. Also that she was informed of the assessment of capacity. The decision is clearly defined and is specific. The evidence provided in the two stage test of the patient's abilities gives good detail about the discussion that the practitioners had with the patient and outcomes. All dates and signatures were completed.

The bad



FAMILY NAME: Lane	NHS Maidstone and Tunbridge Wells NHS Trust
Given name: Janet	
Preferred name: Jan	
Title: Ms Gender: F	
NHS number: 9999999999999	
Hospital number: 88888888888	
Date of birth: 14 / 02 / 1960	
Complete above in full or affix patient label	**Mental Capacity Assessment**
Location: Endoscopy Clinic Maidstone	

NB the Mental Capacity Act's first principle is that a person must be assumed to have capacity unless it is established that they lack capacity

The assessment must be about a particular decision that has to be made at the time the decision needs to be made.

1. Decision requiring assessment of mental capacity (provide details):
Whether to have a Colonoscopy or not, with biopsies to be taken

2. Two- stage test of mental capacity

a. Does the person have impairment of, or disturbance in the mind or brain? (It doesn't matter whether the impairment of disturbance is temporary or permanent) Provide evidence:
The patient cannot hear me as she is deaf

b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made: Yes ☐

3. Practical steps taken to help the person make the relevant decision for themselves (provide details):
I have found out she is deaf but that she can lip read so I have spoken to her really clearly, really defining my lip movements – I didn't realise that strong accents are a problem and I am Scottish but there was no one else available

Can the person:

a. **Understand** the information relevant to the decision?	Yes ☐
b. **Retain** that information?	Yes ☐
c. Use or **weigh up** that information as part of the process of making the decision?	Unclear ☐
d. Communicate their decision (whether by talking or any other means)?	No ☐

Provide evidence in respect of the person's ability in relation to each of these four elements of the test:
I got the feeling that she was able to understand the information as she was using her hands to describe and show me what I had said to her would happen with the colonoscopy.
When I went back to this later in the conversation she was able to show that she remembered the conversation. She also wrote down what I had explained to her. She appears to realise the risks and benefits of the procedure but she did not demonstrate that she was weighing up the pros and cons of the procedure. She wasn't able to communicate her decision to me as she did not have clear speech.

Mental Capacity Assessment
Author: Lead Nurse Dementia Care
Review date: March 2023 RWF-OWP-APP65
Version no.: 5.0 Page 1 of 2
Overarching policy title: Mental Capacity Act Policy and Procedure [RWF-OPPPCS-C-NUR1]
Overarching policy author: Lead Nurse Dementia Care

Patient's full name: Janet Lane..... NHS no.: 999999999999

4. Outcome of Mental Capacity Assessment	
On the balance of probabilities, there is a reasonable belief that:	
The person **has** capacity to make this particular decision at this time:	No
The person **does not have** capacity to make this particular decision at this time:	No Capacity

5. Details of assessor Jane Smith	
Full name:	Jane Smith
Signature:	JSmith
Designation:	Doctor
Date and time:	30/01/2020

0

0

Mental Capacity Assessment
Author: Lead Nurse Dementia Care
Review date: March 2023 RWF-OWP-APP65
Version no.: 5.0 Page 2 of 2
Overarching policy title: Mental Capacity Act Policy and Procedure [RWF-OPPPCS-C-NUR1]
Overarching policy author: Lead Nurse Dementia Care

This assessment of capacity should have been stopped at the first part of the box numbered 2. This patient had no impairment or disturbance of the mind or brain. As the patient had a sensory loss, communication aides pertinent to the patient should have been used to talk through the risks and benefits of the procedure. It is obvious from the document that the patient could communicate by writing and this should have been used for this patient. The patient could have been offered a leaflet explaining the procedure and after effects.

The Ugly

FAMILY NAME:	TO PE
Given name:	ALICE
Preferred name:	ALI
Title: MS	Gender: F
NHS number:	7777112
Hospital number:	89a2979
Date of birth:	29/01/2000
Complete above in full or affix patient label	
Location:	TOS PITA

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Mental Capacity Assessment

NB the Mental Capacity Act's first principle is that a person must be assumed to have capacity unless it is established that they lack capacity

The assessment must be about a particular decision that has to be made at the time the decision needs to be made.

1. Decision requiring assessment of mental capacity (provide details):

MASTECTOMY

2. Two- stage test of mental capacity

a. Does the person have impairment of, or disturbance in the mind or brain? (It doesn't matter whether the impairment of disturbance is temporary or permanent) Provide evidence:

CONFUSION CAUSE UNKNOWN ?

b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made:	Yes ☒ No ☐

3. Practical steps taken to help the person make the relevant decision for themselves (provide details): Talked to PE given literature consent engage with me.

Can the person:

a. **Understand** the information relevant to the decision?	~~Yes~~ ☐ No ☒
b. **Retain** that information?	~~Yes~~ ☐ No ☒
c. Use or **weigh up** that information as part of the process of making the decision?	~~Yes~~ ☐ No ☒
d. Communicate their decision (whether by talking or any other means)?	~~Yes~~ ☐ No ☒

Provide evidence in respect of the person's ability in relation to each of these four elements of the test: PE JUST WOULDN'T engage properly.

NB: if a person cannot do one or more of these four things, they are unable to make the decision

Patient's full name: Alice Hope NHS no.: .....

4. Outcome of Mental Capacity Assessment	
On the balance of probabilities, there is a reasonable belief that:	
The person **has** capacity to make this particular decision at this time:	~~Yes~~ ☒ No ☐
The person **does not have** capacity to make this particular decision at this time:	Yes ☐ ~~No~~ ☒
5. Details of assessor	
Full name:	[illegible]
Signature:	
Designation:	[illegible]
Date and time:	

Comment

The above assessment is difficult to read. If handwriting the document staff must ensure that the writing is legible. Be specific about the ward location. Mastectomy should be elaborated upon – which breast and why. Just because someone is not engaging with the assessment it does not mean that they lack capacity. Seek out advice from S&LT, Liaison Psychiatry, MCA Lead, and/or Trust Lawyer. The name of assessor is not legible and the date and time have not been included.

The following printed forms can be ordered for Ward stock:-
WNS1204 – A4 Mental Capacity Assessment Pad
WNS1205 – A4 Best Interest Decision Making Pad

The April Patient Safety Calendar will focus on safeguarding children.

Report from the Chair of the Trust Board **Chair of the Trust Board**

The last month has been dominated by the growing threat from the COVID-19 virus. I have been impressed by all the work being done by the executive and operational management teams across the Trust to prepare for an increase in pressure on our services which can be anticipated over the coming weeks and months. All our staff deserve tremendous gratitude from the Trust Board for their commitment and dedication. The detail of all the work being done will be covered later in the reports of this meeting, but I wanted to formally record my admiration and thanks to our staff.

Consultant appointments

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

Date of AAC	Title	First name	Surname	Department	Potential/Actual Start date
26/02/20202.	Dr	Griffith Charlotte	Moss	Oncology	June 2020
09/03/2020	Prof	Christopher	Holland	Intensive Care	TBC
18/03/2020	Dr	Bindu	George	Consultant Neonatal	21/09/2020
18/03/2020	Dr	Se-Youn	Park	Consultant Neonatal	01/07/2020

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. We continue to work closely with our partners across the region and nationally to put preparations in place to respond to the challenges health and social care is facing with the Covid-19 (coronavirus) pandemic. Our priority is to provide safe and effective care for our patients and I want to thank our staff for their outstanding dedication and effort in helping us put tried and tested measures in place that will ensure we can continue to do this in the coming months.

   This is a fast moving situation with advice, response plans and guidance being updated regularly. At the time of writing, we are focusing efforts on: caring for patients that most need our help; supporting our staff, their health and wellbeing, and maximising their availability; ensuring we are prepared for potentially significant numbers of patients requiring respiratory support; facilitating ways to use our beds and staff differently so that we can continue to deliver the best care we can; and removing non-urgent and routine processes to focus support into the areas that most need it.

   The key preparations we are implementing include:

   - Establishing a dedicated incident co-ordination centre seven days a week that ensures our staff have the latest information and allows us to redirect resources when required.
   - Restricting visiting hours and visitor numbers to help keep our patients and staff safe and prevent the spread of any infection.
   - Encouraging staff, where it is appropriate to do so, to work from home.
   - Following national guidance and postponing non-urgent planned procedures from 18 March for at least the next three months to ensure our hospitals are prepared for caring for potentially significant numbers of patients requiring specialist clinical support.
   - Conducting outpatient appointments, where it is appropriate to do so, via telephone or video conference service.
   - Working with partners to review hospital capacity and identifying clinical areas that can be used for patients who will require high-dependency clinical care.
   - Training more staff to provide specialist support to potentially more patients needing respiratory care.
   - Rolling out staff welfare measures that support those who are in self-isolation or are caring for dependents that are unwell.
   - Ensuring our Kent Oncology Centre is ringfenced so that we can continue to care for and treat our cancer patients.

2. A huge thank you to the Peggy Wood Foundation who have donated more than £170,000 to fund new cutting-edge equipment to help us treat patients with gynaecological cancers. The innovative ICG Sentinel Lymph Node Detection System provides a quicker, less invasive and more efficient technique for detecting cancer cells, reducing patient side-effects and exposure to radiation. MTW is one of only a handful of trusts in the country to offer this procedure to patients and this generous donation puts us at the forefront of cancer treatment.

3. Development of the implementation of the West Kent Integrated Care Partnership (ICP) is progressing well. Key highlights from the past month include: working with Integrated Care System partners on finance and resourcing for 2020/21; agreeing next steps for leadership training as we transition into an ICP as well as support for organisational development; commissioned work on engaging with local residents about health and social care in west Kent; agreement to submit a bid for funding from The Health Foundation to develop a collaborative approach in developing services between health and social care providers and users.

4. A new end-of-treatment bell has been installed in the Woodlands Unit at Tunbridge Wells Hospital thanks to a generous donation from a local family. Seven-year-old Ollie Ridley unveiled the bell on the children's ward as a symbol of hope for other youngsters to ring when they reach the end of their cancer treatment. It was his idea to install the Trust's first ever bell for children as he was a regular visitor to Tunbridge Wells Hospital during his cancer treatment. His family agreed to sponsor his suggestion and the bell was supplied by charity End of Treatment Bells.

5. A new auricular acupuncture complementary therapy service has been launched at MTW for patients with prostate cancer. The new service is aimed at patients receiving hormone therapy who may like to try alternative ways of managing some of the side effects of their treatment, such as hot flushes, anxiety, stress and sleeplessness. The clinics will be held once a week at each hospital site.

6. MTW's maternity services were busy on Leap Day after 19 babies were born on Saturday 29 February. Congratulations to all the new parents who welcomed their leaplings this year.

7. MTW's new Acute Assessment Unit (AAU) opened its doors to patients this month. A big thank you to all staff involved in the £8m project. The purpose-built unit supports our Same Day Emergency Care (SDEC) pathway and contains 14 short stay beds, eight assessment beds and a treatment suite. It will help us to continue to build on the excellent work we've undertaken to see, care and treat our patients more quickly, which has helped push MTW into the top ten best trusts for Emergency Department performance.

8. MTW is now pushing forward with its plans to implement a hyper acute stroke unit (HASU) at Maidstone Hospital after the High Court recently ruled in favour of the Kent and Medway Stroke Programme Joint Committee of Clinical Commissioning Groups on all grounds. More details on our HASU development plans and timeframe for delivery will be available soon.

9. The Executive Directors and Chiefs of Service continue to meet weekly at Executive Team Meetings. Key areas of discussion over the past month have included:
   a. Covid-19 response plans
   b. NHS National Staff Survey results and action plan
   c. Review of ways to better support staff health and wellbeing, helping make MTW a great place to work
   d. Update on RTT, Emergency Department and Cancer waiting times performance
   e. Review of financial plan

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

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Integrated Performance Report, February 2020	**Chief Executive / Members of the Executive Team**

Enclosed is the Integrated Performance Report for month 11, 2019/20 (which includes an update on progress with the Perinatal Mortality Review Tool (PMRT); and the planned and actual ward staffing for February 2020).

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 14/03/20 (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

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Integrated Performance Report

February 2020

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Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 18 onwards)

- Finance Report
- Safe Staffing Report

Scoring for Performance Wheel

Scoring within a Domain:

Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the domain on a YTD basis that appear on the balance scorecard (below) :

Red = 3 or more red KPIs within the domain
Amber = 2 red KPI rating within the domain
Green = No reds and 2 amber or less within the domain

Overall Report Scoring:

Red = 4 or more red domains
Amber = Up to 3 red domains
Green = No reds and 3 or less amber domains

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

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Performance Wheel and Executive Summary

Previous Month (Jan-20)

Current Month (Feb-20)

2019/2020 Forecast Outturn

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for six consecutive months. The 2 week wait cancer waiting times target was also achieved but the 2 week wait Breast Symptoms standard was not achieved. The trust continues to achieve the 31 Day First Treatment Standard. In addition the Trust also achieved the trajectory for the A&E 4hr standard and is expected to achieve the Referral to Treatment (RTT) standard.

The Trust declared one Never Event in February for Wrong site surgery. Immediate actions are being supported and this is being fully investigated.

The increased use of escalated areas has continued in February (slight reduction) due to pressures with non-elective flow (12% of all occupied beds in February). We continue to move experienced staff from our core clinical areas to ensure our escalation areas have been safely managed.

The rate of Pressure Ulcers and Falls both improved in February but remain slightly above the maximum target YTD. The forecast for the year shows an adverse position to plan for Pressure Ulcers with Falls likely to be slightly above the maximum trajectory.

Activity levels increased for both elective and New Outpatient appointments in February and were above plan overall. Year to date New Outpatient activity is 0.9% below plan but for the main RTT Specialties only this is 8.9% below plan. Elective activity remains 3.7% below plan YTD. This is an improving position for both areas.

Performance for the Referral to Treatment (RTT) standard is currently being finalised but is expected to be 86.7% for February, therefore achieving the trajectory for the year end of 86.67%. The RTT recovery plan for Quarter 4 (January to March 2020) remains in place and is being closely monitored.

Performance Wheel and Executive Summary

Items for Escalation

- **Never Event:** One declared in February for the Trust. This is being investigated with immediate actions taking place.

- **Infection Control:** With the 4 cases of C.Diff reported in February the Trust remains below the maximum trajectory YTD and is expected to achieve the trajectory. Cases of E.Coli have decreased in February but the rate remains above the threshold monthly and year to date. This has resulted in the forecast for the year continuing to show an adverse position to plan.

- **Falls:** The rate of Falls has reduced further this month but remains slightly above the 6.0 maximum trajectory both month and YTD. The forecast for the year is to exceed the 6.0% maximum limit.

- **Pressure Ulcers:** Levels reduced in February with 13 hospital acquired pressure ulcers reported equating to a rate of 2.2 per 1,000 occupied beddays. In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). The forecast for the year shows an adverse position to plan.

- **Stroke:** Performance against the metrics that constitute the Best Practice Tariff remains below the level the Trust aspires to achieve. Compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation.

- **A&E 4 hour Standard:** A&E performance was above the submitted trajectory of 89.42% at 90.59% in February. Average time in department dropped below 3:30 for the first time since Jul-19 and average time to first treatment indicators are all improving. The Trust remains in the 10 best performing Trusts in England.

- **Referral to Treatment (RTT) Incomplete Pathway:** is currently being finalised but is expected to be 86.7% for February, therefore achieving the trajectory for the year end of 86.67%

- **Cancer 2weeks (2ww):** The Trust is maintaining the achievement of the 2ww standard reporting 93.4% for January 2020. However, the Breast Symptoms standard was not achieved with 89.5%. February is expected to achieve.

- **Cancer 62 Day:** Performance against this target has been achieved for six consecutive months (85.6%) with February expected to achieve .

- **Diagnostics Waiting Times <6 weeks:** Performance improved to 99.5% in February, therefore achieving the target.

- **Finance:** The Trust delivered the financial plan for February generating £0.8m deficit including PSF. The Trust was £1.1m better than previously forecasted, £0.7m related to RTT income support which was previously included in the month 12 position, £0.3m related to deferred income adjustment previously planned to be released in month 12 and £0.1m underspends within budgets. Year to date plan the Trust is £0.2m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£2m net), RTT Income reserve (£1.1m), £2.3m CIP slippage, £0.7m overspend against outsourcing, overspends within expenditure budgets (£2.7m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.5m of reserves, QIPP income adjustment (£1.3m).

- **Workforce (various):** The overall staff fill rate has increased further to 79.8% in February which is the highest level all year. The nursing staff fill rate reduced to 97.3%. The overall sickness rate has reduced in February but continues to remain high at 3.7% (3.5% YTD) and the Annual Leave rate remains at normal levels at 11%. The Agency and bank usage remained similar to last month and the length of supernumerary time for some overseas nurse recruits have contributed to a slower than expected reduction in nurse agency expenditure. The overall Trust vacancy rate reduced in February to 9%. When winter escalation posts are removed this falls to 7.8% therefore achieving the Trust plan.

Summary Scorecard

Safe

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Plan	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
S1	Rate C-Diff (Hospital only)	19.9	19.6	22.3	22.7	21.2	22.4	21.1	↘
S2	Number of cases C.Difficile (Hospital)	4	4	50	51	48	55	52	↘
S3	Number of cases MRSA (Hospital)	0	0	3	0	1	0	1	→
S4	Rate of E. Coli Bacteraemia	19.9	24.6	27.6	21.4	31.4	21.5	30.4	↑
S5	Rate of Hospital Pressure Ulcers	*1.35*	2.2	1.4	1.3	1.7	1.3	1.6	↘
S6	Rate of Total Patient Falls	*6.00*	6.09	*6.29*	6.00	6.10	*6.00*	6.08	↑
S7	Number of Never Events	*0*	1	1	0	3	0	3	→
S8	Number of New SIs in month	12	10	146	132	123	144	135	↗
S9	SIs not closed <60 Days Monthly Snapshot	24	5	-	24	5	24	5	↘
S10	Overall Safe staffing fill rate	93.5%	97.3%	96.9%	93.5%	96.2%	93.5%	96.2%	↘

Effective

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Plan	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	1.0132	1.0391	1.0391	1.0132	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	91.8	101.2	100.0	91.8	Lower conf <100	91.8	→
E3	% Total Readmissions	14.1%	13.4%	13.6%	14.1%	14.7%	14.1%	14.7%	↗
E4	Readmissions <30 days: Emergency	14.8%	13.7%	14.1%	14.8%	15.3%	14.8%	15.3%	↗
E5	Readmissions <30 days: Emergency (excl SDE	14.0%	13.4%	13.9%	14.0%	14.7%	14.0%	14.7%	↗
E6	Readmissions <30 days: Elective	6.8%	9.9%	7.1%	6.8%	7.9%	6.8%	7.9%	↘
E7	Stroke: Best Practice (BPT) Overall %	50.0%	44.2%	50.0%	50.0%	42.7%	50.0%	42.7%	↘
E8	Nat CQUIN: % Dementia Screening	90.0%	99.1%	99.8%	90.0%	95.2%	90.0%	95.2%	↘
E9	Nat CQUIN: % Dementia Risk Asssessed	90.0%	100.0%	93.5%	90.0%	101.7%	90.0%	101.7%	↑
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	100.0%	99.1%	90.0%	99.1%	90.0%	99.1%	→

Caring

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Plan	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
C1	Single Sex Accommodation Breaches	0	0	35	0	0	0	0	→
C2	Rate of New Complaints	3.92	2.60	2.21	2.94	2.35	2.93	2.39	↘
C3	% complaints responded to within target	75.0%	67.5%	73.3%	75.0%	67.1%	75.0%	67.8%	↓
C4	IP Resp Rate Recmd to Friends & Family	25.0%	16.7%	18.2%	25.0%	16.4%	25.0%	16.4%	↗
C5	IP Friends & Family (FFT) % Positive	95.0%	97.8%	95.6%	95.0%	95.7%	95.0%	95.7%	→
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	10.0%	7.6%	15.0%	8.5%	15.0%	8.5%	↑
C7	A&E Friends & Family (FFT) % Positive	87.0%	89.5%	91.3%	87.0%	87.7%	87.0%	87.7%	↗
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	10.6%	26.2%	25.0%	21.2%	25.0%	21.2%	↓
C9	Maternity Combined FFT % Positive	95.0%	96.0%	96.5%	95.0%	95.5%	95.0%	95.5%	↘
C10	OP Friends & Family (FFT) % Positive	84.0%	83.2%	84.3%	84.0%	82.6%	84.0%	82.6%	↘

Responsive

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
R1	Emergency A&E 4hr Wait	89.4%	90.6%	91.7%	90.5%	91.7%	90.5%	↘
R2	Emergency A&E >12hr to Admission	0	0	2	0	0	0	→
R3	Ambulance Handover Delays >30mins	369	416	4207	5435	4428	5804	↘
R4	RTT Incomplete Pathway (October)	86.4%	86.7%	81.3%	86.7%	86.7%	86.7%	↗
R5	RTT 52 Week Waiters (New in Month)	8	4	69	66	96	66	↗
R6	% Diagnostics Tests WTimes <6wks	99.0%	99.5%	99.5%	99.5%	99.0%	99.0%	↗
R7	Cancer two week wait	93.0%	93.4%	87.6%	93.4%	93.0%	93.4%	↘
R8	Cancer two week wait-Breast Symptoms	93.0%	89.5%	69.4%	89.5%	93.0%	93.0%	↘
R9	Cancer 31 day wait - First Treatment	96.0%	96.7%	95.9%	96.7%	96.0%	96.7%	↘
R10	Cancer 62 day wait - First Definitive	85.0%	85.6%	65.6%	85.6%	85.0%	85.6%	↘

Responsive - Flow

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
R11	Average LOS Non-Elective	6.40	6.96	6.94	6.88	6.40	6.88	↘
R12	Theatre Utilisation	90.0%	86.3%	91.3%	86.5%	90.0%	86.5%	↘
R13	Primary and Non-Primary Refs	15,673	14101	171,858	181836	199,052	199077	→
R14	Cons to Cons Referrals	4,086	5402	64,229	68331	51,898	72,826	→
R15	OP New Activity	17,806	17765	192,537	204788	226,133	224374	↘
R16	OP Follow Up Activity	27,311	26758	291,291	313284	346,845	343322	↘
R17	Elective Inpatient Activity	585	635	5,652	6572	7,426	7215	↘
R18	Day Case Activity	3,954	4005	40,079	44108	50,210	48457	→
R19	Non Elective Activity (inc Maternity)	5,357	5399	58,505	61345	67,606	67071	↗
R20	A&E Attendances : Type 1	12,223	13112	142,029	154540	159,252	169622	↘

Well-Led

ID	Key Performance Indicators	Curr Month Plan	Curr Month Actual	Year to Date Prev Yr	Year to Date Curr Yr	Year End Plan	Year End FOT	Change on Prev Mth
W1	Surplus (Deficit) against B/E Duty	- 830	- 798	- 1,353	5,189	6,896	6,896	→
W2	CIP Savings	2,039	2,396	11,251	20,522	22,328	22,328	↗
W3	Cash Balance	4,673	21,922	10,625	21,922	3,000	3,000	→
W4	Capital Expenditure	2,010	321	6,285	5,092	14,448	16,328	→
W5	Finance use of Resources Rating	2	3	4	3	2	3	→
W6	Staff Turnover Rate (%)	10.0%	12.7%	8.9%	12.7%	10.0%	12.7%	↘
W7	Vacancy Rate (%)	8.0%	9.0%	10.7%	10.9%	8.0%	10.9%	↗
W8	Total Agency Spend	1,331	1,426	21,243	17,535	17.738	18.574	↘
W9	Statutory and Mandatory Training	90.0%	85.9%	87.1%	86.0%	90.0%	86.0%	↗
W10	Sickness Absence	3.3%	3.7%	3.4%	3.5%	3.3%	3.5%	↗

Target Indicator Key:	
On or above Target	
Review and Corrective Action required	
Significantly below target - urgent action required	
KPI Used in Performance Wheel Scoring	

Change on Previous Indicator Key:	
Significant improvement on Previous (>5%)	↑
Improvement on previous (<5%)	↗
No Change	→

Change on Previous Indicator Key:	
Deterioration on previous (<5%)	↘
Significant deterioration on previous (>5%)	↓

Headlines

Safe:	Positives:	Challenges:
Lead Director(s): **Claire O'Brien/** **Peter Maskell**	**Infection Control**: Compliance in MRSA Screening for the Elective pathway remains above target YTD and performance for MRSA Screening in Non- Elective pathways increased to 96.56% in February, above the target of 95%. There were four cases of C.difficile reported in February against a maximum trajectory of 4. The Trust therefore remains on trajectory with 48 cases against a maximum limit of 51. **Serious Incidents (SI)s:** SIs open at the end of the month decreased further which is the lowest number reported so far this year. Performance for those being closed within the 60 day target remained similar in February with 5 SIs currently open that have passed their breach date for closure. **Safe Staffing**: despite levels reducing to 97.3% in February, performance remains within acceptable levels.	**Never Event:** The Trust declared one Never Event in February for Wrong Site Surgery. This was for the specialty of Ophthalmology in Outpatient services and is being fully investigated. **Infection Control:** Cases of E.Coli have decreased in February but the rate remains above the threshold monthly and year to date and the forecast for the year shows an adverse position to plan. The February safety moment focused on reducing the risk of UTIs. The Trust will further promote the HOUDINI criteria through the distribution of staff information cards. **Falls:** The level of Falls has reduced further in February to 124 equating to a Rate of 6.09 per 1,000 occupied bed days. The rate remains slightly above trajectory YTD at 6.1. The forecast shows this indicator is likely to be just above the 6.0% maximum limit. As part of the NHSi project focussing on Lying and Standing Blood Pressure (LSBP) rollout across all inpatient areas has been completed. The Falls Group will be monitoring the impact of the Falls Training and compliance with he lying and standing blood pressure measurements. **Pressure Ulcers (Hospital Acquired):** In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). This coincided with an overall increase in the number of hospital acquired pressure ulcers (HPAU) reported in December. The number reported has reduced slightly in February with 13 reported equating to a rate of 2.2. The forecast for the year shows this will be an adverse position to plan. A Deep Dive reviewing all hospital acquired pressure ulcers from April 2019 to February 2020 is in progress, themes and learning will be universally shared and presented to the Quality Committee in June 2020. **Duty of Candour:** Individuals within the Patient Safety Team now have clearly defined roles and responsibilities for the management of Duty of Candour and compliance is monitored through the Patient Safety KPI's.

Headlines

Effective:	Positives:	Challenges:
Lead Director(s): **Peter Maskell**	**Mortality:** The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI both continue to remain within acceptable limits. The HSMR has been below 100 for the last eight reporting periods, being reported at 91.7 for the 12 months to October 2019. The latest SHMI published for the period October 2018 – September 2019 is reported at 1.0132 which is banded as level 2 "as expected". **Patients with Dementia**: The percentage of patients screened for Dementia remained similar in January at 99.1% against the 90% national target and remains above target YTD (95.2%). The percentage of those that were risk assessed or referred to a specialist where required both continue to remain significantly above target and were both at 100% compliance for January (data runs one month behind)	**Emergency Readmissions:** Following discussion with the Medical Director it was decided to show the rate of emergency readmissions within 30 days of discharge (non-elective) excluding SDEC (those on a same day emergency care pathway) as well as the total rate of emergency readmissions within 30 days of discharge (non-elective) due to the increased use of short stay units. Performance is monitored against local targets based on improving to above the average of last year. Performance shows improvement in February, but the latest month is prone to undercounting as patients tend not to appear until they have been discharged from their readmitting spell. To 31-Jan-20, Readmissions following NE spells are 15.3%, compared to 14.6% for the equivalent period last year. The rate of zero LoS spells is 16.0% versus 15.6% last year, and rate for non-zero spells is 14.7% versus 13.9% last year **Emergency readmissions (Elective):** The level or emergency readmissions within 30 days of discharge for those who were originally admitted on an elective pathway has increased and is above the target. This year is showing a 1% increase on last year. Initial analysis has not identified any particular trends and therefore a deep dive at patient level is currently underway to see if there are any underlying trends. **Stroke**: Performance against the metrics that constitute the Best Practice Tariff has improved in January, but remains below the level the Trust aspires to achieve. Compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation. Following the decrease in performance against the indicator for the Stroke Ward being the First Ward for Stroke patients in December this has increased back to previous levels in January.

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Headlines

Caring:	Positives:	Challenges:
Lead Director(s): **Claire O'Brien/** **Peter Maskell**	**Complaints:** The overall number of complaints received has remained fairly consistent month on month. Divisional performance increased significantly to 92.5% for February and is at 82.5% YTD which is above the 75% target. **Friends and Family Survey:** The Percentage positive performance for February was above plan in all areas with the exception of Outpatients which was slightly below plan. Year end forecasts are for these indicators to achieve the plan. **Single Sex Accommodation:** Delivery of the Same Sex Accommodation (SSA) remains a priority, promoting privacy and dignity for our patients. There have been no unjustified mixed sex breaches reported since December 2019. Justified mix sex breaches in acute clinical areas are recorded internally. These remain small numbers.	**Complaints:** Performance for the percentage of complaints responded to within their target date decreased in February to 67.5%. YTD performance is 67.1%. The forecast for the year show this will not achieve the 75% target (maximum 70%). **Friends and Family:** Response rates continue to fluctuate for all four areas and all areas remains below plan YTD. The forecast for these indicators show an adverse position to plan with the possible exception of Maternity Services. Action drivers (a flagging system to identify trends which require action to be taken) to be trialled in low response rate areas. Communications team supporting standard signage across the trust to promote & capture FFT

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Headlines

Responsive:	Positives:	Challenges:
Lead Director(s): **Sean Briggs**	**4 hour Emergency Access Standard:** A&E performance for February was 90.59%, above the agreed trajectory of 89.42%. Average time in department dropped below 3:30 for the first time since Jul-19, and the type 1 performance score for January ranks the Trust 20th out of 132 acute trusts nationally. **Ambulance Handovers:** The improvements in Ambulance performance in January have been mostly maintained, with 10.6% of ambulances delayed 30-60 mins and 0.6% over 60 mins	**ED Attendances:** The past 52 weeks have been 9.2% busier than the preceding 52, and 2019/20 attendance is forecast to be 8.8% higher than 2018/19. February was 2% lower than expected but 7.3% higher than the original trajectory at 468.3 per day. **Beds and Escalated Areas**: Due to the continued high level of emergency admissions from A&E (highest ever in December at 93.4 per day with a slight reduction in January and February) and the flow indicators remaining below plan the level of escalated areas has remained at 12% of the total bed occupancy. Many of the available beds are specialist beds not available for general acute admissions. **Inpatient Efficiency (Theatre Utilisation):** Theatre Utilisation with TAT has remained static this month at 86.3% in February but still remains below plan. The activity equated to 79.7 elective cases per working day, a decrease from 80.9 in Jan-20. **Cancellation of outpatient appointments with less than 6weeks notice:** This continues to be an area of concern at 14.8% YTD. After the improvement seen in Jan-20 the rate increased again to 16.4% in Feb-20. **Outpatient Utilisation:** The monthly utilisation figures have been averaging 68%. Although there are several data quality issues with the OP Utilisation figures resulting in them being understated performance remains below plan.

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Headlines

Responsive:	Positives:	Challenges:
Lead Director(s): **Sean Briggs**	**RTT Incomplete Pathway:** Performance is currently being finalised but is expected to be 86.7% for February, therefore achieving the trajectory for the year end of 86.67% **Cancer Waiting Times:** The 62 day standard has now been achieved for six consecutive months at 85.6% for January 2020. The Trust is maintaining the achievement of the 2ww standard reporting 93.4% for January 2020. However, the Breast Symptoms standard was not achieved with 89.5% The Trust has continued to achieve the 96% target for the 31 day wait standard.	**New Outpatient Activity:** Activity was on plan in February and is 0.9% below plan YTD. However, for the main RTT Specialties this is 8.9% below plan YTD (improving position). Specialties furthest from plan remain ENT, Gastroenterology, Trauma & Orthopaedics and Ophthalmology which is directly impacting on their achievement of their non-admitted RTT Trajectories and led to an increase in the RTT Waiting List and backlog in some specialties. **Elective Activity:** Overall activity increased in February and was 2.2% above plan. YTD activity is now 3.7% below plan YTD (DC is 3.8% below plan and IP are 3.1% below plan YTD). The specialties furthest from plan YTD remain T&O, Ophthalmology, Urology, Cardiology and Gynaecology which is directly impacting achievement of the RTT admitted pathway trajectories. General Surgery remains above plan. Some of the speciality initiatives submitted in the speciality business plans have not been funded. The RTT recovery plan from January– March 2020 remains in place and is being closely monitored. **RTT Incomplete Pathways (52 week breaches):** The Trust is still reporting some 52 week breaches on a monthly basis (4 new reported for February). All patients will have a harm review by the managing Consultant. **Diagnostic Waiting Times <6weeks:** Performance improved to 99.5% in February, therefore achieving the target.

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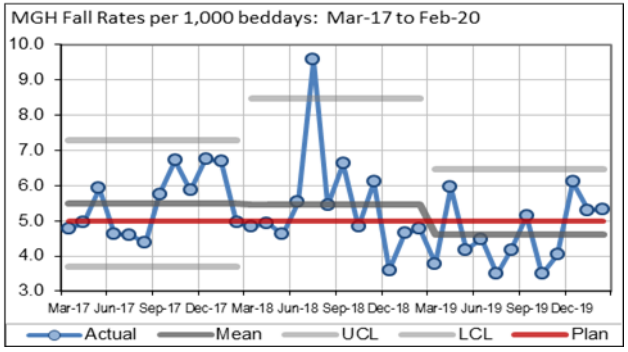
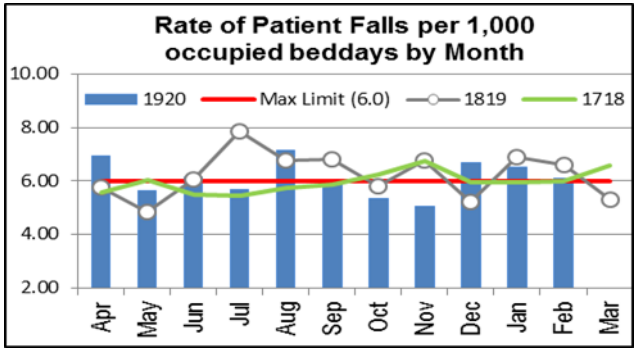
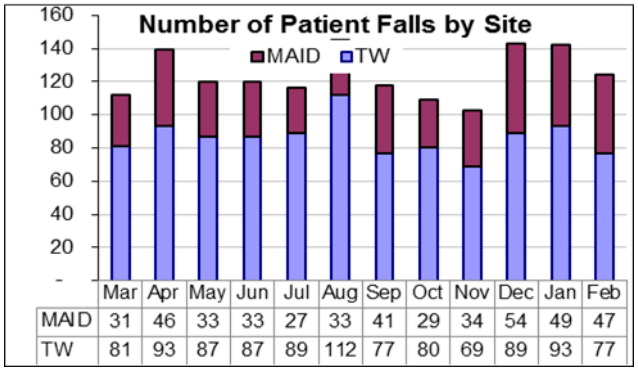
Headlines

Well Led:	Positives:	Challenges:
Lead Director(s): **Steve Orpin/** **Simon Hart**	**Finance**: The Trust has delivered the year to date financial plan resulting in full PSF payment. The Trust is forecasting to meet its control total by the end of the year. The level of mitigations required to be implemented in March has reduced between months by £0.6m. The Trust's overall capital programme is forecast to outturn at £15.7m (excluding donated assets and PFI Lifecycle). This includes the use of £6.4m of asset sale funding (capital resource approved in November 2019 by DHSC); the £2.1m of national Diagnostic Funding notified in December 2019 to purchase two CT scanners, a MRI and Mammography equipment, £1.25m of national funding for the Electronic Prescribing Medicines programme (EPMA) and additional funding expected for IT issues e.g. £427k for cyber risk issues, £578k for Health Led System improvements and £200k for Local Health record. **Vacancy Rate:** The overall Trust vacancy rate reduced in February to 9%. When winter escalation posts are removed this falls to 7.8% therefore achieving the Trust plan. The rate remains 5.5% lower that at the beginning of the financial year. **Annual Leave and Staff Fill Rate:** The overall staff fill rate has increased further to 79.8% in February which is the highest level all year and the annual leave rate is back to usual levels.	**Finance:** The Trust is implementing financial recovery plans and currently has £0.6m of additional mitigations to deliver the plan. The Trusts forecast currently excludes costs associated with COVID 19. The Trust is maintaining a log of additional costs incurred and is in discussion with NHSI/E about additional funding. Medical staffing pay overspent YTD by £2.5m mainly within Medicine and Emergency Division (£2.2m) and Paediatrics (£0.8m). Substantive recruitment has taken place, controls on temporary bookings and review of bank rates have been implemented which should reduce agency spend. Nursing vacancies are being filled through local and overseas recruitment; this should see a reduction in temporary staffing spend which is assumed in the forecast. However the Trust has opened 2 escalation wards earlier than planned which would increase the number of staff required. Shortfall year to date relating to private patient income. Private In patient's beds at TWH have opened in October but as yet we have not seen the expected increase in private patient income. There has also been escalation of NHS patients into these beds. If the I&E forecast moves adversely this will reduce the level of cash available. **Sickness Rate:** The overall sickness rate has reduced slightly to 3.7% in February, above the maximum limit of 3.3% and just below the upper control limit. YTD this is slightly above target at 3.5%. The flu vaccination campaign concluded at the end of February with a vaccination rate of 83% of frontline healthcare workers. We require 80% to obtain full CQUIN monies. The Trust target is 85%.

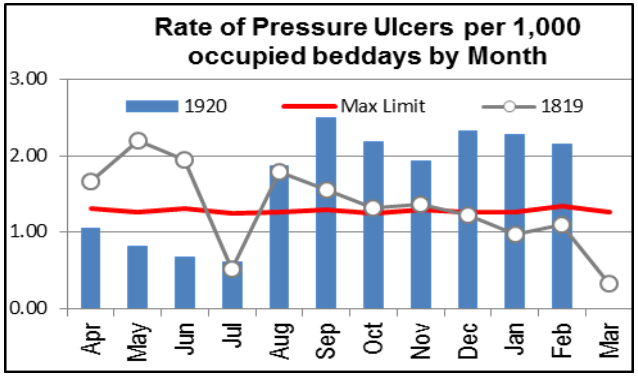
Escalation: Harm Free Care







	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
MAID	31	46	33	33	27	33	41	29	34	54	49	47
TW	81	93	87	87	89	112	77	80	69	89	93	77



Falls: The level of Falls has reduced in February to 124 equating to a Rate of 6.09 per 1,000 occupied bed days. The rate remains slightly above trajectory YTD at 6.1. The numbers reported for the Acute & Geriatric Directorate at Maidstone remains higher than usual at 32 which has led to the overall rate of Falls at Maidstone remaining high at 5.31. The number reported for TWH decreased further in February, particularly for the Acute and Geriatric Directorate, but YTD this remains above trajectory at 7.0, against 6.30.

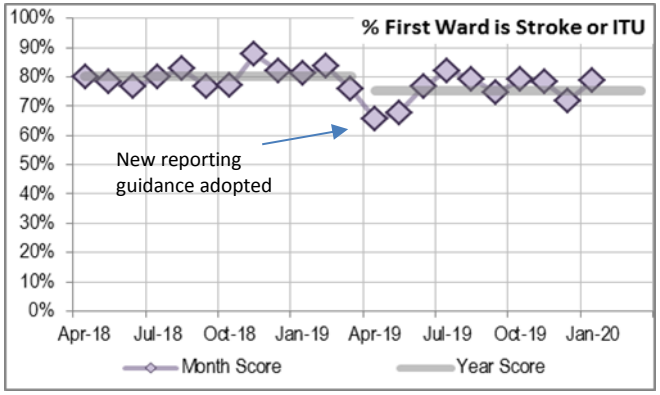
Pressure Ulcers: The level of hospital acquired pressure ulcers (HAPU) has reduced slightly in February with 13 reported equating to a rate of 2.2 against a maximum limit of 1.3. In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). Maidstone saw a reduction in numbers of DTIs in February but Tunbridge Wells saw an increase. The average rate of all pressure ulcers (including those who already had a pressure ulcer on admission) increased to 33.6 in February and has a rate of 24.0 so far this year compared to an average of 16.7 last year.

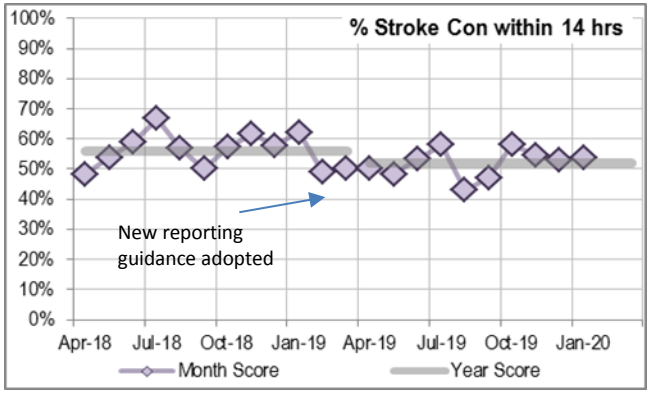
Severity of Falls: Of the 124 Falls reported, 106 resulted in no harm, 16 resulted in low harm, 1 resulted in severe harm and 1 resulted in a death.

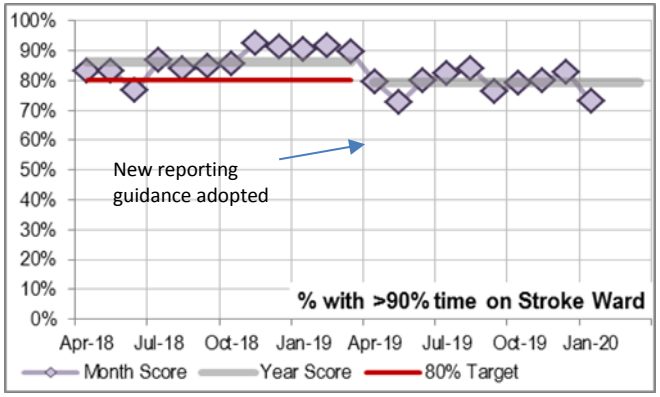
SIs: There were three Serious Incidents relating to Falls declared in February (One of which the SIs occurrence was in October but declared in February)

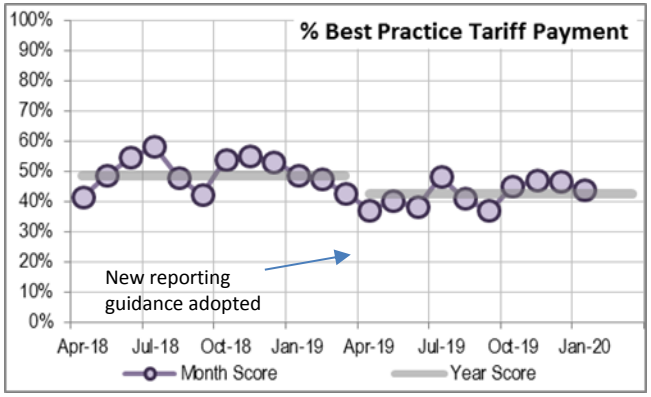
Summary:	Actions:	Assurance:
The level of Falls has reduced further in February to a rate of 6.09 per 1,000 occupied bed days but remains slightly above trajectory for both the month and YTD. The Year End Forecast is expected to be slightly above the maximum limit of 6.0. There were 3 Serious Incidents relating to Falls declared in February (1 related to an occurrence in October). The level of hospital acquired pressure ulcers (HAPU) reduced slightly to 13 reported equating to a rate of 2.2 against a maximum limit of 1.3. The rate of all pressure ulcers remains higher this year than last year and the year end forecast will show an adverse position to plan.	As part of the NHSi project focussing on Lying and Standing Blood Pressure (LSBP) rollout across all inpatient areas has been completed. LSBP is one of the three high impact actions for CQUIN CCG7. The moving and handling facilitator is offering bespoke training in the clinical areas to support staff. In falls prevention strategies. A Study day has been booked in May for the Tissue Viability Champions who are working on action plans to embed the learning from the NHSI collaborative work which the Trust engaged in to support improvements in practice.	Wards on the Falls project are monitored through spot audits monthly. This is to monitor progress, sustainability as well as opportunity to identify if further support required. The Falls Group will be monitoring the impact of the Falls Training and the NHSI project. A Deep Dive reviewing all hospital acquired pressure ulcers from April 2019 to February 2020 is in progress, themes and learning will be universally shared and presented to the Quality Committee in June 2020.

Escalation: Stroke Best Practice Indicators









Data is now reported one month behind (Jan-20) to allow time for the data to be fully captured and validated. The timeliness of data capture and reporting is being addressed with the service.

There are three main stroke indicators that constitute Stroke Best Practice.

First Ward must be a Stroke Ward (or ITU): last year averaged 80.2%, but this year has reduced to 75.3% to end of Jan.

Stroke Consultant within 14 hrs: Performance has been lower in Aug, Sep Oct and Nov due to a combination of annual & compassionate leave, and data quality & completeness. The YTD position to the end of Jan is 51.9%.

90% of Spell on Stroke Ward. Changes in the guidance means that this metric is now calculated differently to last year. In 2018/19, we would have scored 86.2% under the new methodology, but this year is reported at 79.2% YTD.

Summary:

There are three stroke indicators that constitute Stroke Best Practice. a) Admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival (or their stroke if that happens on-site), c) Spend 90% of their spell on a stroke ward. 40.0% of patients this year have qualified by meeting all three indicators.

% Best Practice Tariff : The percentage of patients passing all 3 of these tests is 42.7% to the end of January 2020.

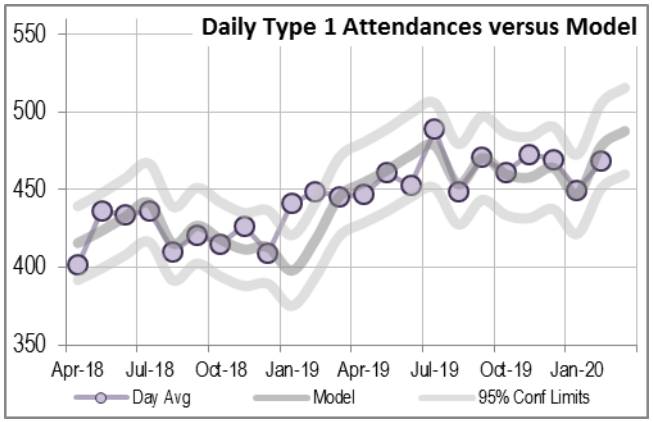
Actions:

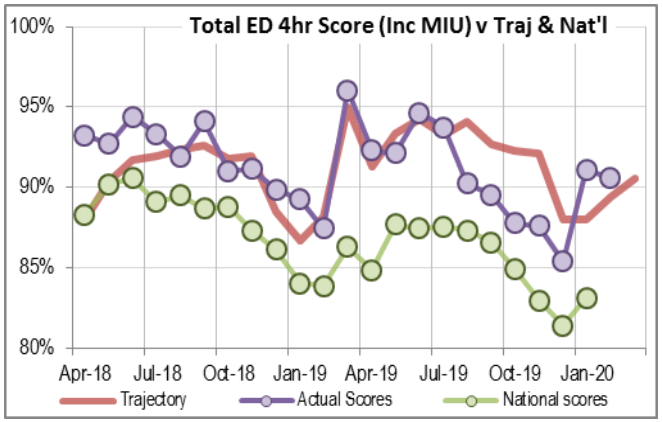
1.Stroke CNS team to monitor compliance against BPT and investigate non-compliance. 2. Current monitoring of these BPT targets have shown that any patient that is transferred to CDU before Stroke ward fails this target. 3. Time to Stroke Consultant impacted by number of patients being admitted out of hours and over weekend. 4. 90% spell on Stroke currently not always achieved due to increased capacity issues on the MGH Site, Stroke patients being moved to other wards once their stroke pathway is complete and minimal Stroke patients chosen to move during rehab stage. 5. Breach meetings to be commenced with Stroke Matron and CNS team to discuss actions for stroke patients who were admitted to other wards first or were transferred to Stroke after the 4hr target.

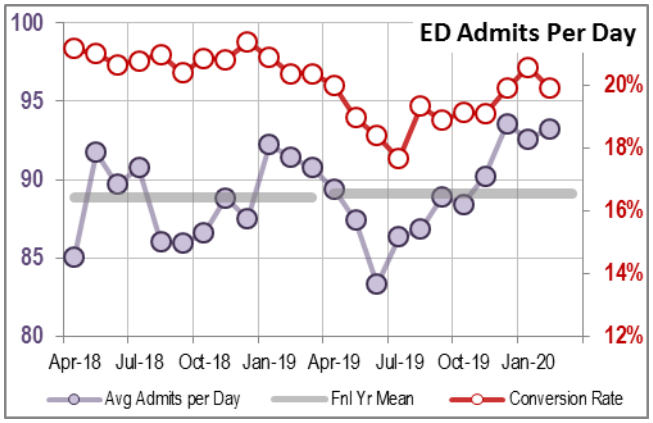
Assurance:

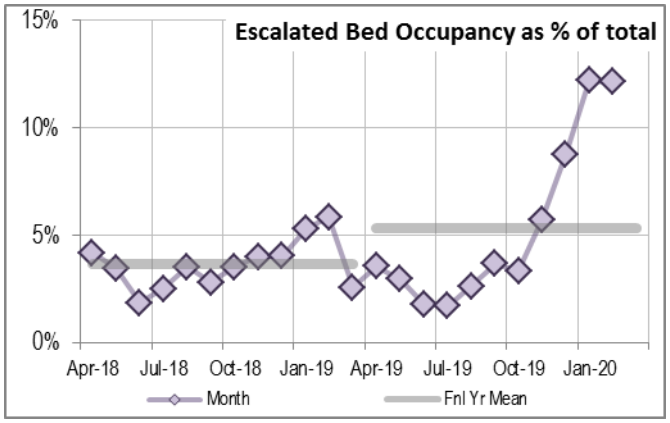
1. CNS team continue with monthly coding validation. 2. ED teaching by CNS team for early recognition of Stroke symptoms and early referral to Stroke to avoid transfer to CDU. 3. We are covering about 80% of weekends with stroke consultants and have full time cover during the week. We will need to recruit one further stroke consultant to get up to 100%. When a stroke consultant is not available, all stroke patients are reviewed by a Consultant Physician. Stroke consultants have now extended hours to 12 hr days Monday-Wednesday. 4. Daily identification of the patients most suitable to move to outlying wards at board round involving the whole MDT continues. 5. First meeting to commence this month and decision will then be taken regarding ongoing frequency of the meetings.

Escalation: A&E Performance









Attendances: Type 1 attendances averaged 427.0 per day in 2018/19 – 7.1% up on the previous year. We are currently forecasting an 8.8% increase on that for 2019/20. February averaged 468.3 per day. 2.0% lower than predicted by the most up-to-date model, but 7.3% higher than the original trajectory.

4 Hr Time in Department: February was 90.59% against an agreed trajectory of 89.42%, but an internal plan of 91.0%. We are consistently in the 10 best performing Trusts in England

Escalated Bed Occupancy: Last year, escalated beds were an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. So far this year, we are at 4.7%, with much of that seen in the past 10-12 weeks. Escalated beds tends to spike in January / February, but this year is worse than normal.

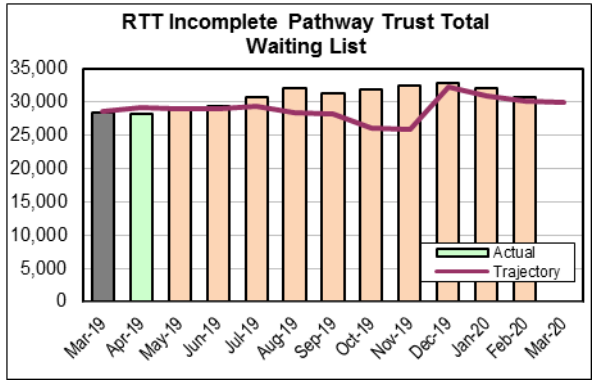
ED admits per day to main IP: 2018/19 averaged 88.9 per day, or 20.8% of attendances. This year we averaged 89.1 against much higher attendances, so the percentage is now 19.3%. Dec saw the highest ever daily rate of 93.5, and Feb was 93.3.
were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far its 11.7% delayed 30-60 mins and 1.28% >60. Feb was 10.6% / 0.6%

Summary:	Actions:	Assurance:
Performance was 1.15% above trajectory target in Feb. YTD, the average Time in Department is now significantly up on the same as last year at 3h33m. The non-elective average LOS and DTOC both remain above plan which has meant that bed occupancy was 94.4% in February and there continues to be an increased use of escalated beds (12% of total in February). The improvement in ambulance handovers seen last month has largely been maintained in February.	SDEC running 7 days per week. Commencing trial of Medical Consultant in ED in Jan to support SDEC streaming. Ambulance handover plan in place with increased SECAmb / CCG/ MTW working. Improvement seen in handover performance. New ED Consultant in place with additional ED consultant starting March. Nursing planned to be fully recruited by June 2020. EDPs supporting "hello" nurse on ongoing trial on both sites. Further developing the GP in ED service to enable more patients to be streamed. Delay to RAP build at Maidstone due to delay on AMU build.	Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard –Increased profile on ambulance handovers. Focused bed meetings on actions. Working with A&E Delivery Board on monthly basis to support region wide issues/ actions. System call put in on a daily basis where required when system is tight. Audit run in both EDs to identify opportunity for GP flow Winter escalation wards are open to support flow and maintain ED Performance. Maintaining top 10 ED performance in the country consistently. Regular site meetings/ winter huddles to support decision making.

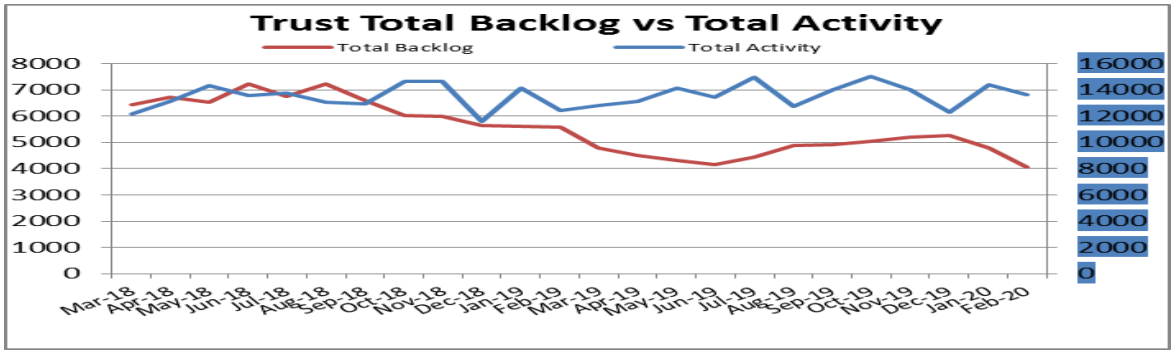
Escalation: RTT Incomplete Pathways

Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Trajectory Total WL	28508	29152	28932	28908	29273	28433	28261	25964	25959	32154	30956	30102
Actual Total Waiting List	28412	28268	29027	29068	30705	32085	31344	31828	32446	32725	31966	30609
Trajectory Backlog	4146	4806	4578	4622	5089	4576	4543	3536	3740	5379	4648	4100
Actual Total Backlog	4797	4510	4305	4163	4430	4868	4910	5052	5192	5257	4784	4059
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%	83.9%	86.4%	85.6%	83.3%	85.0%	86.4%
Actual Total % Performance	83.1%	84.0%	85.2%	85.8%	85.6%	84.8%	84.3%	84.1%	84.0%	83.9%	85.0%	86.7%

RTT performance is currently being finalised but is expected to be 86.7% for February, therefore achieving the trajectory for the year end of 86.67%. The overall waiting list and backlog (patients who have been waiting over 18 weeks) have both decreased.



The overall waiting list and backlog (patients who have been waiting over 18 weeks) have both decreased in February but the overall waiting list is slightly above plan.



This shows the total Activity in February as well as the RTT admitted backlog which decreased in February.

RTT by Specialty: All specialties are expected to see an improvement in performance in February

Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (22%, 19% and 10% respectively)

RTT Backlog: The majority of the RTT backlog continues to be concentrated in surgical specialties as well as Neurology, Cardiology and Gastroenterology. These are being carefully monitored against forecasts and action plans on a weekly basis

RTT 52 week Breaches: 4 reported for February (4 new for February). All patients will have a harm review by the managing Consultant. 52 Week Panel established.

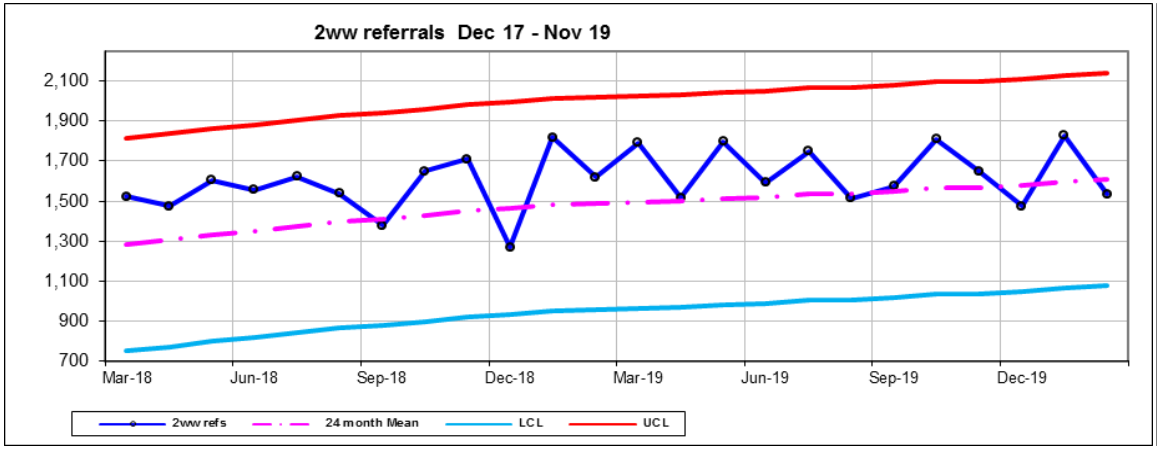
RTT Data Quality: This has become business as usual and is monitored weekly at the Access Performance meeting.

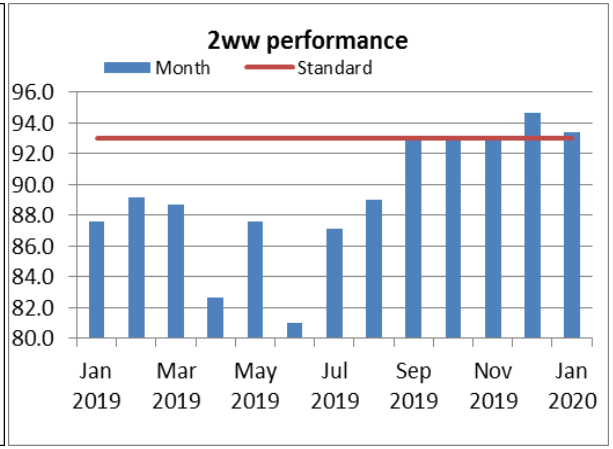
Diagnostics <6weeks: Performance improved to 99.5% in February, therefore achieving the target.

Theatre Utilisation: Theatre Utilisation with TAT has remained static this month at 86.3% in February but still remains below plan. The activity equated to 79.7 elective cases per working day, a decrease from 80.9 in Jan-20.

Summary:	Actions:	Assurance:
Performance is currently being finalised but is expected to be 86.7% for February, therefore achieving the trajectory for the year end of 86.67%	Some of the speciality initiatives submitted in the speciality business plans have not been funded. RTT recovery plan from Jan – March 20 has been implemented.	Weekly monitoring of the specialty plans for activity, diagnostics, and theatre scheduling, backlog and waiting list size, through the Access Performance meetings and specialty meetings. All patients over 40 weeks monitored daily ensure treatment occurs before 52 weeks.
	Review operational plan for RTT data quality project.	This has become business as usual and is monitored weekly at the Access Performance meeting.

Escalation: Cancer Waiting Times – 2 Weeks





2ww GP referrals to MTW	Breast	Childre n	Gynae	Haem	Head & Neck	Lower GI	Lung	Other (inc	Upper GI	Urology	Total	BSYM	Breast total
2017	319	4	119	9	109	261	47	8	139	154	1164	165	404
2018	343	9	141	17	123	310	48	4	146	207	1289	141	484
2019	393	14	157	26	146	359	53	5	145	208	1659	155	548
2020 (Jan - Jan)	450	25	193	17	150	389	68	7	156	235	1829	139	589
% change last 12 mths	14.6%	76.5%	23.1%	-35.0%	3.0%	8.5%	27.5%	35.5%	7.3%	12.8%	10.2%	-10.5%	7.5%

Demand: There was an overall decrease of 19% in the number of referrals received in February in comparison to the referrals from January 2020. Testicular, Haematology and Brain referrals increased slightly in February (over January) whereas all other tumour sites had a decrease in referral numbers. Last month Breast reported the highest number of referrals with 450 for 2ww and it is therefore not surprising that Breast has reported the greatest decrease of 43.8% in February. Lower GI had the highest number of referrals this month with 374. Year to date - the 2 month average of referrals for January and February 2020 is reflecting an overall increase of 1.4% from the total average over 2019

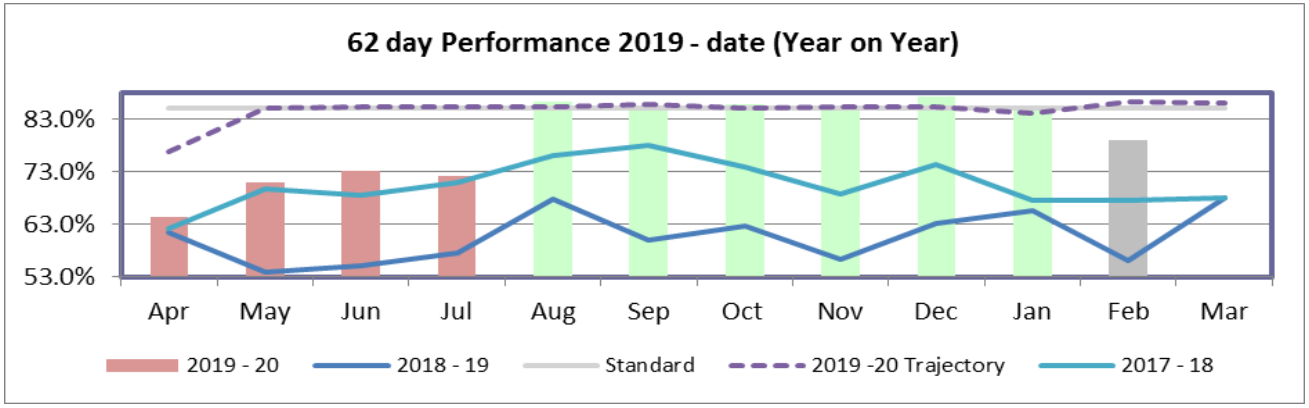
2 Week Wait (2WW) Performance:
The Trust is maintaining the achievement of the 2ww standard reporting 93.4% for January 2020. However, the Breast Symptoms standard was not achieved with 89.5%, reporting 13 breaches of the 14 day standard

Overall, a number of tumour sites achieved the standard for first appointment within 14 days, with 4 tumours sites reporting below the 2ww standard (Lower GI 89.6%, Lung 88.2%, Upper GI 91.4% and Urology 91.3%

The current un-validated position for February is 94.0%

Summary:	Actions:	Assurance:
The Trust has continued to achieve the 2ww standard with 93.4% for January 2020. Following the increased numbers of referrals in January (1828 2ww) there will be increased numbers of patients to be seen in February 2020	Work has taken place to revise the LGI and UGI STT endoscopy booking process and ensure that patients are fully booked at point of telephone triage. During the first week of go live, booking days reduced from 10-14 to 7-10. Nurse triage twice a day has reduced the pathway time by one day and ensured complete utilisation of clinic space. The lung team have set up a new one-stop clinic process, which has allowed for 2ww patients to be scanned and then seen in clinic within the same day.	A 2ww working group has been set up with involvement from General Managers across breast, urology, haematology and gynaecology. This group is focused on reducing patients booked past 7 days to ensure compliance with the 28 day standard. A 2ww action log monitors transformation and development, and holds services to account. A report has been developed, and is reviewed daily, to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days. A new report to monitor patients unregistered on the system within 24 hours is in production to provide additional assurance that all patients with a 2WW referral are captured.

Escalation: Cancer Waiting Times – 62 Day



Trust Performance: With 85.6% for the overall 62 day standard, the Trust has now achieved this standard for 6 consecutive months and is again a significant improvement over 2019, with 65.6% reported for January 2019

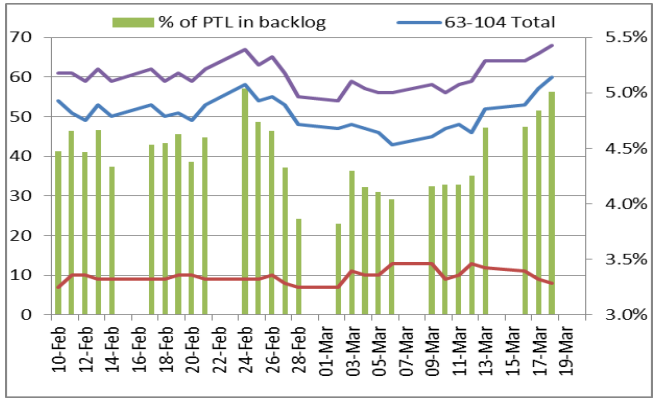
Tumour Specific Performance:
Following on from December, Breast has reported 100% achievement with 25.5 accountable treatments in December 2019
Gynaecology, Lower GI and Urology have all achieved the 62d Standard with 89.7 for Lower GI, 93.7% for Urology and 93.8% for Gynae.

Lung, Haematology, Head & Neck and Upper GI have reported below target with Lung reporting the lowest standard of 42.9%

The current, un-validated position for February 2020 is 79%.

Conversion rates for 2ww referrals: In the 6 month period from September 19 to February 20, the overall conversion rate has changed from 8% to 6.43% across all tumour sites

62 Day Performance						
December 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	21.0	0.0	100.0	21	0	100.0
Gynae	8.5	1.0	88.2	5	1	80.0
Haematology	7.0	2.0	71.4	6	1	83.3
Head & Neck	5.5	1.5	72.7	3	1	66.7
Lower GI	6.5	1.5	76.9	6	1	83.3
Lung	7.5	3.0	60.0	5	2	60.0
Other	2.0	0.0	100.0	2	0	100.0
Upper GI	6.5	1.0	84.6	6	1	83.3
Urology	26.0	1.5	94.2	21	1	95.2
TOTAL	90.5	11.5	87.3	75	8	89.3



PTL Backlog- For the beginning of February 2020, the 62 day PTL backlog is being maintained at less than 5% of the total backlog. There are currently 61 patients in the backlog, 10 of which are over 104 days. The majority of the patients over 104 days are between Lower GI and Upper GI.

Summary:	Actions:	Assurance:
With 47.5 accountable treatments Urology has treated 36% of the total 62 day standard in January 2020, with a tumour achievement of 93.7%. Breast has achieved 100% again this month. Both of these have contributed to the Trust's achievement of the 62 day standard for the 6th consecutive month. PTL Backlog:- For the beginning of February 2020, the 62 day PTL backlog is being maintained at less than 5% of the total backlog.	Action plans for each pathway have been developed for each tumour site with timeframes and accountability clearly assigned. Increased imaging capacity has been identified and is supporting a reduction in the time between request and scan and between scan and report in order to deliver faster diagnosis and staging so that patients can be treated more quickly. A new lung MDTC has been recruited, in addition to the navigator role, to provide more support at the treatment end of the pathway. 'All options' clinic for the prostate pathway and doubling the number of brachytherapy lists each week.	Daily huddles with each tumour site team are in place Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements. Harm reviews are conducted for all patients treated over 104 days. Daily PTLs with GMs and DDOs for all tumour sites with endoscopy, radiology, pathology and oncology presence. Weekly cancer performance meeting to review breach risks and outstanding tumour site issues.

Appendices

Safe		2018/19	2019/20	Q2			Q3			Q4			Q1			Q2			Q3			Q4		YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators	Outturn	Target	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			
S1	Rate of Cdifficile per 100,000 beddays	22.8	22.4	35.5	39.2	46.4	19.2	15.1	9.7	32.1	19.9	28.4	44.6	0.0	25.6	14.8	29.6	35.1	19.6	29.4	4.7	13.7	19.6	21.2	21.1	-6.4%
S2	CDifficile (Post 72hrs) - Hospital	56	55	7	8	9	4	3	2	7	4	6	9	0	5	3	6	7	4	6	1	3	4	48	52	-3
S3	MRSA Bacteraemia (Post 48hrs) Hospital	3	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1
S3.1	% Elective MRSA Screening	98.0%	98.0%	98.7%	98.5%	98.7%	99.0%	99.0%	99.0%	98.0%	99.0%	98.0%	99.0%	99.1%	99.0%	99.0%	99.0%	99.0%	98.9%	99.4%	98.8%	100.0%	96.6%	96.6%	96.6%	-1.4%
S3.2	% Non-Elective MRSA Screening	93.1%	95.0%	No data	No data	No data	93.0%	95.2%	95.0%	86.0%	92.5%	93.1%	89.0%	92.0%	90.0%	92.3%	95.0%	92.9%	91.6%	90.8%	94.1%	92.3%	95.8%	95.8%	95.8%	0.8%
S4	Rate of E. Coli Bacteraemia per 100,000 beddays	28.1	21.5	35.5	34.3	15.5	24.0	50.3	24.3	13.8	19.9	33.2	29.8	14.1	35.8	19.8	34.5	55.1	63.5	19.6	14.0	36.6	24.6	31.4	30.4	10.1
S4.1	MSSA Bacteraemia (Post 48hrs)	19	19	2	5	0	1	0	1	2	0	2	1	3	0	4	1	6	0	3	6	1	0	25	27	8
S4.2	E. Coli Bacteraemia (Post 48hrs)	69	52	7	7	3	5	10	5	3	4	7	6	3	7	4	7	11	13	4	3	8	5	71	75	23
S4.3	Cases of Gram Negative Bactareamia	113	113	10	10	7	11	12	9	5	8	11	8	4	7	8	8	14	16	5	6	8	6	90	101	-12
S4.4	Catheters inserted	1,160	225	222	No data	No data	310	209	No data	No data	No data	205	213	224	245	181	212	191	278	-	-	207	226	226	226	1
S5	Rate of Hospital Acquired Pressure Ulcers	1.32	1.35	0.51	1.79	1.56	1.31	1.36	1.23	0.97	1.09	0.32	1.05	0.81	0.68	0.61	1.86	2.49	2.19	1.93	2.32	2.28	2.15	1.68	1.65	0.3
S5.1	Rate of All Pressure Ulcers	16.5	16.0	18.6	15.1	15.8	18.2	16.5	17.2	16.5	18.6	14.4	23.0	20.9	23.7	22.1	22.5	24.3	27.6	21.9	20.9	23.7	33.6	24.0	24.0	8.0
S5.2	Pressure Ulcers Grade 2	49	36	1	5	2	4	2	4	3	1	0	1	1	1	1	1	4	5	0	6	6	3	29	32	- 4
S5.3	Pressure Ulcers Grades 3	3	-	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
S5.4	Pressure Ulcers Grades 4	3	-	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	1	0	0	2	2	2
S5.5	Pressure Ulcers Deemed "Un-gradeable"	13	24	2	4	3	0	0	0	-	-	0	3	0	1	0	2	4	4	3	5	2	1	25	27	3
S5.6	Pressure Ulcers DTIs	25	36	0	0	4	4	6	3	1	5	2	2	4	2	3	8	7	5	8	3	7	9	58	61	25
S5.7	Pressure Ulcers MASD	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
S5.8	Pressure UlcersTotal	93	96	3	11	9	8	8	7	6	6	2	6	5	4	4	11	15	14	12	15	15	13	114	122	26
S6	Rate of Patient Falls	6.21	6.00	7.86	6.76	6.80	5.81	6.79	5.21	6.88	6.58	5.31	6.94	5.66	6.14	5.68	7.14	5.91	5.33	5.04	6.69	6.50	6.09	6.10	6.08	0.10
S6.1	Rate of Patient Falls TWH	6.75	6.30	6.90	7.53	6.90	6.38	7.18	6.19	8.29	7.73	6.28	7.48	6.53	7.14	7.11	9.03	6.44	6.58	5.75	7.09	7.39	6.69	7.03	6.97	0.73
S6.2	Rate of Patient Falls MH	5.31	5.05	9.57	5.44	6.62	4.84	6.11	3.60	4.64	4.76	3.78	5.96	4.18	4.48	3.49	4.18	5.13	3.49	4.04	6.11	5.29	5.31	4.72	4.72	-0.28
S6.3	Falls resulting in "No Harm"	1,170	1,116	122	93	97	99	97	82	115	102	89	93	92	97	78	119	93	90	78	117	116	106	1079	1172	56
S6.4	Falls resulting in "Low Harm"	312	300	39	35	29	18	34	22	31	26	16	37	21	20	30	19	20	19	22	22	23	16	249	274	- 26
S6.5	Falls resulting in "Moderate Harm"	33	24	7	5	2	2	3	2	2	2	6	6	3	2	3	2	2	0	3	0	3	0	24	26	2
S6.6	Falls resulting in "Severe Harm"	22	24	0	5	3	2	1	1	3	1	1	2	4	1	5	5	3	0	0	4	0	1	25	27	3
S6.7	Falls resulting in "Death"	2	-	0	0	1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	2	2	2
S6.8	Total Number of Patient Falls	1,525	1,464	155	138	132	121	135	107	150	132	112	140	120	120	115	145	118	109	103	143	142	124	1379	1501	37
S6.9	Total Number of Patient Falls TWH	1,033	996	87	97	85	84	90	79	111	95	81	93	87	87	89	112	77	80	69	89	93	77	953	1036	40
S6.10	Total Number of Patient Falls MH	492	468	68	41	47	37	45	28	39	37	31	46	33	33	27	33	41	29	34	54	49	47	426	465	- 3
S7	Never Events	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	3	3	3
S8	Number of New SIs in month	154	144	11	18	17	19	11	5	10	8	8	17	15	8	9	17	7	10	6	13	11	10	123	135	- 9
S8.1	Serious Incidents rate	0.63	0.59	0.56	0.88	0.88	0.91	0.55	0.24	0.46	0.40	0.38	0.84	0.71	0.41	0.44	0.84	0.35	0.49	0.29	0.61	0.50	0.49	0.54	0.55	0.00
S8.2	Number of Open Sis	81	95	96	96	110	97	90	104	87	81	85	97	99	93	84	83	80	82	62	59	48	46	46	46	- 49
S9	SIs not closed <60 Days Monthly Snapshot		24										57	50	52	39	21	31	25	11	11	3	5	5	5	- 19
S10	Overall Safe staffing fill rate	96.8%	93.5%	95.8%	94.3%	95.0%	99.2%	99.5%	95.3%	98.0%	95.8%	95.5%	94.8%	94.2%	94.0%	94.4%	93.4%	92.5%	97.4%	101.2%	98.1%	100.3%	97.3%	96.2%	96.2%	2.7%
S11	Safety Thermometer % of Harm Free Care	97.4%	95.0%	98.2%	98.3%	97.6%	97.3%	97.5%	98.4%	97.9%	98.5%	97.4%	97.5%	98.5%	98.0%	97.8%	98.3%	82.8%	85.7%	88.5%	89.3%	86.7%	No data	No data	No data	-95.0%
S11.1	Safety Thermometer % of New Harms	2.6%	3.0%	1.8%	1.7%	2.4%	2.6%	2.3%	1.6%	2.1%	1.5%	2.6%	2.4%	1.5%	1.9%	2.3%	1.7%	8.8%	6.5%	5.6%	5.4%	7.4%	0.0%	0.0%	0.0%	-3.0%
S12	Number of Central Alerting System Alerts Overdue	8	12	0	2	0	1	1	0	1	1	1	1	2	1	0	1	1	1	1	1	5	0	14	15	3
S13	Medication Errors - Low Harm	86	72	8	10	3	2	8	3	6	6	17	7	4	12	12	8	8	9	5	13	4	5	87	93	21
S13.1	Medication Errors - Moderate Harm	11	12	1	3	0	0	1	1	0	4	1	3	0	1	1	0	0	0	1	0	0	2	8	9	-3
S13.2	Medication Errors - Severe Harm	4	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S14	Number of Incidents reported in month	11,737	11,700	1,083	1,088	950	1,026	1,033	850	1,084	947	939	954	934	886	945	950	969	1130	1104	1121	1209	1189	11391	12366	666
S14.1	Rate of Incidents that are Harmful	1.01	1.23	1.11	1.10	1.47	1.07	0.77	0.47	1.01	0.53	0.96	1.05	1.39	1.13	1.38	1.89	1.03	0.71	0.27	0.89	0.33	0.76	0.95	0.95	-0.28
S14.2	Number of Incidents open >45 days	1,931	1,931	2,273	1,959	1,515	2,135	1,469	2,095	2,046	2,205	1,416	1448	1931	2025	1940	1478	2844	2946	1665	2088	1724	1461	1461	1461	-470

Effective		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4		YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	Band 2	1.0440	1.0219	1.0219	1.0371	1.0244	1.0244	1.0391	1.0391	1.0391	1.0391	1.0296	1.0235	1.0165	1.0224	1.0363	1.0412	1.0348	1.0331	1.0249	1.0132	1.0132	1.0132	Band 2
E2	Standardised Mortality HSMR		Lower Confidence <100	106.70	105.80	104.80	103.70	102.40	103.30	102.30	101.20	99.40	96.30	97.20	92.70	93.10	91.50	91.50	91.70	92.70	91.00	91.70	91.80	91.8	91.8	-8.2
E2.1	Crude Mortality	1.00%	1.00%	0.94%	0.90%	1.14%	0.88%	0.77%	1.02%	1.25%	1.11%	1.07%	1.01%	0.85%	0.70%	0.86%	0.83%	0.99%	0.86%	0.94%	0.99%	1.07%	1.01%	0.92%	0.92%	-0.1%
E3	% Total Readmissions	14.13%	14.13%	14.24%	14.14%	13.69%	14.56%	14.01%	15.33%	14.35%	14.59%	14.73%	14.91%	13.55%	14.92%	15.21%	14.64%	15.38%	14.65%	15.53%	15.21%	13.41%	10.12%	14.73%	14.73%	0.6%
E4	Readmissions <30 days: Emergency	14.76%	14.76%	14.78%	14.67%	14.33%	15.36%	14.85%	16.10%	14.80%	15.23%	15.36%	15.54%	14.31%	15.29%	15.94%	15.12%	16.05%	15.24%	16.18%	15.70%	13.69%	10.45%	15.30%	15.30%	0.5%
E5	Readmissions <30 days: Emergency (excl SDEC)	13.99%	13.99%	15.04%	13.64%	13.08%	14.12%	13.84%	14.38%	14.53%	14.11%	14.45%	15.16%	13.93%	14.10%	14.85%	14.95%	16.04%	14.76%	15.19%	14.54%	13.37%	9.74%	14.67%	14.67%	0.0%
E6	Readmissions <30 days: Elective	6.83%	6.83%	7.75%	8.06%	6.08%	5.64%	5.99%	5.96%	8.04%	6.58%	7.43%	7.97%	5.34%	10.21%	6.58%	9.00%	7.12%	7.66%	8.05%	8.03%	9.88%	6.36%	7.92%	7.92%	1.1%
E7	Stroke: Best Practice Tariff Overall %	43.1%	50.0%	58.3%	48.1%	42.3%	54.3%	55.4%	53.3%	49.1%	47.5%	43.1%	37.5%	40.3%	38.3%	48.4%	41.3%	37.3%	45.2%	47.3%	46.9%	44.2%	Data runs one month behind	42.7%	42.7%	-7.3%
E7.1	Stroke BPT Part 1: First Ward	75.9%	80.0%	80.0%	82.7%	76.9%	77.1%	87.7%	82.2%	81.1%	83.6%	75.9%	65.6%	67.7%	76.7%	82.3%	79.4%	74.5%	79.0%	78.2%	71.9%	78.8%		75.3%	75.3%	-4.7%
E7.2	Stroke BPT Part 2: Cons <=14 Hours	50.0%	58.0%	66.7%	56.8%	50.0%	57.1%	61.5%	57.8%	62.3%	49.2%	50.0%	50.0%	48.4%	53.3%	58.1%	42.9%	47.1%	58.1%	54.5%	53.1%	53.8%		51.9%	51.9%	-6.1%
E7.3	Stroke BPT Part 3: 90% Time on Stroke Ward	89.7%	80.0%	86.67%	83.95%	84.62%	85.71%	92.31%	91.11%	90.57%	91.80%	89.66%	79.7%	72.6%	80.0%	82.3%	84.1%	76.5%	79.0%	80.0%	82.8%	73.1%		79.2%	79.2%	-0.8%
E7.4	% TIA <24hrs	64.7%	60.0%	29.2%	65.2%	63.2%	66.7%	70.6%	58.3%	91.7%	61.9%	42.1%	60.6%	53.3%	54.5%	57.7%	51.9%	36.4%	71.4%	70.8%	68.2%	No data	No data	58.1%	58.1%	5.2%
E8	Nat CQUIN: % Dementia Screening	98.8%	90.0%	99.6%	100.0%	99.8%	99.6%	99.8%	100.0%	100.0%	99.8%	98.8%	94.3%	92.3%	84.4%	91.0%	95.5%	98.7%	98.4%	98.8%	99.6%	99.1%	Data runs one month behind	95.2%	95.2%	-6.5%
E9	Nat CQUIN: % Dementia Risk Asssessed	98.7%	90.0%	94%	96%	90.0%	95.5%	100.0%	99.0%	100.0%	100.0%	98.7%	98.2%	93.9%	92.2%	96.4%	89.6%	700.0%	97.3%	96.2%	82.1%	100.0%		101.7%	101.7%	0.7%
E10	Nat CQUIN: % Dementia Referred to Specialist	100.0%	90.0%	98%	100%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		99.1%	99.1%	-3.8%
E10.1	NE LOS for Patients with Dementia												7.7	8.8	7.9	9.4	8.9	9.0	8.3	9.0	8.3	8.8	8.5	8.6	0.0	0.0
E10.2	Readmissions <30 Days for Pt with Dementia												21.0%	20.7%	22.4%	29.4%	27.7%	23.0%	22.6%	22.6%	24.1%	21.2%	0.0%	22.3%	22.3%	-1.4%
E11	C-Section Rate (elective or non-elective)	27.9%	25.0%	26.9%	28.8%	24.0%	29.7%	30.2%	26.5%	31.3%	29.5%	27.0%	31.1%	32.3%	27.5%	28.6%	27.5%	29.6%	30.8%	29.3%	27.8%	25.2%	26.6%	14.8%	28.9%	-10.2%
E11.1	% Mothers initiating Breastfeeding	82.2%	78.0%	79.14%	84.02%	81.74%	77.72%	83.50%	80.45%	84.37%	84.01%	85.19%	83.3%	83.8%	79.3%	82.6%	80.9%	80.5%	81.5%	84.9%	80.0%	83.9%	77.9%	81.7%	81.7%	3.7%
E11.2	% Stillbirths Rate	0.17%	0.47%	0.20%	0.19%	0.20%	0.00%	0.20%	0.00%	0.42%	0.23%	0.21%	0.48%	0.39%	0.21%	0.00%	0.22%	0.83%	0.00%	0.21%	0.47%	0.22%	1.36%	0.38%	0.38%	-0.1%

Caring		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4		YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			
C1	Single Sex Accommodation Breaches	35	0	5	12	0	10	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C2	Rate of New Complaints	2.30	2.93	1.93	1.67	2.22	2.84	2.41	2.34	2.39	2.04	3.17	2.28	2.21	2.71	2.27	2.51	1.85	2.93	2.25	2.01	2.20	2.60	2.35	2.39	-0.59
C3	% complaints responded to within target	75.7%	75.0%	73.3%	62.8%	54.3%	65.3%	75.0%	66.7%	82.8%	73.3%	75.7%	66.7%	37.5%	45.7%	65.4%	65.1%	71.4%	85.4%	74.0%	80.0%	80.4%	67.5%	67.1%	67.8%	-7.9%
C3.1	Total Open Complaints	149	140	155	137	144	139	129	129	130	120	149	155	173	154	134	149	132	143	145	127	125	141	141	141	1
C3.2	Number of new complaints received	564	720	38	34	43	59	48	48	52	41	67	46	47	53	46	51	37	60	46	43	48	53	530	590	- 130
C3.3	Number of Nursing Complaints	107	108	8	5	7	9	13	12	10	12	10	5	9	11	7	10	5	5	9	2	7	10	80	89	- 19
C3.4	Number of Medical Complaints	353	336	24	21	26	41	32	32	31	23	43	30	26	33	31	26	23	39	22	28	34	32	324	352	16
C3.5	Number of Complaints open 60-90 days	182	180	15	18	11	12	10	11	13	12	19	14	25	18	16	22	13	9	10	13	6	13	159	174	- 6
C3.6	Number of Complaints open >90 days	349	348	36	37	43	29	25	20	19	18	20	30	33	33	27	32	24	24	25	23	29	22	302	331	- 17
C4	% IP Response Rate Friends & Family	17.9%	25.0%	19.5%	18.7%	20.1%	15.3%	24.5%	19.6%	18.7%	18.2%	17.9%	18.7%	20.4%	16.5%	16.0%	15.4%	16.6%	8.0%	19.5%	17.1%	16.0%	16.7%	16.4%	16.4%	-8.6%
C5	IP Friends & Family (FFT)% positive	94.8%	95.0%	94.2%	95.9%	93.8%	94.2%	93.7%	93.9%	93.5%	95.6%	94.8%	94.2%	95.6%	96.7%	95.1%	93.9%	94.0%	98.5%	95.7%	96.5%	96.3%	97.8%	95.7%	95.7%	0.7%
C6	% A&E Response Rate Friends & Family	8.9%	15.0%	12.1%	8.1%	12.3%	4.2%	21.2%	12.9%	5.4%	7.6%	8.9%	11.0%	14.6%	12.3%	9.6%	10.1%	9.1%	0.8%	2.3%	12.1%	1.9%	10.0%	8.5%	8.5%	-6.5%
C7	A&E Friends & Family (FFT) % positive	92.0%	87.0%	89.4%	92.6%	90.9%	91.4%	91.0%	89.9%	90.5%	91.3%	92.0%	81.2%	86.1%	91.6%	91.5%	88.1%	85.7%	96.4%	88.7%	87.3%	87.2%	89.5%	87.7%	87.7%	0.7%
C8	% Maternity Combined Q2 Response Rate	20.3%	25.0%	27.0%	9.9%	43.8%	18.2%	11.8%	23.9%	37.6%	26.2%	20.3%	20.1%	6.0%	45.5%	44.5%	33.4%	17.3%	7.8%	12.0%	16.3%	20.1%	10.6%	21.2%	21.2%	-3.8%
C9	Maternity Combined FFT % Positive	98.4%	95.0%	93.5%	98.0%	92.1%	95.0%	99.1%	90.4%	95.8%	96.5%	98.4%	93.8%	97.1%	94.2%	94.0%	93.6%	94.7%	97.0%	97.8%	99.7%	96.9%	96.0%	95.5%	95.5%	0.5%
C10	OP Friends & Family (FFT) % Positive	81.2%	84.0%	85.2%	81.7%	83.9%	82.7%	84.1%	84.2%	84.4%	84.3%	81.2%	82.5%	82.5%	81.5%	82.1%	83.0%	81.3%	82.3%	84.2%	82.2%	83.6%	83.2%	82.6%	82.6%	-1.4%
C10.1	OP Friends & Family (FFT) Response Rate	68.5%	68.0%	66.2%	66.2%	67.4%	68.6%	68.8%	67.4%	69.0%	68.5%	68.5%	49.3%	62.5%	56.9%	55.4%	56.5%	51.3%	59.0%	67.7%	48.8%	59.2%	61.2%	57.1%	57.1%	-10.9%
C11	VTE Risk Assessment (%)	96.4%	95.0%	97.2%	95.4%	96.1%	96.9%	97.2%	96.5%	97.2%	97.4%	96.4%	97.0%	96.9%	97.1%	97.3%	96.7%	96.7%	96.9%	95.9%	95.6%	96.4%	95.8%	96.6%	96.6%	1.6%

Responsive		2018/19	2019/20	Q2			Q3			Q4			Q1			Q2			Q3			Q4		YTD	FOT	YTD Var
ID	Key Performance Indicators	Outturn	Target	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			From Plan
R1	A&E % 4hrs Arrival to Exit - Trust (Inc MIU)	92.09%	91.67%	93.16%	91.79%	93.93%	90.75%	90.93%	89.6%	88.91%	87.16%	95.85%	92.29%	92.16%	94.65%	93.73%	90.27%	89.54%	87.78%	87.63%	85.41%	91.13%	90.59%	90.48%	90.51%	-1.3%
R1.1	A&E % 4hrs Arrival to Exit - Maidstone	95.07%	95.23%	94.41%	93.42%	97.17%	96.26%	95.21%	92.22%	92.87%	90.80%	97.81%	94.35%	94.00%	95.95%	96.79%	89.89%	92.96%	88.79%	89.04%	86.17%	91.05%	88.11%	91.57%	91.87%	-3.7%
R1.2	A&E % 4hrs Arrival to Exit - TWells	86.25%	85.08%	88.79%	86.60%	88.45%	82.33%	84.05%	83.58%	81.32%	78.91%	92.60%	87.11%	87.30%	91.10%	88.36%	86.15%	81.83%	81.94%	81.78%	79.61%	87.80%	89.14%	85.57%	85.40%	0.3%
R1.3	A&E Conversion Rate	20.8%	20.8%	20.8%	21.0%	20.4%	20.9%	20.8%	21.4%	20.9%	20.4%	20.4%	20.0%	19.0%	18.4%	17.7%	19.4%	18.9%	19.2%	19.1%	19.9%	20.6%	19.9%	19.3%	19.3%	-1.6%
R1.4	A&E Left without being Seen Rate (%)	2.8%	2.8%	3.4%	3.2%	2.5%	2.3%	2.4%	2.5%	2.6%	3.3%	2.4%	2.8%	2.4%	2.5%	2.8%	2.8%	2.8%	2.4%	2.7%	3.2%	2.0%	2.2%	2.6%	2.6%	-0.1%
R1.5	A&E Time to Assessment 15 mins	95.3%	95.0%	95.9%	94.9%	97.0%	95.2%	95.9%	95.3%	94.7%	91.5%	95.2%	94.5%	90.0%	92.0%	90.9%	89.0%	87.0%	87.4%	88.4%	76.0%	89.2%	56.8%	83.0%	83.0%	-12.0%
R1.6	A&E Time to Treatment 60 mins	55.9%	55.9%	53.5%	54.7%	57.5%	55.4%	58.1%	55.3%	56.7%	52.9%	57.2%	55.7%	56.4%	58.9%	58.8%	58.1%	57.8%	60.1%	57.3%	51.0%	60.1%	59.6%	57.6%	57.6%	1.7%
R1.7	A&E Unplanned Re-Attendance Rate (%)	8.0%	8.0%	8.3%	8.7%	7.6%	8.4%	8.1%	8.1%	7.8%	8.3%	8.0%	8.3%	8.5%	8.4%	8.3%	8.7%	9.1%	8.3%	8.8%	8.5%	8.7%	8.9%	8.6%	8.6%	0.5%
R1.8	A&E Average Time in Department (Hours)	0.14	0.15	0.14	0.14	0.13	0.15	0.14	0.15	0.15	0.16	0.13	0.14	0.14	0.13	0.14	0.15	0.15	0.15	0.16	0.17	0.15	0.14	0.15	0.15	-0.03
R2	A&E 12hr Breaches	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R3	Ambulance Handover Delays >60mins	596	540	22	60	31	67	82	70	74	83	13	57	59	26	42	56	77	57	50	75	14	21	534	579	7.9%
R3.1	Ambulance Handover Delays >30mins	4,487	4,428	250	400	284	486	442	441	613	444	280	494	531	384	528	490	581	508	492	641	370	416	5435	5804	33.9%
R4	RTT Incomplete Pathway	83.12%	86.67%	80.4%	79.4%	79.7%	80.67%	81.01%	81.61%	81.10%	81.29%	83.12%	84.05%	85.17%	85.78%	85.57%	84.83%	84.34%	84.12%	84.00%	83.91%	85.03%	86.7%	86.7%	86.7%	0.3%
R4.1	RTT Incomplete Admitted Backlog	2,606	2,315	3,434	3,348	3,065	2,930	2,867	2,779	2,829	2,781	2,606	2391	2157	2156	2171	2135	2004	1932	2079	2224	2153	Data not available	2153	2447	-8.1%
R4.2	RTT Incomplete Non-Admitted Backlog	2,182	872	3,298	3,911	3,578	3,200	3,235	2,886	2,781	2,807	2,182	2119	2148	2007	2259	2733	2906	3120	3113	3042	2631		2631	2733	216.3%
R4.3	RTT Specialties Not Achieved Nat Target	9	0	11	12	10	10	9	9	9	9	9	9	10	9	9	11	11	12	11	11	11	11	115	115	115
R4.4	RTT Incomplete Total Backlog	4,788	3,186	6,732	7,259	6,643	6,130	6,102	5,665	5,610	5,588	4,788	4510	4305	4163	4430	4868	4910	5052	5192	5266	4784	4,059	4784	5180	50.6%
R5	RTT 52 Week Waiters (New in Month)	8	96	6	4	8	8	11	5	7	8	8	6	10	3	3	6	8	5	14	2	5	4	66	66	-22
R6	% Diagnostics Tests WTimes <6wks	99.2%	99.0%	99.7%	99.6%	99.4%	99.5%	99.4%	99.1%	99.1%	99.5%	99.2%	99.1%	99.1%	98.7%	98.5%	96.5%	98.7%	99.3%	99.1%	98.0%	98.2%	99.5%	99.5%	99.0%	0.5%
R7	*Cancer two week wait	88.7%	93.0%	82.3%	76.4%	78.0%	86.5%	90.0%	88.1%	87.6%	89.2%	88.7%	82.6%	87.6%	81.0%	87.1%	89.0%	93.1%	93.0%	93.0%	94.7%	93.4%		93.4%	93.4%	0.4%
R8	*Cancer WT - Breast Symptons 2WW	73.2%	93.0%	67.5%	58.5%	71.3%	83.1%	81.7%	58.3%	69.4%	74.7%	73.2%	56.4%	65.2%	63.4%	81.7%	91.5%	98.2%	94.1%	95.2%	94.4%	89.5%		89.5%	89.5%	-3.5%
R9	*Cancer 31 day wait - First Treatment	96.1%	96.0%	97.9%	96.2%	95.1%	96.2%	96.8%	97.2%	95.9%	96.2%	96.1%	96.5%	96.0%	96.8%	97.7%	97.2%	96.4%	97.5%	97.2%	99.5%	96.7%		96.7%	96.7%	0.7%
R9.1	*Cancer 31 day - Subs Treatment - Surgery	92.9%	94.0%	96.4%	96.2%	82.4%	92.0%	79.4%	100.0%	82.4%	96.0%	92.9%	87.1%	96.3%	96.7%	100.0%	86.2%	95.8%	97.0%	96.7%	85.7%	85.3%		85.3%	85.3%	-8.7%
R9.2	*Cancer 31 day - Subs Treatment - Drugs	99.0%	98.0%	100.0%	99.1%	98.7%	99.3%	98.7%	98.3%	96.7%	98.2%	99.0%	100.0%	100.0%	100.0%	98.9%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	Data runs one month behind	100.0%	100.0%	2.0%
R9.3	*Cancer 31 day Subs Treatment Radio	92.8%	94.0%	95.4%	97.6%	93.7%	98.2%	96.7%	99.2%	90.5%	94.5%	92.8%	92.5%	91.4%	94.3%	93.1%	93.4%	92.7%	95.0%	95.3%	97.3%	89.9%		89.9%	89.9%	-4.1%
R10	*Cancer 62 day wait - First Definitive	67.9%	85.0%	57.5%	67.7%	60.1%	62.6%	56.4%	63.3%	65.6%	56.0%	67.9%	64.5%	70.9%	73.1%	72.2%	86.3%	85.4%	85.8%	85.6%	87.3%	85.6%		85.6%	85.6%	0.6%
R10.1	*Cancer 62 day wait - First Definitive - MTW	72.8%	85.0%	59.3%	70.9%	65.1%	63.8%	58.8%	65.6%	69.2%	58.8%	72.8%	68.6%	80.4%	80.0%	78.4%	90.1%	88.9%	86.8%	90.5%	89.3%	91.7%		91.7%	91.7%	6.7%
R10.2	*Cancer WT - 62 Day Screening Referrals	74.4%	90.0%	79.5%	83.7%	69.0%	88.2%	97.3%	84.8%	80.6%	55.2%	74.4%	84.6%	87.8%	94.7%	80.0%	89.7%	91.7%	95.3%	94.9%	94.1%	95.7%		95.7%	95.7%	5.7%
R10.3	*Cancer WT - 62 Day Cons Specialist	82.4%	85.0%	61.5%	76.5%	40.0%	86.4%	72.2%	69.2%	64.0%	86.7%	82.4%	100.0%	41.7%	67.7%	65.5%	56.3%	55.6%	55.0%	41.7%	54.5%	58.8%		58.8%	58.8%	-26.2%

Well-Led		2018/19	2019/20	Q2			Q3			Q4			Q1			Q2			Q3			Q4		YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators	Outturn	Target	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			
W1	Surplus (Deficit) against B/E Duty	12,006	6,896	574	82	-1,014	3,075	2,030	136	-2,567	-457	13,359	-2,001	-71	-1,272	2,569	1,036	407	1,535	24	2,039	1,720	-798	5,189	6,896	3.3%
W2	CIP Savings	13,825	22,329	1,200	1,151	917	1,221	1,151	678	1,428	986	2,574	725	1,012	1,291	1,868	3,882	1,792	1,728	1,812	1,847	1,781	2,396	20,522	22,328	1.4%
W3	Cash Balance	10,405	3,000	18,207	14,126	13,493	12,640	8,566	12,766	7,956	10,625	10,405	41,294	39,537	44,793	56,821	45,854	42,824	30,327	28,428	23,239	17,669	21,922	21,922	3,000	369.1%
W4	Capital Expenditure	19,185	14,448	327	365	82	547	1,106	2,420	295	430	12,900	358	45	380	149	250	442	378	197	2,033	539	321	5,092	16,328	-58.5%
W4.1	Income	465,038	502,732	41,154	38,606	36,805	40,695	40,821	38,634	37,148	34,981	44,309	40,150	41,400	40,363	43,400	41,228	40,971	42,902	39,701	44,349	43,346	38,567	456,376	500,256	-0.7%
W4.2	EBITDA	28,347	37,810	2,998	2,515	1,545	5,533	4,475	2,603	-104	-1,934	6,386	540	2,452	1,895	5,133	3,575	2,838	4,063	2,465	5,071	4,177	1,623	33,831	37,809	1.5%
W5	Finance use of Resources Rating	3	2	4	4	4	3	3	3	3	4	3		3	3	3	3	3	3	3	3	3	3	3	3	1
W6	Staff Turnover Rate	9.1%	10.0%	9.9%	9.7%	9.39%	9.09%	9.22%	9.10%	8.90%	8.86%	9.12%	9.54%	9.79%	10.14%	10.79%	10.89%	11.43%	11.7%	11.9%	12.3%	12.6%	12.7%	12.65%	12.65%	2.7%
W7	Vacancy Rate (%)	10.0%	8.0%	10.3%	11.1%	10.65%	9.63%	9.57%	10.83%	10.33%	10.26%	9.99%	13.31%	13.27%	13.11%	12.60%	11.97%	10.40%	9.1%	8.5%	8.3%	9.0%	7.8%	10.87%	10.87%	2.9%
W7.1	Contracted WTE	5,153	5,479	5,049	5,069	5,064	5,148	5,017	5,124	5,139	5,145	5,153	5,147	5,105	5,122	5,169	5,219	5,323	5,393	5,425	5,444	5,472	5,474	5,474	5,474	-0.2%
W7.2	Establishment WTE	5,670	6,134	5,617	5,627	5,628	5,632	5,631	5,685	5,684	5,684	5,670	5,906	5,891	5,921	5,972	6,016	6,033	6,065	6,031	6,117	6,134	6,131	6,131	6,131	0.0%
W7.3	Substantive Staff Used	5,012	5,597	4,907	4,937	4,949	4,996	5,036	5,002	4,995	5,009	5,012	4,998	5,019	5,032	5,040	5,101	5,152	5,240	5,285	5,357	5,364	5,369	5,369	5,369	-4.1%
W7.4	Worked WTE	5,826	6,134	5,597	5,732	5,654	5,688	5,631	5,733	5,747	5,784	5,826	5,623	5,808	5,667	5,733	5,938	5,810	5,927	6,014	6,126	6,072	6,102	6,102	6,102	-0.5%
W7.5	Vacancies WTE	517	656	568	558	564	483	614	561	545	539	517	758	786	799	803	797	710	672	606	673	662	657	657	657	1.3%
W8	Total Agency Spend	22,651	18	2,113	2,072	1,901	1,787	1,734	1,747	1,901	2,097	1,408	1,649	1,655	1,531	1,852	1,770	1,786	1,653	1,075	1,520	1,618	1,426	17,535	19	0
W8.1	Nurse Agency Spend	-9,434	-4,933	-853	-847	-822	-823	-661	-728	-862	-860	-963	-577	-563	-468	-474	-612	-641	-706	-473	-649	-628	-475	-6,265	-6,265	27.3%
W8.2	Medical Locum & Agency Spend	-19,052	-15,229	-1,567	-1,585	-1,517	-1,261	-1,456	-1,806	-1,663	-1,674	-1,933	-1,656	-1,699	-1,718	-1,957	-1,886	-1,902	-1,573	-1,484	-1,740	-1,685	-1,440	-18,740	-18,740	23.5%
W8.3	Bank Staff Used	500	305	338	448	383	372	365	416	433	442	500	332	511	356	426	574	392	426	502	529	467	507	507	507	67.3%
W8.4	Agency Staff Used	277	232	310	302	277	271	229	270	283	286	277	249	241	243	233	229	234	226	196	206	210	186	186	186	-18.6%
W8.5	Overtime Used	36	No data	42	46	46	49	-	45	37	47	36	45	37	35	35	33	33	35	32	34	30	40	40	40	No data
W8.6	Temp costs & overtime as % of total pay bill	No data	12.0%	16.6%	18.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.0%	16.1%	15.9%	17.1%	18.2%	17.8%	0	0	0	0	0	15.6%	15.6%	3.6%
W9	Statutory and Mandatory Training	83.3%	90.0%	89.0%	85.8%	82.9%	No data	No data	No data	No data	No data	83.3%	83.5%	84.5%	86.1%	87.2%	88.9%	85.8%	86.4%	86.6%	85.8%	85.3%	85.9%	86.0%	86.0%	-4.0%
W10	Sickness Absence	3.6%	3.3%	3.2%	3.3%	3.4%	3.4%	3.4%	3.9%	3.4%	3.8%	3.6%	3.1%	3.5%	3.3%	3.2%	3.5%	3.4%	3.6%	3.7%	3.9%	3.9%	3.7%	3.5%	3.5%	0.2%
W11	Staff FFT % recommended work	82.2%	57.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	82.2%	82.2%	82.2%	53.3%	53.3%	53.3%	72.2%	72.2%	72.2%	72.2%	72.2%	72.2%	66.0%	66.0%	66.0%	66.0%	9.0%
W11.1	Staff Friends & Family (FFT) % rec care	89.0%	80.0%	78.2%	78.2%	78.2%	78.2%	78.2%	78.2%	89.0%	89.0%	89.0%	75.3%	75.3%	75.3%	77.8%	77.8%	77.8%	77.8%	77.8%	77.8%	74.0%	74.0%	74.0%	74.0%	-6.0%
W12	Appraisal Completeness	92.0%	95.0%	76.5%	82.6%	84.7%	86.2%	88.1%	90.2%	91.0%	92.1%	92.0%	2.6%	11.7%	26.7%	78.2%	87.4%	89.8%	91.1%	91.8%	91.8%	90.5%	90.4%	90.4%	90.4%	-4.6%

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the financial plan for February generating £0.8m deficit including PSF. The Trust was £1.1m better than previously forecasted, £0.7m related to RTT income support which was previously included in the month 12 position, £0.3m related to deferred income adjustment previously planned to be released in month 12 and £0.1m underspend within budgets.
- The Trust's normalised run rate (excluding PSF and MRET funding) in February was £2.9m deficit which was £0.6m adverse to plan.
- In February the Trust operated with an EBITDA surplus of £1.6m which was £0.1m adverse plan.
- Year to date plan the Trust is £0.2m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£2m net), RTT Income reserve (£1.1m), £2.3m CIP slippage, £0.7m overspend against outsourcing, overspends within expenditure budgets (£2.7m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.5m of reserves, QIPP income adjustment (£1.3m).
- The Trust was £1.1m better than the month 10 forecast, the main movements to forecast were: £1m improvement due to realignment of additional income previously planned to be actioned into month 12 and £0.1m underspend against budgets mainly within clinical supplies within Estates and Facilities.
- The key current month variances are as follows:
    - Income adjusted for pass-through items is £0.3m favourable to plan. Clinical Income over performed in February is due to £0.5m additional RTT income support (over performance compared to planned value for February) partly offset by underperformance within direct access radiology activity (£0.2m).
    - Pay budgets adjusted for pass-through items was on plan in February, Medical staffing pressures (£0.2m) and Nursing (£0.1m) were offset by underspend within STT (£0.2m) and Support staff (£0.1m). The pressure within Medical and Nursing is predominantly within the Medical and Emergency division due to higher than planned costs associated with in escalation and use of high cost medical agency to cover vacancies.
    - Non Pay budgets adjusted for pass through items and release of reserves overspent by £1m in February. The main pressure related to higher than planned outsourcing costs relating to patient choice activity (£0.9m).
- The closing cash balance at the end of February 2020 was £21.9m which is higher than cash plan of £4.7m. Primarily the variance relates to YTD capital spend being £5.1m compared to the plan value of £12.3m. The Trust is also awaiting invoices totalling c£2.5m relating to Prime Provider with £1m from WK CCG. Within the original cash plan the Trust had also forecast to pay in February c£1.6m for the quarter 4 pathology managed service invoice.
- The overall capital programme FOT is £16.3m, excluding donated assets. This includes internally generated capital of £4.85m and £6.4m asset sales carried forward from 2018/19. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of forecast underspend on depreciation resulting from the reduction in the overall programme value (removal of a external financing items) and slippage in the timing of schemes due to the planning issues around the national capital position).Overall £16.0m is already spent or committed (excluding donated assets) e.g. ICT; EPR/EPMA £5.28m, Infrastructure £0.7m, Equipment; £0.9m general equipment, £2.1m CTs x 2, MRI & Mammography, £1.8m equipment from asset sales (includes balance of costs for Diagnostics) and Estates; £2.4m for backlog, Linac enabling and additional schemes from the asset sale.
- The Trust is forecasting to deliver the planned surplus including PSF and MRET of £6.9m however this includes £0.6m of risks to the financial positon.

To mitigate these overspends the Trust is focusing on identifying identify revenue costs that could be capitalised (£0.1m) and additional income opportunities (£0.5m) from CCGs including and Cancer support and deferred income.

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 11
2019/20

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for February 2020

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

February 2019/20

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	38.6	40.1	(1.5)	(1.9)	0.3		456.4	458.4	(2.0)	(0.3)	(1.7)		500.7	501.1	(0.4)	
Expenditure	(36.9)	(38.4)	1.4	1.9	(0.5)		(422.5)	(425.0)	2.5	0.3	2.2		(462.4)	(463.2)	0.8	
EBITDA (Income less Expenditure)	1.6	1.7	(0.1)	0.0	(0.1)		33.8	33.3	0.5	0.0	0.5		38.2	37.8	0.4	
Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1		(27.8)	(29.0)	1.2	0.0	1.2		(31.3)	(32.0)	0.7	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		(0.8)	0.7	(1.5)	0.0	(1.5)		0.0	1.1	(1.0)	
Net Surplus / Deficit (Incl PSF and MRET)	**(0.8)**	**(0.8)**	**0.0**	**0.0**	**0.0**		**5.2**	**5.0**	**0.2**	**0.0**	**0.2**		**6.9**	**6.9**	**(0.0)**	
CIPs	2.4	2.0	0.4		0.4		20.5	20.2	0.3		0.3		22.4	22.3	0.1	
Cash Balance	21.9	4.7	17.2		17.2		21.9	4.7	17.2		17.2		3.0	3.0	0.0	
Capital Expenditure	0.3	2.0	1.7		1.7		5.1	12.3	7.2		7.2		16.3	14.4	(1.9)	
Capital service cover rating							4	4					4	4		
Liquidity rating							4	3					4	4		
I&E margin rating							1	1					1	1		
I&E margin: distance from financial plan							1	1					1	1		
Agency rating							4	3					4	3		
Finance and use of resources rating							3	3					3	3		

Summary:

- The Trust delivered the financial plan for February generating £0.8m deficit including PSF. The Trust was £1.1m better than previously forecasted, £0.7m related to RTT income support which was previously included in the month 12 position, £0.3m related to deferred income adjustment previously planned to be released in month 12 and £0.1m underspends within budgets.
- Year to date plan the Trust is £0.2m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£2m net), RTT Income reserve (£1.1m), £2.3m CIP slippage, £0.7m overspend against outsourcing, overspends within expenditure budgets (£2.7m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.5m of reserves, QIPP income adjustment (£1.3m).
- The Trust has delivered £20.5m savings YTD which is £0.3m favourable to plan.

Key Points:

- The Trusts normalised run rate in February was £2.9m deficit pre PSF which was £0.6m adverse to plan (pre PSF).
- The Trust was £1.1m better than the month 10 forecast, the main movements to forecast were: £1m improvement due to realignment of additional income previously planned to be actioned into month 12 and £0.1m underspend against budgets mainly within clinical supplies within Estates and Facilities.

Risks:

- The Trust is forecasting to deliver the planned £6.9m surplus including PSF. In order to deliver the financial plan the Trust must deliver £0.6m of mitigations in month 12 to offset risks to the financial position. These risks and mitigating actions are shown in section 5.

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure February 2019/20

	Current Month					Year to Date				
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m
Income	37.2	38.7	(1.5)	(1.9)	0.3	441.4	445.9	(4.6)	(0.3)	(4.3)
Expenditure	(36.9)	(38.4)	1.4	1.9	(0.5)	(425.3)	(425.0)	(0.3)	0.3	(0.6)
Trust Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1	(27.8)	(29.0)	1.2	0.0	1.2
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.8)	0.7	(1.5)	0.0	(1.5)
Net Revenue Surplus / (Deficit) before Exceptional Items	**(2.2)**	**(2.2)**	**0.0**	**0.0**	**0.0**	**(12.6)**	**(7.4)**	**(5.2)**	**0.0**	**(5.2)**
Exceptional Items	0.0		0.0		0.0	4.8		4.8		4.8
Net Position	**(2.2)**	**(2.2)**	**0.0**	**0.0**	**0.0**	**(7.8)**	**(7.4)**	**(0.4)**	**0.0**	**(0.4)**
PSF and MRET Funding	1.4	1.4	(0.0)	0.0	(0.0)	13.0	12.4	0.6	0.0	0.6
Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items	(0.8)	(0.8)	0.0	0.0	0.0	5.2	5.0	0.2	0.0	0.2

Key messages:
Year to date the Trust position before exceptional items is £5.2m adverse to plan, the Trust has benefited by £4.8m of exceptional items relating to release of old year provisions (£3.5m) and QIPP adjustment (£1.3m).

Income:
Income YTD net of pass-through related costs and exceptional items is £4.1m adverse to plan. The main pressures relate to under delivery of Private Patient income (£3.2m) and slippage within Cancer and RTT recovery plan funding (£1.7m).

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £0.6m adverse, the key favourable variances relate to: release of reserves (£3.5m), underspends relating to Cancer recovery plans (£0.6m), and Private Patient activity underperformance (£1.2m). The key pressures within expenditure budgets relate to Medical Staffing (£2.5m), CIP slippage (£1.5m), Nursing overspend (£0.3m) and drug overspend (£0.8m).

Reserves: The Trust has now fully committed its contingency reserves and therefore any net developments requiring investment will need to be offset by additional savings.

PSF: The Trust received £0.6m bonus PSF relating to 2018/19 which is treated as a technical adjustment and therefore does not contribute to the delivery of the 2019/20 control total.

2.a Income & Expenditure

Income & Expenditure February 2019/20

	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	31.3	30.9	0.4	0.0	0.4	356.3	356.6	(0.3)	0.0	(0.3)	392.6	390.0	2.7
High Cost Drugs and Devices	3.7	3.7	0.0	0.1	(0.1)	43.3	41.4	1.9	2.0	(0.1)	45.2	45.2	0.0
Total Clinical Income	**35.0**	**34.6**	**0.5**	**0.1**	**0.3**	**399.6**	**398.0**	**1.6**	**2.0**	**(0.4)**	**437.8**	**435.1**	**2.7**
PSF and MRET	1.4	1.4	(0.0)	0.0	(0.0)	13.0	12.4	0.6	0.0	0.6	14.4	13.8	0.6
Other Operating Income	2.1	4.1	(2.0)	(2.0)	0.0	43.7	48.0	(4.2)	(2.3)	(1.9)	48.4	52.1	(3.6)
Total Revenue	**38.6**	**40.1**	**(1.5)**	**(1.9)**	**0.3**	**456.4**	**458.4**	**(2.0)**	**(0.3)**	**(1.7)**	**500.7**	**501.1**	**(0.4)**
Substantive	(20.7)	(21.5)	0.9	(0.0)	0.9	(220.7)	(232.7)	12.0	0.4	11.6	(241.6)	(254.2)	12.7
Bank	(1.4)	(0.9)	(0.5)	0.0	(0.5)	(13.8)	(9.3)	(4.4)	0.0	(4.4)	(15.1)	(10.2)	(4.9)
Locum	(0.9)	(0.6)	(0.3)	0.0	(0.3)	(10.7)	(7.8)	(2.9)	0.0	(2.9)	(11.6)	(8.4)	(3.3)
Agency	(1.4)	(1.3)	(0.1)	0.0	(0.1)	(17.5)	(14.5)	(3.0)	0.2	(3.2)	(18.9)	(15.8)	(3.2)
Pay Reserves	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(0.4)	(1.9)	1.6	0.0	1.6	(0.5)	(2.0)	1.5
Total Pay	**(24.5)**	**(24.4)**	**(0.1)**	**(0.0)**	**(0.0)**	**(263.1)**	**(266.3)**	**3.2**	**0.6**	**2.6**	**(287.7)**	**(290.6)**	**2.9**
Drugs & Medical Gases	(4.5)	(4.3)	(0.2)	(0.2)	(0.0)	(50.4)	(47.1)	(3.3)	(2.4)	(0.8)	(54.9)	(51.4)	(3.5)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(2.2)	(2.1)	(0.1)	0.0	(0.1)	(2.4)	(2.2)	(0.1)
Supplies & Services - Clinical	(2.7)	(2.8)	0.2	0.0	0.1	(30.7)	(31.2)	0.5	0.4	0.1	(33.5)	(33.9)	0.4
Supplies & Services - General	(0.4)	(0.5)	0.1	0.0	0.1	(4.8)	(4.9)	0.1	0.0	0.1	(5.3)	(5.3)	0.1
Services from Other NHS Bodies	(0.5)	(0.5)	(0.0)	(0.0)	(0.0)	(7.0)	(7.2)	0.1	0.8	(0.7)	(7.5)	(7.6)	0.0
Purchase of Healthcare from Non-NHS	(1.3)	(0.4)	(0.9)	0.0	(0.9)	(14.4)	(8.1)	(6.3)	(0.1)	(6.2)	(15.8)	(8.6)	(7.2)
Clinical Negligence	(1.5)	(1.5)	(0.0)	0.0	(0.0)	(16.1)	(16.1)	0.0	0.0	0.0	(17.6)	(17.6)	0.0
Establishment	(0.2)	(0.3)	0.0	(0.0)	0.0	(3.4)	(3.1)	(0.3)	0.0	(0.3)	(3.7)	(3.4)	(0.3)
Premises	(2.6)	(2.3)	(0.3)	0.0	(0.3)	(23.5)	(23.8)	0.2	0.1	0.2	(26.4)	(26.1)	(0.4)
Transport	(0.2)	(0.1)	(0.1)	0.0	(0.1)	(1.6)	(1.5)	(0.1)	(0.0)	(0.1)	(1.8)	(1.6)	(0.1)
Other Non-Pay Costs	1.6	(0.4)	2.0	2.0	(0.0)	(5.9)	(7.0)	1.2	0.8	0.4	(6.4)	(7.5)	1.0
Non-Pay Reserves	0.0	(0.6)	0.6	0.0	0.6	0.4	(6.7)	7.2	0.1	7.1	0.4	(7.5)	8.0
Total Non Pay	**(12.5)**	**(14.0)**	**1.5**	**1.9**	**(0.4)**	**(159.5)**	**(158.8)**	**(0.7)**	**(0.3)**	**(0.4)**	**(174.8)**	**(172.7)**	**(2.1)**
Total Expenditure	**(36.9)**	**(38.4)**	**1.4**	**1.9**	**(0.5)**	**(422.5)**	**(425.0)**	**2.5**	**0.3**	**2.2**	**(462.4)**	**(463.2)**	**0.8**
EBITDA	**1.6**	**1.7**	**(0.1)**	**0.0**	**(0.1)**	**33.8**	**33.3**	**0.5**	**0.0**	**0.5**	**38.2**	**37.8**	**0.4**
	0.0	*0.0*	*0.0*	*%*		*7.4%*	*7.3%*	*-24.8%*	*-1.8%*	*-28.8%*	*7.6%*	*7.5%*	*-93.5%*
Depreciation	(1.1)	(1.1)	0.1	0.0	0.1	(11.9)	(12.3)	0.4	0.0	0.4	(13.1)	(13.5)	0.4
Interest	(0.1)	(0.1)	0.0	0.0	0.0	(1.3)	(1.4)	0.2	0.0	0.2	(1.4)	(1.6)	0.2
Dividend	(0.1)	(0.1)	0.0	0.0	0	(1.5)	(1.5)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.2)	0.0	0.0	0.0	(13.2)	(13.8)	0.6	0.0	0.6	(15.3)	(15.4)	0.1
Total Finance Costs	**(2.5)**	**(2.6)**	**0.1**	**0.0**	**0.1**	**(27.8)**	**(29.0)**	**1.2**	**0**	**1.2**	**(31.3)**	**(32.0)**	**0.7**
Net Surplus / Deficit (-)	**(0.8)**	**(0.8)**	**0.0**	**0.0**	**0.0**	**6.0**	**4.3**	**1.7**	**0.0**	**1.7**	**6.9**	**5.8**	**1.0**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.8)	0.7	(1.5)	0.0	(1.5)	0.0	1.1	(1.0)
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	**(0.8)**	**(0.8)**	**0.0**	**0.0**	**0.0**	**5.2**	**5.0**	**0.2**	**0.0**	**0.2**	**6.9**	**6.9**	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET	**(2.2)**	**(2.2)**	**0.0**	**0.0**	**0.0**	**(7.3)**	**(7.4)**	**0.2**	**0.0**	**0.2**	**(7.0)**	**(7.0)**	**(0.0)**

Commentary

The Trust delivered the financial plan for February generating £0.8m deficit including PSF. The Trust was £1.1m better than previously forecasted, £0.7m related to RTT income support which was previously included in the month 12 position, £0.3m related to deferred income adjustment previously planned to be released in month 12 and £0.1m underspends within budgets.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, and Research and Development costs.

Clinical Income excluding HCDs was above plan in February by £0.4m and adverse to plan by £0.3m year to date. The key favourable variances before AIC adjustment are in Elective In-Patients (£0.3m) and Adult Critical Care (£0.4m) offset by adverse variances in Day Cases (£0.2m), and Direct Access Radiology (£0.2m).

The Trust received £0.6m additional bonus PSF in June relating to 2018/19, the bonus PSF is treated as a technical adjustment and therefore does not support the 2019/20 I&E position.

Other Operating Income excluding pass-through costs was on plan in February. The main pressures in month were Private Patient Unit activity below planned levels (£0.3m) offset by £0.3m release of deferred income.

Pay budgets adjusted for pass-through items was on plan in February, Medical staffing pressures (£0.2m) and Nursing (£0.1m) were offset by underspend within STT (£0.2m) and Support staff (£0.1m). The pressure within Medical and Nursing is predominantly within the Medical and Emergency division due to higher than planned costs associated within escalation and use of high cost medical agency to cover vacancies.

Non Pay budgets adjusted for pass through items and release of reserves overspent by £1m in February. The main pressure related to higher than planned outsourcing costs relating to patient choice activity (£0.9m).

The Trust is currently forecasting to deliver the planned surplus of £6.9m including PSF and MRET funding.

2b. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Change between Months
Revenue	Clinical Income	30.6	34.5	35.2	36.4	34.3	37.9	36.3	35.9	38.2	35.2	37.1	38.1	35.0	(3.0)
	STF / PSF	0.0	12.8	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	2.8	1.4	1.4	0.0
	High Cost Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.4	5.3	4.1	4.1	4.6	4.5	3.9	4.1	4.2	4.0	4.4	3.9	2.1	(1.8)
	Total Revenue	**35.0**	**52.6**	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.9**	**39.7**	**44.3**	**43.3**	**38.6**	**(4.8)**
Expenditure	Substantive	(18.7)	(19.9)	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(20.8)	(20.5)	(20.7)	(0.2)
	Bank	(1.3)	(1.4)	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	(1.4)	(0.2)
	Locum	(0.7)	(1.1)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.1)	(1.1)	(0.9)	0.2
	Agency	(2.1)	(1.4)	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.6)	(1.4)	0.2
	Pay Reserves	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	(0.1)	(0.1)	(0.1)	(0.0)
	Total Pay	(23.0)	(23.9)	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(24.1)	(23.3)	(24.8)	(24.5)	(24.5)	0.0
Non-Pay	Drugs & Medical Gases	(4.5)	(4.5)	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.8)	(4.5)	0.3
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.8)	(2.7)	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	(2.8)	(2.9)	(2.9)	(3.0)	(2.6)	(2.7)	(0.0)
	Supplies & Services - General	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	0.1
	Services from Other NHS Bodies	(0.2)	(3.2)	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(0.5)	(0.6)	(0.5)	(0.5)	(0.5)	(0.0)
	Purchase of Healthcare from Non-NHS	(0.4)	(0.5)	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(1.3)	(1.3)	(0.0)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.4)	(1.5)	(1.5)	(0.0)
	Establishment	(0.3)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.2)	0.1
	Premises	(1.9)	(2.3)	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(1.9)	(2.2)	(1.9)	(1.8)	(2.3)	(2.6)	(0.3)
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.1)
	Other Non-Pay Costs	(1.5)	1.8	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	(1.0)	(0.7)	(0.6)	(0.6)	(0.7)	1.6	2.2
	Non-Pay Reserves	0.0	0.0	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0.0	0.5	0.0	0.0	0.0	0.0
	Total Non Pay	(13.9)	(14.0)	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	(14.8)	(13.9)	(14.4)	(14.7)	(12.5)	2.2
	Total Expenditure	(36.9)	(38.0)	(39.6)	(38.9)	(38.5)	(38.3)	(37.7)	(38.1)	(38.8)	(37.2)	(39.3)	(39.2)	(36.9)	2.2
EBITDA	EBITDA	(1.9)	14.7	0.5	2.5	1.9	5.1	3.6	2.8	4.1	2.5	5.1	4.2	1.6	(2.6)
		-6%	*28%*	*1%*	*6%*	*5%*	*12%*	*9%*	*7%*	*9%*	*6%*	*11%*	*10%*	*4%*	
Other Finance Costs	Depreciation	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.1)	(1.0)	(1.1)	(1.1)	(1.1)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	0.5	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	2.7	7.9	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
	Total Other Finance Costs	**1.4**	**7.2**	**(2.6)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**0.0**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(0.5)	21.9	(2.0)	(0.1)	(0.7)	2.5	1.0	0.5	1.4	(0.0)	2.6	1.7	(0.8)	(2.5)
Technical Adjustments	Technical Adjustments	0.0	(0.2)	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	(0.5)	0.0	0.0	(0.0)
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	(0.5)	21.7	(2.0)	(0.1)	(1.3)	2.6	1.0	0.4	1.5	0.0	2.0	1.7	(0.8)	(2.5)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(0.5)	8.9	(2.9)	(1.0)	(2.8)	1.5	0.0	(0.6)	1.0	(0.5)	(0.8)	0.3	(2.2)	(2.5)

3a. Cost Improvement Plan

Savings by Division

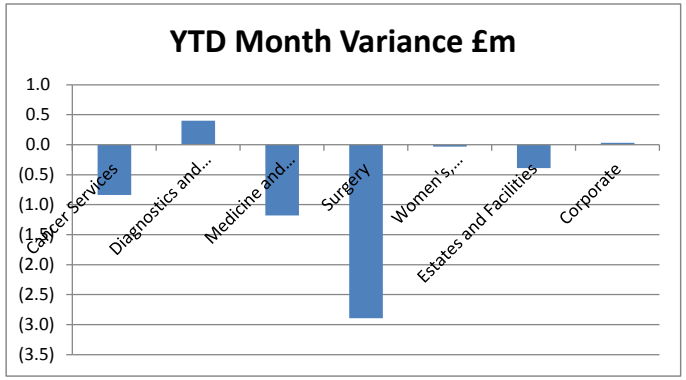
	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	(0.02)	0.12	(0.13)	0.49	1.33	(0.84)	0.55		0.55	1.45	(0.9)
Diagnostics and Clinical Support	0.34	0.25	0.09	3.27	2.87	0.40	3.54		3.54	3.11	0.4
Medicine and Emergency Care	0.35	0.50	(0.15)	3.78	4.96	(1.18)	4.13		4.13	5.46	(1.3)
Surgery	0.51	0.66	(0.16)	4.59	7.48	(2.89)	5.15		5.15	8.15	(3.0)
Women's, Children's and Sexual Health	0.19	0.21	(0.02)	2.27	2.31	(0.03)	2.46		2.46	2.56	(0.10)
Estates and Facilities	0.11	0.14	(0.03)	1.77	2.16	(0.39)	1.93		1.93	2.30	(0.4)
Corporate	0.76	0.18	0.59	1.94	1.91	0.03	2.07		2.07	2.09	(0.0)
Total	**2.25**	**2.05**	**0.19**	**18.12**	**23.02**	**(4.90)**	**19.84**	**0.00**	**19.84**	**25.12**	**(5.3)**
Internal Savings Plan stretch	0.15	(0.01)	0.16	2.41	(2.78)	5.18	2.54		2.54	(2.79)	5.3
Total	**2.40**	**2.04**	**0.36**	**20.52**	**20.24**	**0.28**	**22.39**	**0.00**	**22.39**	**22.33**	**0.1**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.58	0.45	0.13	6.43	4.13	2.30	6.95		6.95	4.58	2.4
Non Pay	0.52	0.33	0.19	(0.41)	2.16	(2.57)	(0.31)		(0.31)	2.54	(2.9)
Income	1.30	1.25	0.04	14.50	13.95	0.56	15.75		15.75	15.20	0.5
Total	**2.40**	**2.04**	**0.36**	**20.52**	**20.24**	**0.28**	**22.39**	**0.00**	**22.39**	**22.33**	**0.1**

Savings by NHSI RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	1.93	1.33	0.61	16.16	14.13	2.03	17.38		17.38	14.33	3.1
Amber	0.37	0.22	0.14	3.51	2.35	1.17	3.89		3.89	3.08	0.8
Red	0.10	0.49	(0.39)	0.84	3.76	(2.92)	1.11	0.00	1.11	4.92	(3.8)
Total	**2.40**	**2.04**	**0.36**	**20.52**	**20.24**	**0.28**	**22.39**	**0.00**	**22.39**	**22.33**	**0.1**



Comment

The Trust was favourable to plan in the month by £0.4m, the in month position included £0.7m year to date adjustment relating to ICT contract reviews.

The Trust is £0.3m favourable to plan year to date which is mainly due to over performance within workforce savings (£2.6m) and Best use of Resources (£1.8m) offset by slippage within patient flow (£4.1m).

The Trust has an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m.

The divisions are currently forecasting to deliver £22.3m savings in 2019/20 which is £2.8m short of the internal stretch target of £25.1m but delivers the external plan target.

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast Run Rate £m

Year End Forecast February 2019/20

Forecast Trend

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Budget	Variance
Clinical Income	35.2	36.4	34.3	37.9	36.3	35.9	38.2	35.2	37.1	38.1	35.0	37.9	437.5	435.1	2.3
PSF and MRET	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	2.8	1.4	1.4	0.5	13.5	13.8	(0.3)
Private Patients	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	1.4	5.1	(3.6)
Other Operating Income	4.0	4.0	4.4	4.4	3.8	3.9	4.1	3.9	4.3	3.8	2.0	4.3	46.8	47.0	(0.2)
Total Revenue	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.9**	**39.7**	**44.3**	**43.3**	**38.6**	**42.9**	**499.2**	**501.1**	**(1.8)**
Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(20.8)	(20.5)	(20.7)	(20.8)	(241.6)	(254.2)	12.7
Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	(1.4)	(1.3)	(15.1)	(10.2)	(4.9)
Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.1)	(1.1)	(0.9)	(1.0)	(11.6)	(8.4)	(3.3)
Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.6)	(1.4)	(1.4)	(18.9)	(15.8)	(3.2)
Pay Reserves	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	(0.1)	(0.1)	(0.1)	(0.1)	(0.5)	(2.0)	1.5
Total Pay	**(24.2)**	**(23.5)**	**(23.1)**	**(23.9)**	**(23.3)**	**(23.9)**	**(24.1)**	**(23.3)**	**(24.8)**	**(24.5)**	**(24.5)**	**(24.6)**	**(287.7)**	**(290.6)**	**2.9**
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.8)	(4.5)	(4.6)	(54.9)	(51.4)	(3.5)
Clinical Supplies	(3.2)	(3.1)	(3.2)	(3.5)	(3.0)	(3.2)	(3.4)	(3.4)	(3.5)	(3.1)	(3.0)	(3.3)	(38.8)	(39.3)	0.5
Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(1.3)	(1.3)	(1.4)	(15.8)	(8.6)	(7.2)
Other Non-Pay Costs	(5.6)	(5.6)	(5.9)	(5.7)	(5.8)	(5.9)	(5.5)	(5.2)	(5.1)	(5.5)	(3.7)	(6.2)	(65.8)	(65.9)	0.1
Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0	0.5	0	0	0	0	0.4	(7.5)	7.9
Total Non Pay	**(15.4)**	**(15.4)**	**(15.4)**	**(14.3)**	**(14.4)**	**(14.3)**	**(14.8)**	**(13.9)**	**(14.4)**	**(14.7)**	**(12.5)**	**(15.4)**	**(174.9)**	**(172.7)**	**(2.2)**
Other Finance Costs	(2.6)	(2.6)	(2.5)	(2.6)	(2.6)	(2.4)	(2.6)	(2.5)	(2.5)	(2.5)	(2.5)	(3.5)	(31.3)	(32.0)	0.7
Technical Adjustments	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	(0.5)	0.0	0.0	0.8	0.0	1.1	(1.1)
Surplus/ Deficit (-) to B/E Duty	**(2.0)**	**(0.1)**	**(1.3)**	**2.6**	**1.0**	**0.4**	**1.5**	**0.0**	**2.0**	**1.7**	**(0.8)**	**0.2**	**5.4**	**6.9**	**(1.5)**
Surplus/ Deficit (-) to B/E Duty Excl PSF	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.0**	**(0.5)**	**(0.8)**	**0.3**	**(2.2)**	**(0.3)**	**(7.6)**	**(7.0)**	**(0.6)**
Plan Excluding PSF and MRET Funding	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.5**	**(0.5)**	**(1.3)**	**0.3**	**(2.2)**	**0.5**	**(7.0)**	**(7.0)**	**(0.0)**
Variance to Plan Excl PSF Pre Mitigations	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	0.6	0.0	0.0	(0.8)	(0.6)	0	(0.6)
Variance by Quarter			0.0			0.0			0.1			(0.7)			
Total Mitigations / Recovery Actions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.6**	**0.6**	**0**	**0.6**
Revised Forecast Including Mitigations	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.0**	**(0.5)**	**(0.8)**	**0.3**	**(2.2)**	**0.3**	**(7.0)**	**(7.0)**	**(0.0)**
Variance by month	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	0.6	0.0	0.0	(0.2)			
Variance by Quarter			0.0			0.0			0.1			(0.1)			

5a. Balance Sheet

February 2020

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	February Reported	February Plan	Variance	January Reported	Full year Plan	Revised FOT
Property, Plant and Equipment (Fixed Assets)	286.9	292.8	(5.9)	287.5	307.6	310.1
Intangibles	2.5	2.8	(0.3)	2.6	2.8	2.8
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.8	1.4	0.4	1.8	1.4	1.9
Total Non-Current Assets	**291.2**	**297.0**	**(5.8)**	**291.9**	**311.8**	**314.8**
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	8.4	7.8	0.6	8.4	7.8	7.8
Receivables (Debtors) - NHS	30.2	26.4	3.8	33.3	24.7	24.7
Receivables (Debtors) - Non-NHS	11.0	10.9	0.1	13.1	9.2	8.7
Cash	21.9	4.7	17.2	17.7	3.0	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**71.5**	**49.8**	**21.7**	**72.5**	**44.7**	**44.2**
Current Liabilities						
Payables (Creditors) - NHS	(7.7)	(5.5)	(2.2)	(5.4)	(5.1)	(5.1)
Payables (Creditors) - Non-NHS	(41.9)	(34.3)	(7.6)	(42.0)	(31.2)	(32.0)
Deferred Income	(10.5)	(4.0)	(6.5)	(14.1)	(2.6)	(2.6)
Capital Loan	(2.3)	(2.2)	(0.1)	(2.3)	(2.2)	(2.2)
Working Capital Loan	(12.3)	0.0	(12.3)	(12.3)	(26.1)	(26.1)
Other loans	(0.4)	(0.4)	0.0	(0.4)	(0.4)	(0.4)
Borrowings - PFI	(5.4)	(5.4)	0.0	(5.4)	(5.3)	(5.3)
Provisions for Liabilities and Charges	(1.6)	(1.5)	(0.1)	(1.6)	(1.5)	(1.5)
Total Current Liabilities	**(82.1)**	**(53.3)**	**(28.8)**	**(83.5)**	**(74.4)**	**(75.2)**
Net Current Assets	(10.6)	(3.5)	(7.1)	(11.0)	(29.7)	(31.0)
non-current liabilities: Borrowings - PFI > 1yr	(182.0)	(182.6)	0.6	(182.5)	(182.2)	(182.2)
Capital Loans	(6.9)	(7.7)	0.8	(6.9)	(6.6)	(5.8)
Working Capital Facility & Revenue loans	(14.1)	(26.1)	12.0	(14.1)	0.0	0.0
Other loans	(1.3)	(1.3)	0.0	(1.3)	(1.3)	(1.3)
Provisions for Liabilities and Charges- Long term	(0.8)	(1.0)	0.2	(1.0)	(1.0)	(1.0)
Total Assets Employed	**75.5**	**74.8**	**0.7**	**75.1**	**91.0**	**93.5**
Financed By:						
Capital & Reserves						
Public dividend capital	213.0	213.3	(0.3)	211.8	213.2	216.1
Revaluation reserve	31.8	31.8	0.0	31.8	46.2	46.2
Retained Earnings Reserve	(169.3)	(170.3)	1.0	(168.5)	(168.4)	(168.8)
Total Capital & Reserves	**75.5**	**74.8**	**0.7**	**75.1**	**91.0**	**93.5**

Commentary:

The overall working capital within the month results in a increase in Debtors of £3.9m against plan with an increase in creditors of £16.3m compared to the revised plan submitted in May. The cash balance held at the end of the month is higher than the plan by £17.2m. Further information is given below.

Non-Current Assets -

The FOT for 2019/20 capital additions are c£16.6m of which £0.9m relates to donated assets. The YTD spend up to and including February is £5.7m against a plan of £12.2m. 2019/20 is the fifth year in the current five year cyclical valuation period; a full valuation will be undertaken in March 2020 by the Trust's professional valuers Montagu Evans LLP, the FOT value includ es an assumption of 5% increase in values.

Current Assets -

Inventories of £8.4m is slightly higher that the planned value of £7.8m. The main stock balances are pharmacy £2.8m, TWH theatres £1.4m, Materials Management £1m and Cardiology £1.4m.

NHS Receivables have decreased from the January's position by £3.1m to £30.2m. Of the £30.2m reported balance, £9m relates to invoiced debt of which £3m is aged debt over 90 days. Invoiced debt over 90 days has decreased since the January's position of £3.5m to £3m. The remaining £21.2m relates to uninvoiced accrued income including quarter 3 PSF of £2.3m and mth 10 & 11 PSF of £1.8m and work in progress - partially completed spells £2.7m. 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 has reduced by £2.1m to £11m from the reported January position of £13.1m . Included within the £11m balance is trade invoiced debt of £2.8m and private patient invoiced debt of £0.6m. Also included within the £11m are prepayments and accrued income totalling £6.5m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.

The closing cash balance at the end of February 2020 was £21.9m which is higher than cash plan of £4.7m. Primarily the variance relates to YTD capital spend being £5.1m compared to the plan value of £12.3m. The Trust is also awaiting invoices totalling c£2.5m relating to Prime Provider with £1m from WKCCG. Within the original cash plan the Trust had also forecast to pay in February c£1.6m quarter 4 pathology managed service invoice which the Trust is currently chasing to be received from the company.

The Trust is using the cash forecast to invest available funds weekly in the National Loans Funds which currently earns an interest rate of 0.67% compared to the RBS rate of 0.64%.

Current Liabilities -

NHS payables have increased from January's reported balance by £2.2m to £7.7m . This variance relates to the Trust receiving an invoice for £2.1m from Kent Community FT transferring funds relating to STP from when the Trust hosted the service. This ha s been authorised and paid in March. Non-NHS trade payables have reduced slightly to £41.9m from £42m giving a combined payables balance of £49.6m.

Of the £49.6m combined payables balances, £15m relates to actual invoices of which £6.2m are approved for payment and will be released when they fall due, the remaining balance of payables of £34.6m relates to uninvoiced accruals.

Deferred income of £10.5m primarily is in relation to £2.1m advance contract payment received from WKCCG and £2.1m from High Weald CCG, £1.9m relating to Maternity Pathway and £1.1m Health Education England Learning & Development income for mth 12.

Non current liabilities:

The Trust has 2 working capital loans totalling c£26.1m. The two loans are due to be repaid in 2020/21, £12.132m which is due to be repaid in October 2020 and the remaining £13.99m loan is based on a phased repayment plan throughout 2020/21.

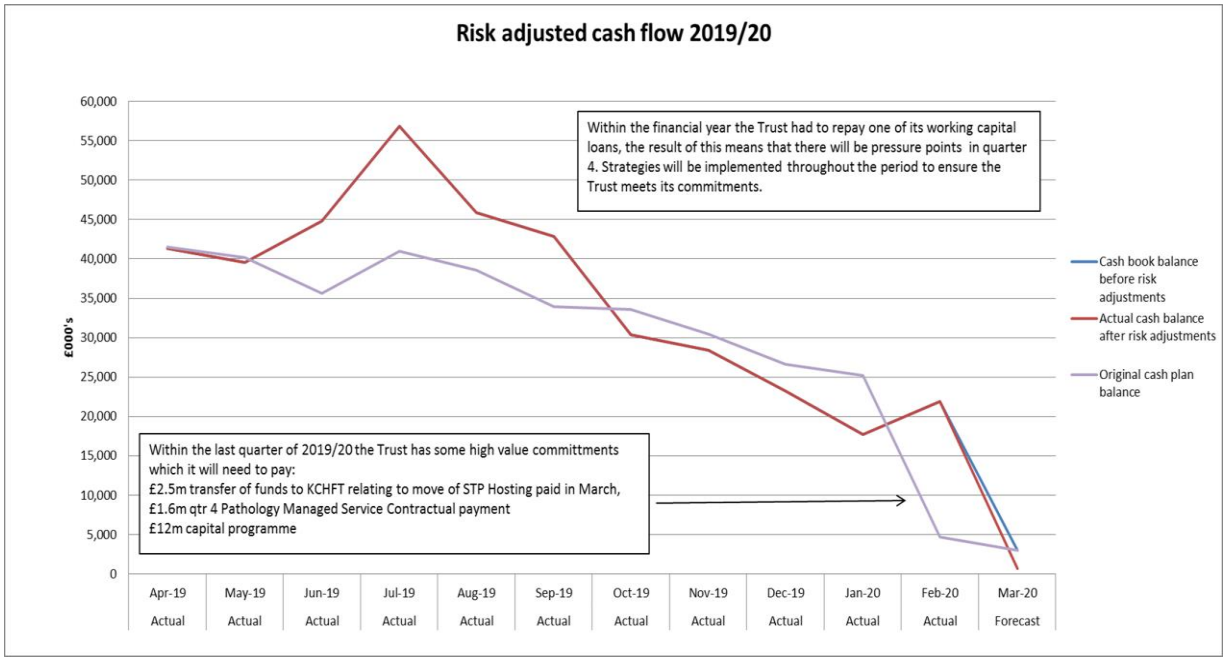
Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the ene rgy efficiency of the Trust.

Forecast outturn:

The public dividend capital increases by the end of the financial year by £4.3m. £1.3m is in relation to ICT - EPMA project and £2.1m for Diagnostic funding to purchase an MRI and 2 CT scanners, the funding for both the projects are expected to be received in quarter 4.

The increase between years for the revaluation reserve relates to the Trust forecasting a 5% increase in values on its buildi ngs and land assets totalling £14.4m.

5b. | Cash Flow



Information on loans:

	Rate	Value £m's	19/20 Annual Repayment £m's	19/20 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2020
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	15/09/2025
Capital investment loan	4.73%	6.000	0.24	0.16	15/09/2035
Other loans:					
Salix loan (interest free)	0.00%	2.217	0.37	0.00	2024/25

Commentary:

The blue line shows the Trust's cash position for 2019/20 and the purple line shows the original plan values. The red risk adjusted line shows the position if the relevant risk items are not received.

The cash balance of £21.9m is higher than the plan of £4.7m. Primarily the variance relates to YTD capital spend being £5.1m compared to the original cash plan value of £12.3m. The Trust is also awaiting invoices totalling c£2.5m relating to Prime Provider with £1m from WKCCG. Within the original cash plan the Trust had also forecast to pay in February c£1.6m quarter 4 pathology managed service .

The cash flow original plan is based on the I&E original plan, during the year as the I&E forecast position gets revised the cash flow forecast also gets revised. There are differences between the I&E and the cash flow, where the I&E can spread costs over the life of the contract but the cash will be impacted at the time it is paid.

Due to the Trust having surplus cash as result of the items above, the Trust was able to repay the working capital loan earlier in the year than the plan of February - the loan was for £16.9m.
The Trust received approval back in December to convert the proceeds from the asset sales in 2018/19 to capital totalling £6.36m for 2019/20, with the remaining £2m being carried forward to 2020/21 as per the original plan.

The Trust achieved the relevant targets to secure the qtr 3 PSF funding, this is forecast to be received in March. This item is risk adjusted just in case there is a delay in receiving the funds. Quarter 4 PSF will be included within 2020/21 cash flow.

5c. Capital Programme

Capital Projects/Schemes

	Year to Date			Forecast			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	
	£000	£000	£000	£000	£000	£000	£000
Estates	5,168	894	4,274	6,588	2,600	-3,988	2,438
ICT	3,710	3,730	-20	4,103	7,479	3,376	7,286
Equipment	2,963	469	2,494	3,163	5,655	2,492	5,658
PFI Lifecycle (IFRIC 12)	419	0	419	594	594	0	594
Donated Assets	300	555	-255	400	1,017	617	915
Total Including Donated Assets	**12,560**	**5,647**	**6,913**	**14,848**	**17,346**	**2,498**	**16,890**
Less donated assets	-300	-555	255	-400	-1,017	-617	0
Total Excluding Donated Assets	**12,260**	**5,092**	**7,168**	**14,448**	**16,329**	**1,881**	

The Trust's original plan has been varied during the year by a number of additional national funds. The Trust's bid for national EPMA capital funding was approved at a level of £1.25m. The Trust also received approval in early December from NHSE/I to the allocation of funding from the national Diagnostic Equipment Fund covering two CT scanners, a MRI and Mammography equipment in this financial year (£2.1m) as well as £578k HSLI funding, £427k Cyber Funding and £200k LHCRE funding.

The overall capital programme FOT is £16.3m, excluding donated assets. This includes internally generated capital of £4.85m and £6.4m asset sales carried forward from 2018/19. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of forecast underspend on depreciation resulting from the reduction in the overall programme value (removal of a external financing items) and slippage in the timing of schemes due to the planning issues around the national capital position)

Overall £16.0m is already spent or committed (excluding donated assets) e.g. ICT; EPR/EPMA £5.28m, Infrastructure £0.7m, Equipment; £0.9m general equipment, £2.1m CTs x 2, MRI & Mammography, £1.8m equipment from asset sales (includes balance of costs for Diagnostics) and Estates; £2.4m for backlog, Linac enabling and additional schemes from the asset sale.

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

Feb-20		DAY				NIGHT				TEMPORARY STAFFING								Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Temporary Demand Unfilled RM/M comparison of previous month	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	97.6%	77.4%	-	100.0%	100.9%	100.0%	-	-	21.2%	33.5%	75	↓	5.18	10	↑	8.7	8.6%	100.0%	5	1	RMN requirements and enhanced care needs required throughout the month.	126,934	137,306	(10,372)
MAIDSTONE	Cornwallis (M) - NS959	123.8%	133.6%	-	100.0%	104.1%	144.4%	-	-	26.7%	9.2%	26	↘	1.54	4	→	7.3	43.9%	120.0%	2	0	Surgical bed coordination supported in staffing levels	124,053	90,216	33,837
MAIDSTONE	Culpepper Ward (M) - NS551	90.6%	79.0%	-	-	100.9%	100.0%	-	-	22.0%	11.5%	64	↓	4.44	1	↘	7.5	58.8%	100.0%	2	0	1 fall above threshold	113,018	108,079	4,939
MAIDSTONE	John Day Respiratory Ward (M) - NT151	103.9%	100.0%	-	-	104.4%	103.6%	-	-	33.8%	16.9%	76	↗	5.13	5	↘	6.3	7.8%	100.0%	4	0	Additional RN requirements at night due to acuity.	132,265	141,102	(8,837)
MAIDSTONE	Intensive Care (M) - NA251	94.2%	70.9%	-	-	87.5%	-	-	-	5.1%	11.4%	36	↘	2.59	10	↑	31.6			1	0	1 fall above threshold. Reduced fill rate in line with bed occupancy which varied between 3-8 within the month.	185,039	152,540	32,499
MAIDSTONE	Pye Oliver (Medical) - NK259	82.4%	109.4%	-	-	102.9%	102.3%	-	-	22.1%	57.3%	96	↑	6.41	17	↑	5.9	9.1%	50.0%	4	1	Ward supporting SPNs. Some STS in month. Increase in requirements for temporary staffing cover with 17 unfilled shifts	119,314	117,216	2,098
MAIDSTONE	Chaucer Ward (M) - NS951	114.5%	100.3%	-	-	112.4%	112.8%	-	-	41.1%	23.7%	121	↑	8.17	26	↑	7.3	0.0%	0.0%	8	0	2 falls above threshold	165,185	160,558	4,627
MAIDSTONE	Whatman Ward - NK959	86.5%	97.3%	-	100.0%	174.6%	187.9%	-	-	47.1%	27.3%	141	↑	10.01	20	↗	7.0	42.0%	94.1%	7	0	1 fall above threshold. Increased fill rate at night due to escalation throughout the month. Bed occupancy between 18 - 25	92,372	98,265	(5,893)
MAIDSTONE	Lord North Ward (M) - NF651	101.5%	151.9%	-	100.0%	100.2%	103.4%	-	-	13.4%	9.9%	26	↓	1.86	1	↓	7.1	33.3%	100.0%	3	0	1 fall above threshold. Increased CSW fill rate to support increased dependency levels on ward	88,181	102,407	(14,226)
MAIDSTONE	Mercer Ward (M) - NJ251	107.0%	95.8%	-	100.0%	98.9%	98.3%	-	-	21.7%	58.2%	82	↑	5.32	7	↘	6.1	50.0%	84.6%	4	1	1 fall SI. Staff redeployment to support escalation area.	119,487	108,267	11,220
MAIDSTONE	Acute Medical Unit (M) - NG551	106.2%	88.7%	-	-	160.4%	192.5%	-	-	45.8%	53.0%	174	↑	11.76	19	↓	8.8	0.0%	0.0%	1	0	Increased fill rate at night due to ongoing escalation. Increase in demand for temporary staff throughout the month but with an improved fill rate in addtion to RMN requirements across 12 days in the month.	117,548	152,700	(35,152)
TWH	Ward 22 (TW) - NG332	119.0%	97.4%	-	100.0%	109.2%	105.1%	-	-	30.9%	17.3%	109	↑	7.18	21	↘	6.2	13.0%	100.0%	6	2	Increased RN fill rate due to RMN requirements . Enhanced care requirements reported throughout the month	129,106	132,564	(3,458)
TWH	Coronary Care Unit (TW) - NP301	116.6%	133.2%	-	-	99.0%	-	-	-	25.3%	15.0%	57	→	3.37	8	↗	11.8	112.5%	100.0%	0	0	Staff redeployed on occasion to support organisation staffing levels	69,979	68,382	1,597
TWH	Ward 33 (Gynae) (TW) - ND302	95.9%	108.0%	-	-	97.7%	94.6%	-	-	21.9%	5.7%	56	↘	3.38	6	↗	11.0	0.0%	0.0%	3	0	3 falls above threshold. 7 episodes recorded of enhanced care requirements.	81,468	94,020	(12,552)
TWH	Intensive Care (TW) - NA201	98.2%	95.0%	-	-	95.7%	87.5%	-	-	5.9%	0.0%	37	↓	2.42	5	↘	32.4			1	0	1 fall above threshold	206,692	165,363	41,329
TWH	Acute Medical Unit (TW) - NA901	96.2%	96.4%	-	100.0%	101.7%	98.9%	-	-	37.2%	45.0%	220	↓	15.48	29	↓	8.3	13.3%	97.9%	3	2	STS managed in month . Fill rate improved with 29 unfilled shifts and a reduction in requests for temporary staffing.	184,662	187,474	(2,812)
TWH	Surgical Assessment Unit (TW) - NE701	91.9%	130.7%	-	-	98.3%	100.0%	-	-	11.2%	0.0%	11	↓	0.62	1	→	14.5	0.0%	0.0%	0	0	Staffing levels to support escalation throughout the month.	61,157	60,761	396
TWH	Ward 32 (TW) - NG130	71.8%	69.5%	-	-	95.4%	73.6%	-	-	5.2%	15.8%	29	↑	1.63	7	↗	7.0	25.0%	100.0%	0	0	Reduced fill rate due to lack of available temporary staff with 7 unfilled shifts. Increase in temporary staff requests.	115,442	112,218	3,224
TWH	Ward 10 (TW) - NG131	100.4%	108.8%	-	100.0%	96.6%	129.3%	-	-	28.1%	11.4%	98	↑	6.54	10	↗	4.7	4.1%	100.0%	4	0	2 falls above threshold. Increased CSW fill rate at night a considered skill mix adjustment.	119,152	156,130	(36,978)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	125.6%	82.9%	-	-	103.4%	102.2%	-	-	76.4%	30.4%	172	↓	11.37	22	↓	7.3	0.0%	0.0%	8	2	4 falls above threshold. Increased RN fill rate to support ward escalation.	0	88,848	(88,848)
TWH	Ward 12 (TW) - NG132	105.6%	108.4%	-	100.0%	102.2%	99.1%	-	-	24.7%	31.3%	91	↓	5.55	21	↑	7.0	22.7%	100.0%	8	0	2 falls above threshold. Skill mix adjustments recorded to support staffing requirements	124,066	145,260	(21,194)
TWH	Ward 20 (TW) - NG230	99.3%	94.6%	-	-	101.1%	95.7%	-	-	31.6%	5.3%	51	↑	3.47	3	↘	5.1	43.5%	100.0%	16	0	9 falls above threshold	112,116	117,975	(5,859)
MAIDSTONE	Foster Winter Escalation 2019 (M) - NR359	98.8%	67.0%	-	-	100.0%	90.8%	-	-	65.8%	34.2%	148	↓	10.56	6	↓	5.4	0.0%	0.0%	5	0	Escalation area with lack of available temporary staff to cover CSW fill rate. Staff redeployed to area to support staffing levels	148,543	78,875	69,668
TWH	Ward 21 (TW) - NG231	100.0%	84.1%	-	100.0%	114.4%	103.4%	-	-	26.1%	50.1%	132	↑	8.79	26	↓	6.5	8.3%	100.0%	4	0	STS managed during the month and increase in level 2 patients reported.	144,590	138,681	5,909
TWH	Ward 2 (TW) - NG442	119.0%	93.7%	-	100.0%	110.8%	116.8%	-	-	32.3%	26.8%	101	↑	6.29	17	↓	7.7	50.0%	92.6%	6	0	Increased fill rate to support AFU escalation and enhanced care requirements. Bed occupancy between 26-30 throughout the month. Increase in temporary demand but improved temporary fill rate.	116,959	116,957	2
TWH	Ward 30 (TW) - NG330	113.9%	111.8%	-	100.0%	104.6%	100.0%	-	-	38.8%	14.3%	94	↗	6.01	13	↗	6.9	23.3%	90.5%	6	1	1 fall above threshold. Increased CSW fill rate to support enhanced care requirements	118,756	141,156	(22,400)
TWH	Ward 31 (TW) - NG331	105.8%	101.1%	-	100.0%	97.2%	108.0%	-	-	35.8%	14.6%	119	↑	7.35	21	↑	7.0	14.3%	100.0%	11	1	5 falls above threshold. Skill mix adjustment reported during month to provide appropriate staffing levels.	144,652	158,072	(13,420)
Crowborough	Crowborough Birth Centre (CBC) - NP775	99.2%	117.5%	-	-	95.8%	100.0%	-	-	6.6%	0.0%	15	→	0.72	1	↗		10.0%	100.0%		0		67,938	74,333	(6,395)
TWH	Midwifery (multiple rosters)	88.1%	47.0%	-	-	97.7%	51.1%	-	-	13.5%	6.9%	461	↑	26.07	55	↑	21.9	3.9%	100.0%	0	0	Reduced fill rate due to lack of available temporary staff. Increased in temporary demand this month and increase in unfilled shifts. Delivery suite prioritised to ensure safe staffing levels. MSW	671,782	646,489	25,293
TWH	Hedgehog Ward (TW) - ND702	101.0%	68.1%	-	-	110.0%	-	-	-	36.5%	43.1%	169	↓	11.38	14	↗	9.8	3.6%	100.0%	1	0	1 fall above threshold. RMN requirements report across 14 days. Bed occupancy between 12 - 25.	161,546	171,768	(10,222)
MAIDSTONE	Maidstone Birth Centre - NP751	104.8%	-	-	-	96.4%	96.6%	-	-	21.8%	0.0%	35	↗	2.01	1	↗		75.8%	100.0%	0	0		72,406	73,585	(1,179)
TWH	SCBU (TW) - NA102	71.5%	508.7%	-	-	94.5%	-	-	-	13.6%	0.0%	92	↗	4.86	2	↓	17.8				0	RN fill rate aligned to bed occupancy between 6-14 throughout the month. Amber escalation across 2 days. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	179,170	159,795	19,375
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	97.2%	78.7%	-	-	156.9%	-	-	-	35.3%	25.5%	69	↑	4.75	10	↑	8.5			1	0	1 fall above threshold. Increased fill rate at night due to increased dependancyu, Saturday night opening and enhanced care requirement.	43,595	59,259	(15,664)
TWH	Short Stay Surgical Unit (TW) - NE901	107.3%	107.1%	-	-	137.5%	254.5%	-	-	71.6%	24.6%	111	↓	6.66	7	↓	9.9			0	0	Increased fill rate due to ongoing escalation.	162,043	91,357	70,686
MAIDSTONE	Accident & Emergency (M) - NA351	92.4%	75.0%	-	-	107.5%	114.7%	-	-	29.6%	27.7%	236	↑	15.29	52	↑		14.6%	89.3%	2	0	MH - Increase in requirements for temporary staffing throughout the month and lack of available temporary staff across 52 shifts.	193,850	228,106	(34,256)
TWH	Accident & Emergency (TW) - NA301	87.1%	90.7%	-	100.0%	95.3%	97.3%	-	-	39.4%	43.1%	401	↓	27.75	53	↓		5.7%	89.8%	4	0	TWH - Reduced fill rate due to vacancies and lack of available temporary staff across 53 shifts.	352,524	362,991	(10,467)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	88.6%	93.2%	-	-	89.7%	-	-	-	33.4%	18.8%	58	↓	4.03	3	↘	17.0	77.4%	100.0%	0	0		43,805	45,672	(1,867)
MAIDSTONE	Peale Ward (M) - NE959	103.2%	108.9%	-	100.0%	102.0%	103.7%	-	100.0%	19.9%	31.0%	52	↗	3.15	13	↗	7.6	35.8%	100.0%	0	0	Bed occpuancy at capacity (with the exception of 4 days) throughout the month.	81,233	80,055	1,178
																						Total Established Wards	5,209,395	5,244,748	(35,353)
																						Additional Capacity beds Cath Labs	40,411	44,463	(4,052)
																						Whatman	0	-830	830
																						Edith Cavell (M) - NS459	-6,836	-372	(6,464)
																						Ward 32 (Wells Suite) (TW) - PP010	-7,699	-1,348	(6,351)
																						Other associated nursing costs	3,348,843	3,358,153	-9,310
																							8,584,114	8,644,814	(60,700)

RAG Key

Under fill

Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

↗→ Remains equal to Or less than a difference of 5

Only complete sites your organisation is accountable for			Day								Night								Day				Night				Care Hours Per Patient Day (CHPPD)			
Ward name	Main 2 Specialties on each ward		Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Average fill rate - registered nurses/ midwives (%)	Average fill rate - non-registered nurses/midwives staff (%)	Average fill rate - Registered nursing associates (%)	Average fill rate - trainee nursing associates (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - nursing associates (%)	Average fill rate - trainee nursing associates (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,996	1,949	1,222	945	0	0	228	228	1,276	1,287	638	638	0	0	0	0	97.6%	77.4%	No data	100.0%	100.9%	100.0%	No data	No data				
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,148	1,421	696	930	0	0	72	72	935	974	297	429	0	0	0	0	123.8%	133.6%	No data	100.0%	104.1%	144.4%	No data	No data				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,632	1,479	1,311	1,036	0	0	0	0	1,265	1,276	319	319	0	0	0	0	90.6%	79.0%	No data	No data	100.9%	100.0%	No data	No data				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1,862	1,935	1,415	1,415	0	0	0	0	1,595	1,665	638	661	0	0	0	0	103.9%	100.0%	No data	No data	104.4%	103.6%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,026	2,850	182	129	0	0	0	0	2,668	2,335	69	0	0	0	0	0	94.2%	70.9%	No data	No data	87.5%	0.0%	No data	No data				
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,599	1,317	1,431	1,566	0	0	0	0	957	985	957	979	0	0	0	0	82.4%	109.4%	No data	No data	102.9%	102.3%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,926	2,205	1,797	1,802	0	0	0	0	1,230	1,419	1,276	1,440	0	0	0	0	114.5%	100.3%	No data	No data	115.4%	112.8%	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,635	1,659	512	776	0	0	76	76	1,042	1,044	348	360	0	0	0	0	101.5%	151.5%	No data	100.0%	100.2%	103.4%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,523	1,629	1,380	1,322	0	0	84	84	957	946	638	627	0	0	0	0	107.0%	95.8%	No data	100.0%	98.9%	98.3%	No data	No data				
Edith Cavel	300 - GENERAL MEDICINE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data	No data	No data	No data	No data	No data	No data	No data				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,427	2,577	1,409	1,249	0	0	0	0	957	1,621	308	594	0	0	0	0	106.2%	88.7%	No data	No data	169.4%	192.9%	No data	No data				
Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,539	1,832	1,464	1,426	0	0	56	56	957	1,045	1,276	1,342	0	0	0	0	119.0%	97.4%	No data	100.0%	109.2%	105.1%	No data	No data				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,117	1,302	348	464	0	0	0	0	957	948	0	0	0	0	0	0	116.6%	133.2%	No data	No data	99.0%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,451	1,391	708	765	0	0	0	0	957	935	407	385	0	0	0	0	95.9%	108.0%	No data	No data	97.7%	94.6%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,272	3,214	348	331	0	0	0	0	2,616	2,504	319	279	0	0	0	0	98.2%	95.0%	No data	No data	95.7%	87.5%	No data	No data				
Medical Assesment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,102	2,985	1,369	1,320	0	0	90	90	2,001	2,035	1,001	989	0	0	0	0	96.2%	96.4%	No data	100.0%	101.7%	98.9%	No data	No data				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,036	952	348	420	0	0	0	0	638	627	319	319	0	0	0	0	91.9%	120.7%	No data	No data	98.3%	100.0%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		1,999	1,436	1,421	987	0	0	0	0	957	913	957	704	0	0	0	0	71.8%	69.5%	No data	No data	95.4%	73.6%	No data	No data				
Ward 10	100 - GENERAL SURGERY		2,129	2,137	1,226	1,334	0	0	59	59	1,276	1,232	638	825	0	0	0	0	100.4%	108.8%	No data	100.0%	96.6%	129.3%	No data	No data				
Ward 11 (TW) Winter Escalation 2019 - NG144	100 - GENERAL SURGERY		1,181	1,483	1,198	993	0	0	0	0	957	990	1,100	1,124	0	0	0	0	125.6%	82.9%	No data	No data	103.4%	102.2%	No data	No data				
Ward 11 (TW) - NG131	100 - GENERAL SURGERY		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data	No data	No data	No data	No data	No data	No data	No data				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	1,913	2,021	1,394	1,511	0	0	84	84	957	978	1,276	1,265	0	0	0	0	105.6%	108.4%	No data	100.0%	102.2%	99.1%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	846	840	1,481	1,400	0	0	0	0	957	968	1,276	1,221	0	0	0	0	99.3%	94.6%	No data	No data	101.1%	95.7%	No data	No data				
Foster Winter Escalation 2019 (M) - NR359			1,542	1,524	1,424	954	0	0	0	0	638	957	957	869	0	0	0	0	98.8%	67.0%	No data	No data	150.0%	90.8%	No data	No data				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,127	2,127	951	800	0	0	120	120	1,595	1,793	638	660	0	0	0	0	100.0%	84.1%	No data	100.0%	112.4%	103.4%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,793	2,061	1,651	1,547	0	0	56	56	913	1,012	913	1,067	0	0	0	0	115.0%	93.7%	No data	100.0%	110.8%	116.8%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		1,860	2,118	1,393	1,558	0	0	24	24	957	1,001	1,243	1,243	0	0	0	0	113.9%	111.8%	No data	100.0%	104.6%	100.0%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		1,894	2,003	1,514	1,531	0	0	120	120	1,276	1,240	957	1,034	0	0	0	0	105.8%	101.1%	No data	100.0%	97.2%	108.0%	No data	No data				
Birth Centre (Crowborough).	501 - OBSTETRICS		765	758	322	379	0	0	0	0	703	673	334	334	0	0	0	0	99.2%	117.5%	No data	No data	95.8%	100.0%	No data	No data				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		20,878	18,399	8,308	3,901	0	0	0	0	4,988	4,872	3,429	1,751	0	0	0	0	88.1%	47.0%	No data	No data	97.7%	51.1%	No data	No data				
Hedgehog	420 - PAEDIATRICS		2,536	2,562	360	245	0	0	0	0	1,967	2,163	0	204	0	0	0	0	101.0%	68.1%	No data	No data	110.0%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		784	821	0	19	0	0	0	0	634	611	312	301	0	0	0	0	104.8%	No data	No data	No data	96.4%	96.6%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		3,856	2,758	150	763	0	0	0	0	2,222	2,099	0	209	0	0	0	0	71.5%	508.7%	No data	No data	94.5%	No data	No data	No data				
MSSU	100 - GENERAL SURGERY		1,099	1,068	641	504	0	0	0	0	440	691	0	3	0	0	0	0	97.2%	78.7%	No data	No data	156.9%	No data	No data	No data				
Peale	100 - GENERAL SURGERY		1,126	1,162	535	582	0	0	128	128	638	651	297	308	0	0	22	22	103.2%	108.9%	No data	100.0%	102.0%	103.7%	No data	100.0%				
SSSU	100 - GENERAL SURGERY		1,296	2,168	516	552	0	0	0	0	440	605	220	560	0	0	0	0	167.3%	107.1%	No data	No data	137.5%	254.5%	No data	No data				
Whatman	300 - GENERAL MEDICINE		1,930	1,670	1,334	1,298	0	0	66	66	638	1,114	319	440	0	0	0	0	86.5%	97.3%	No data	100.0%	174.6%	137.9%	No data	No data				
MDU			838	743	746	696	0	0	0	0	638	572	0	43	0	0	0	0	88.6%	93.2%	No data	No data	89.7%	No data	No data	No data				

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
March 2020

Main author: Rachel Thomas, Deputy Head of Midwifery and Gynaecology

Division: Women's and Children's

Specialty: Maternity

1. Introduction

All perinatal deaths are reported to MBRRACE which is a national organisation that collates information and produces reports on learning from deaths. It is the expectation that all perinatal deaths are reviewed in a multidisciplinary forum using the Perinatal Mortality Review Tool. This tool was introduced in 2018 and from December 2018, all eligible cases are reviewed using this questionnaire.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to

support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;

- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere

2. Overview:

There have been four 3rd trimester losses within the first 3 months of the year. All these cases have had a RCA review and will have PMRT. The risk team will conduct a review of these 4 cases and the one 3rd trimester loss in December all together to ascertain whether there are any common themes.

3. 2019 cases

Date	Case type	SI declared	PMRT COMPLETED
02/1/19	25 Stillbirth	No	complete
30/1/19	Term IUD	Yes	complete
22/2/19	26+6 IUD	No	complete
30/4/19	Term IUD at home	Yes	complete
30/4/19	Term IUD reduced FM	Yes	complete
01/5/19	22+1 NND (extreme prem)	No	complete
28/5/19	IUD 25+1	No	complete
30/5/19	IUD at 27w mother with severe morbidity	Yes	complete
13/6/19	36w IUD	No	complete
25/07/2019	22 NND extreme prem	No	complete
5/8/2019	27+4 NND/ SB	No	Under review
28/08/2019	38+1 IUD	Yes	complete
10/09/2019	38+0 IUD	No	complete
12/09/2019	31+1 IUD	No	complete
17/09/2019	34+2 stillbirth	No	complete
7/11/19	22+5 NND (extreme prem)	No	complete
25/11/19	30 stillbirth	No	complete
19/12/19	36 stillbirth	No	complete

2020 Cases

Date	Case type	SI declared	PMRT COMPLETED
15/01/20	25+6 Stillbirth	No	PMRT meeting held, report in progress
07/02/20	35 Stillbirth	No	No
25/02/20	29+3 Stillbirth	No	No
25/02/20	41+5 Stillbirth	No	No
10/03/20	40 Stillbirth	No	No

4. Learning from cases

Learning	Action	Action required/Completed	Completed
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.	1. Rachel Thomas to email the community team leads and the Antenatal clinic team lead to ensure that midwives know that this is the expectation By 31st March 2. Invigorated training for Gap and Grow needs to be undertaken. This will be led by the new in post Fetal Wellbeing midwives who are due to start in April. Till then there is a focus on the online training compliance and feedback to individuals where issues have been identified.	√ 20/3/2020 Fetal Wellbeing Midwives May 2020
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	1. Nathan Sims/Sarah Mander-McGregor/ Alison Mendes to formulate pathway should there be lack of antenatal clinic appointments	30th April 2020 NS/SMM/AM
The mother should have	Matrons to be aware of the	Email to ensure awareness that	√ 11/2/2020

had an interpreter at every visit and especially at booking. However it was not clear on the referral what language was spoken by the mother and so the midwife would not have known to book one. It is unclear whether the mother understood the information about smoking cessation as she declined intervention.it is documented that she was waiting for a prescription for aspirin at 20w which suggests that she had not fully understood that process for obtaining aspirin and the importance of taking it from 12 weeks. Every effort should be made by the maternity service to ensure that an interpreter is present or that language line	case and cascade to teams the importance of booking a face to face interpreter. It is difficult when no language is specified on the booking however the appointment should be rebooked with an interpreter is necessary	interpreters are necessary at every visit Community midwives leads to do an audit to assess whether partners are being used as interpreters. This will be fed back through the Maternity Forum in September	Sept 2020
The mother had investigations on the antenatal ward and was discharged before the results were available. There is no pathway for ensuring the results are communicated to the woman until the next contact with a health professional who would be relied upon to look up them up.	The Antenatal ward should formulate a robust system for following up test results and communicating them to the women	Majority of women will have their results before they are discharged. There is a results book now on Antenatal ward which is the responsibility of the Band 7 to check each day to see if any results are communicated. As a failsafe, women are also told to call Triage if they do not hear about their results	√ Louise Jarvis, Deputy Antenatal Ward Manager 20/3/2020
Symphysis Fundal Height not correctly plotted on Gap and Grow chart	Invigorate training for Gap and Grow. New Fetal Wellbeing Midwives to start in April who will undertake the training. Random audits to be undertaken by community leads	Fetal Wellbeing midwife will include SFH training in their remit. In the meantime, midwives are reminded to use the correct methods by their team leads.	Action for Fetal Wellbeing Midwives End May 2020 Email sent to team leads 20/3/2020
Inadequate assessment on	Feedback to individual	Maggie Matthews Consultant Obstetrician	30th April 2020

Triage when presenting with abdominal pain at 25+4w	doctor		

5. Summary

A review of all the PMRT cases from 2019 will be undertaken. This will form part of the review of all SIs, Complaints, Legal cases and HSIB cases which has been initiated as a response to the East Kent situation.

Families continue to be supported by the bereavement midwives. The maternity service presented a proposal to offer 6 counselling sessions for bereaved parents at a “Dragon’s Den” event. This idea was wholly supported by the executive and plans for how this can be realised are being discussed.

Work is ongoing to embed the standards of the National Bereavement Care Pathway (NBCP) within our care of bereaved parents across the areas of A/E, Screening, Gynae, Maternity, NNU and Paediatrics.

NHS Maidstone and Tunbridge Wells NHS Trust

Review of Nurse staffing Ward and non-Ward areas (major review) **Chief Nurse**

Summary / Key points
This paper provides the board with the outcomes of the staffing establishment reviews that have been undertaken in non-ward areas, ward areas and specialities across the organisation It is critical that the Trust has the right level of staff in place to support the on-going ability of the nursing and midwifery workforce to deliver high quality care.

The review is in line with recommendations set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018) which includes recommendations on workforce safeguards to strengthen the commitment to safe, high quality care in the current climate. NQB's guidance states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- must use an approach that reflects current legislation and guidance where it is available.

Current Position Staffing levels are closely monitored daily in real time, at site meetings and through weekly staffing huddle conference calls, weekly bank and agency usage monitoring and weekly recruitment activity progress. A monthly report and publication return to NHSI / E indicating 'planned' and 'actual' nurse staffing by ward is submitted now with the inclusion of Trainee Nursing Associates and Nursing Associates. The safe staffing paper is published monthly at Trust Board and shared with Divisional Nursing and Midwifery Leads.

The following report provides assurance of the systematic approach undertaken, summary of staffing reviews, outcomes and the recommendations made in line with current guidance and legislation to support Maidstone and Tunbridge Wells NHS Trust to workforce plan, effectively deploy staff and ensure governance to the redesign and / or deployment of new roles within the Nursing and Midwifery workforce.

Section 1 of the report covers the review outcomes for Non ward areas and Specialities to include:

- Accident & Emergency
- Paediatrics
- Critical Care
- Theatres
- Head & Neck
- Oncology
- Maternity
- Gynaecology
- Endoscopy
- Cardiac Catheter Labs
- Main Outpatients

Recommendations from relevant Royal Colleges, professional bodies and NICE guidance have been considered where appropriate.

Section 2 of the report focuses on the review outcomes of the In Patient Ward Areas:

Maidstone Hospital	**Tunbridge Wells Hospital**
Ambulatory Medical Unit (AMU)	Short Stay Surgical Unit (SSSU)
Acute Stoke Unit (ASU)	Surgical Assessment Unit
Chaucer Ward	Ambulatory Medical Unit (TAMU)
Cornwallis	Coronary Care Unit (CCU)
Culpepper / CCU	Ward 2 / Acute Frailty Unit
John Day	Ward 10 Ward 22
Lord North	Ward 11 Ward 30
Mercer	Ward 12 Ward 31
Maidstone ITU	Ward 20 Ward 32
Maidstone Short Stay Surgical Unit (MSSU)	Ward 21 Ward 33
Maidstone Orthopaedic Unit (MOU)	Tunbridge Wells ITU
Peale	
Pye Oliver	
Whatman / Frailty	

Ward establishments were reviewed in line with National Quality Board Guidance (2016), NICE guidance (2017), Shelford Acuity & Dependency model and Professional Judgement (Telford) model, Carter Model Hospital (CHPPD) and Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

As we work towards full implementation and embedding the Developing Workforce Standards (2018) we fully recognise the importance of effective staff deployment and workforce planning for Maidstone and Tunbridge Wells NHS Trust to provide including redesigning or introducing new roles and ways of working. As part of any proposed change in skill mix, there will need to be a formal review of skill mix supported by the completion of a quality impact assessment undertaken to ensure that any impact on the provision of safe staffing is clearly understood.

New ways of working to deliver safe, effective and high quality care was the subject of much discussion and in line with workforce recommendations. Services continue to need to consider the integration of new roles and apprenticeships as we begin to map out what a future nursing workforce looks like with the inclusion of roles including the Trainee Nursing Associates, Nursing Associates, CSW apprenticeships and potential apprenticeships in development.

In the lead up to the comprehensive safe staffing review a key piece of work to triangulate the safe staffing recommendations, the Healthroster and finance and establishments was commenced. This piece of work is ongoing and will be vital to support effective deployment and future workforce planning

There has been a high priority and extensive work stream which has had a key focus on nurse recruitment to reduce the previously significant gaps in vacancies and a reliance on temporary workforce. Through this key work stream MTW has seen the successful recruitment of 221 overseas nurses, regional collaborative working to agree agency costs and weekly monitoring of agency requirements and staffing huddles. MTW has also worked to pilot a successful OSCE ready programme which will support overseas recruitment moving into the next financial year.

The Trust has furthered its work on Advanced Clinical Practice following publication of the competency framework. The governance for ACP is now in place through the Advanced Practice Assurance Group (APAG) and an initial scoping project has been completed to map the Nursing workforce against the competencies. This work is a key enabler for MTW to move towards a standardised position and definition of titles and competencies for ACP that will influence the development and deployment of new advanced roles that will enhance our patient pathways but also support us in meeting the wider workforce needs.

In summary, the budgeted establishment for the departments is broadly correct when at establishment. The key successes and challenges for this reporting period has been the extensive recruitment activity and appointment of overseas nurses which, whilst has significantly reduced the vacancy levels across specialities, has changed the skill mix and level of supervision requirements to support new staff, new learners and integrate new roles within the context of the high operational demands of the acute provider setting. Staffing skill mix and Quality provision is closely monitored to ensure patient safety

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at 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

Report to: **Trust Board**

Report from: **Claire O'Brien - Chief Nurse**

Date: **March 2020**

Subject **Nursing & Midwifery Staffing Review :**
A Comprehensive review of Maidstone and Tunbridge Wells NHS Trust Ward Areas, Non-Ward Areas and Speciality Services.

1. Introduction:

1.1 This paper provides the board with information relating to staffing establishment reviews undertaken in non-ward areas, ward areas and specialities.

1.2 This is in line with recommendations set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the new Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

Section 1 of the report covers Non ward areas and Specialities to include:

- Accident & Emergency
- Paediatrics
- Critical Care
- Theatres
- Head & Neck
    - Ophthalmology OP and EEMU
- Oncology
- Maternity
- Gynaecology
- Endoscopy
- Cardiac Catheter Labs
- Main Out Patients

Section 2 of the report focuses on the In Patient Ward Areas to include:

Maidstone Hospital	**Tunbridge Wells Hospital**
Ambulatory Medical Unit (AMU)	Short Stay Surgical Unit (SSSU)
Acute Stoke Unit (ASU)	Surgical Assessment Unit
Chaucer Ward	Ambulatory Medical Unit (TAMU)
Cornwallis	Coronary Care Unit (CCU)
Culpepper / CCU	Ward 2 / Acute Frailty Unit
John Day	Ward 10 Ward 22
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Mercer	Ward 12 Ward 31
Maidstone ITU	Ward 20 Ward 32
Maidstone Short Stay Surgical Unit (MSSU)	Ward 21 Ward 33
Maidstone Orthopaedic Unit (MOU)	Tunbridge Wells ITU

Peale
Pye Oliver
Whatman / Frailty

2. Background

2.1 The NQB published guidance on nursing and midwifery staffing capacity and capability in November 2013.

2.2 The document sets out to articulate the underpinning principles of setting safe staffing levels, ensuring that wards have not only the right numbers of staff but have staff with the right skills. The document acknowledges that mandating for minimum numbers or ratios 'misses the point', rather hospitals should use an evidence base approach to support professional judgement, as no one model will fit all specialties at all times.

The NQB published further guidance in July 2016 (with updates in 2017) to support the provision of safe, sustainable and productive staffing. This document sets out 3 expectations that are applicable to all acute care settings (where the previous document focussed primarily on in-patient ward areas).

These expectations are:

Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff: 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

NHS improvement published the Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018). This most recent guidance was published to address an identified gap in support around workforce design and deployment for safe staffing planning with recommendations to ensure a consistent approach setting out good practice for:

- Effective workforce planning
- Deployment of staff by using evidence based tools
- Governance considerations when redesigning roles/skills mix
- Responding to unplanned workforce challenges

2.3 There is a requirement that Trusts formally ensure NQB's 2016 guidance is embedded in their safe staffing governance and ensure the triangulated approach is used in their safe staffing processes which include:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

Based on patients' needs, acuity, dependency and risks,

2.4 The purpose of this review is to address Expectation 1 and 2 as set out by the NQB and to move to compliance in the recommendations set out the NHSi Developing workforce safeguards with consideration to new roles and integrating these into workforce plans.

2.5 The NQB recommend the use of other quality data sets to inform professional judgement including acuity and dependency tools, review of incident data, completion of key clinical processes such as drug administration, sickness/absence, and user feedback.
In addition to this, relevant guidance from the National Institute for Health and Care Excellence (NICE) and relevant Royal Colleges and professional bodies have been considered. This will be noted in the body of the report as appropriate.

2.6 Other elements of the NQB expectations, as outlined above, are supported via a number of work streams within the Best Care Programme and the triangulation work which conintues.

3. Methodology:

3.1 The key methodology used for the establishment review is the Professional Judgement (Telford) model the National Audit Commission, endorsed by the RCN, supported by the NQB and NHSi Developing Workforce Standards. For ward areas the Carter Model was applied to include consideration of Care hours Per Patient Day (CHPPD).

3.2 There is an expectation that the reviews should ideally be a combination of 'bottom-up'; that is informed by the Ward / Unit / Speciality team led by the Ward Sister / Unit manager , and 'top-down'; informed by the Chief Nurse, Divisional Directors of Nursing and Quality and Head of Midwifery. Discussion / review meetings in MTW included Ward / Unit Manager, Matron, Finance Manager, Divisional Director of Nursing and Quality, Deputy Chief Nurse using a triangulation of ward quality indicators (pressure injury, falls, nursing care complaints and FFT results), performance and incidence. The template for review and discussion can be found in Appendix 1

3.3 The review period for all areas contained within this report place during September / October 2019, December 2019 and January 2020. Quarter 3 data has been post-meeting analysis. Consideration has also been given to the following:

- Acuity & dependency (Shelford Acuity Tool/Safer Nursing Care Tool (SNCT)
- Geography of ward / unit and relationship with co-dependent departments (eg: surgical ward in relation to theatres).

3.4 To facilitate such a wide review across all of these services the reviews were staged over an extended period to ensure a comprehensive review of all ward, non-ward and speciality areas were included. The process was consciously undertaken at this time in the year to ensure that any recommendations for changes to establishments could be considered as part of the directorate business planning processes later in the year.

Any issues that might give cause for concern would have been escalated to the Chief Nurse, Chief Operating Officer and other relevant Executives throughout the review period should the need arise.

There were no issues of concern that required immediate escalation.

4.0 Section 1:

Non Ward Areas and Specialities Current Position:

Accident & Emergency:

4.1 Accident & Emergency (A&E) departments at both Maidstone and Tunbridge Wells were reviewed. Reference was made to NICE guidance for Safe Staffing in A&E departments (2015). It was acknowledged that this was only a consultation document, having never been finally published. Reference was also made to Royal College of Nursing (RCN) acuity and dependency tool for emergency care. This had been piloted previously, but there was insufficient data to inform this round of discussions. This tool, whilst developed by the RCN, has not been fully validated.

Maidstone A&E

Maidstone A&E generally runs with a combination of the following plan:

Early : 8 Registered Nurses (RN) and 2 x Clinical Support Worker (CSW)
Late: 10 RN's and 2 x CSW's
Twilight: 1 RN
Nights: 7 RN and 1 CSW

This staffing profile covers the Resuscitation room (3 adults bays and 1 child bay), 2 rooms, 9 majors cubicles, 8 minors cubicles, 10 chairs, Clinical Decision Unit 6 chairs, Rapid Assessment (3 trolleys) and Triage.

The unit has a turnover of between 200 – 250 patients per day.

This staffing profile provides a ratio of nurse to patients as:
1:2 in Resus
1:4 in Majors
This is in-line with current recommendations.
The unit is also support by Emergency Nurse Practitioners

The unit also provides a paediatric service. This is staffed by an RN (Child) between 10.00 and 22.30hrs and 1 x Nursery Nurse. This is based on attendance data which indicates this is the peak period for paediatric attendances.

Quality indicators

Time to triage: the waiting standard should be less than 15 minutes. At times this has been up to 60 minutes with one RN covering triage.

Falls: the unit is at or below agreed threshold consistently for patient falls within the department for Q3.

Pressure Ulcer incidence: Whilst the unit is rarely implicated in any pressure ulcer root cause analysis an opportunity has been identified to consider the patient pathway from admission to A+E and time in the department +/- reason for admission to department.

Complaints: There have been 3 complaints in the last 6 months relating to CAMHS and communication.

Friends & Family: during the transition period to the trusts new provider for FFT the unit has had fluctuating response rates. Optimum data in Q3 reported a positive response rate of 94.5% which is above the national average.

Summary: establishments are satisfactory if fully recruited to. This is with a reducing vacancy factor and the unit have welcomed recruitment of overseas nurses. Consideration to be given to additional CSW to support flow in majors / resus with increasing attendances and consider new roles including an RMN across sites (ideally dual trained).

Recommendation: The team are keen to trial a band 3 /4 flow coordinator within the department and to employ an ENP to work at nights to support triage as a 'Hello' nurse. This would need to be incorporated into current business planning. To undertake a further review of staffing requirements and impact of any future changes as part of the Quality Impact Assessment of service development such as RAP, AMU, HASU and geographical boarders.

Tunbridge Wells A&E

Tunbridge Wells A&E runs with a combination of the following plan:

Early : 13 RN's and 2 CSW's
Late: 13 RN's and 3 CSW's
Nights: 13 RN's and 2 CSW's

The unit is also support by Emergency Nurse Practitioners
This provides cover for 6 resus cubicles, 16 majors cubicles, 8 minors cubicles, 6 Rapid Assessment (RAP) cubicles, 6 clinical decision unit chairs, 10 red chairs and Triage.

This staffing profile provides a nurse to patient ratio of:

1:2 in resus
1:5 in majors
1:6 in RAP (+ a doctor)
1:6 CDU
1:WR / minors

There is a separate paediatric unit located adjacent to the main department. This is staffed by 2 RN (Child) and 1 Nursery Nurse and 2 RN and 1 NN between 11.30 – 00.00 or 10.00 – 22.30.

Quality Indicators:

Falls: the unit is at or below agreed threshold consistently for patient falls within the department for Q3.

Pressure Ulcers: The unit also ensure adult safeguarding concerns, where related to community care, are reported. Whilst the unit is rarely implicated in any pressure ulcer root cause analysis an opportunity has been identified to consider the patient pathway from admission to A+E and time in the department +/- reason for admission to department.

Complaints: common theme around long stay in department for speciality patients and stay overnight in department.

Friends & Family: as with Maidstone, during the transition period to the trusts new provider for FFT the unit has had fluctuating response rates. Optimum data in Q3 reported a positive response rate of between 85.9% - 100% which is above the national average. Overall positive responses remain above the national average, and do not alter significantly when the response rate increases.

Summary: the key issue for the unit has continued to be a high vacancy factor and recruitment. The unit has a current RN vacancy of 19.54 WTE at time of submission to Trust Board. This is an improving picture and the unit has welcomed recruitment of overseas nurses and supporting ENP roles. The team have continued to be proactive in considering new roles and currently are supporting two trainee nursing associates (TNAs) in practice.

Recommendation: to undertake a further review of staffing requirements and impact of any future changes as part of the Quality Impact Assessment of service development which includes a business case plan to increase MRAP to a 7/7 service to include increase in CSW hours to support.

4.2 **Paediatrics**

The majority of paediatric services are provided at the Tunbridge Wells Hospital. There is a paediatric provision at the Maidstone Hospital for day attenders, and Accident & Emergency department. The Accident and Emergency paediatric services are included in the A+E reviews.

The Paediatric service based at Tunbridge Wells provides an inpatient service for neonates, children and young people, accident & emergency cover, out-patient and community services.

This review considered the paediatric services for HedgeHog Ward, Woodlands, Riverbank Ambulatory and day surgery units. As part of this review reference was made to the relevant national guidance including the NQB 'Safe, sustainable and produce staffing. An improvement resource for children and young people's inpatient wards in acute hospitals' (June 2018), NQB 'An improvement resource for neonatal care (June 2018) and the RCN document 'Defining staffing levels for children and young people's services' (August 2013).

The service is compliant against the NCQ recommendations.
The RCN have 18 standards which cover the full range of paediatric provision. The service is compliant with all the standards bar one. This one relates to the recommended 'head room' allowance to cover leave. The head room for this service is set in line with the rest of the Trust (21% compared to an RCN recommendation of 25%).

Hedgehog Inpatient Ward (TWH): Please refer to Appendix 1

There are a number of challenges for the service, most notably the increasing demand for mental health services and the challenges in onward referral to the Children, Adolescent Mental Health Service (CAMHS). The team continue to explore the opportunity of recruiting mental health nurses with paediatric experience. In addition, there has been an increase in the

requirement to use escalation beds extending into August 2019 instead of planned closure in the April.

Woodlands (TWH) provides a 7 day service between 07.00 – 24.00 with planned surgery on 4 days. The unit consists of 5 assessment rooms for emergency care and 10 day case beds for medical and planned day surgery use

Riverbank (MH) provides a 5 day service between 07.00 – 19.30 Mon-Fri with planned surgery across 4 days. The unit consists of 7 assessment beds and 6 beds for day surgery

The consultation to work towards a more effective roster management and staff deployment model for paediatric services through the separation of ward / area budgets has now completed. This work will now move to implementing these changes on the Healthroster.

Clinical incidents related to nursing are low.

Friends & Family: response rates are variable however positive response scores are high, generally greater than 95%.

Summary: The directorate are working to ensure a more effective roster and budget management system with a plan to split by area (currently all amalgamated). There is ongoing discussion around roles including the ANP role and considering a TNA type role in paediatrics alongside career pathways from B5 to 8A. Also, considering apprenticeships to take play service to 7/7 which is a National requirement. Review of seasonal escalation plan currently mapped between October – March.

4.3 **Critical Care**

The underpinning approach for setting safe staffing levels within Critical Care was based in a concordance of recommendations from the British Association of Critical Care Nursing, the RCN Critical Care Forum and the Critical Care Society published as the Core Standards for Intensive Care Units (2013) with now more recent Guidelines for Provision of Intensive Care Services recommendations (GPICS) in October 2018. The recommendations for setting safe staffing levels are based on the acuity and levels of care provided based on national definitions.

The historical definitions have been levels 1,2 and 3 with level 3 being either full mechanical ventilation plus support for one or more organ/system failure, level 2 being respiratory support or support for a single organ/system failure, and level 1 being ‘ward fit’ care.

This approach was rationalised for the purposes of staffing establishments and capacity planning.

The traditional level 3 care bed is scored as 1 and level 2 or HDU style care being scored as 0.5. This means a critical care unit can flex both bed base and staffing accordingly.

The trust has provision for critical care beds on both sites. Both sites have a capacity equivalent to a dependency score of 7, with both units having physical capacity for 9 beds each.

Both units are staffed to the same level: **1 x RN to 1 x level 3 patient and 1x RN to 2 x level 2 patients.**

Both units have a shift leader or coordinator who is supervisory, with a unit manager providing overarching supervision and support Monday to Friday as part of their overall leadership role.

The nursing workforce involved in direct patient care is all Registered Nurses, with a small number of CSWs utilised for 'runner' activity and to support direct patient care on an ad hoc basis.

There is a clinical educator on both sites who supports the accredited Foundations of Critical Care Course.

Quality Indicators:
Review Appendix 1

Summary: shift profiles in line with national critical care guidance. Key staffing risk is age related (7 experienced staff reach potential retirement age within the next 2 years).
There is scope to increase critical care course numbers; external funding permitting. This would need additional resource to support learners in practice; this could be achieved by closer cross-site working and deployment of staff.

Recommendation: undertake review annually or as part of the Quality Impact Assessment for any planned service change. Current GPIC recommendations include consideration of the ITU RN workforce to be representative of B6's for up to 50% of the overarching level of establishment. Currently, the unit supports 3-4 nurses training on the ITU course but without guarantee on completion of the course of a B6. The team are considering how this could map into a training post / apprenticeship and ways to support career development in line with the GPIC recommendations however, current position of B6 establishments is unchanged.

Further establishment review is now recommended following the decision and confirmation of the surgical reconfiguration plans which will increase the dependency and requirements of ITU / HDU capacity. CSW support 24/7 will be recommended to support flow across the unit (5 areas) and communication.

4.4 **Theatres**

The methodology used for setting safe staffing levels for theatres is as described previously. Evidence base and guidance from the Association of Perioperative Practitioners (AfPP 2008 & 2011) was referenced to.

The principles for a single operating theatre are:

- Operating Department Practitioner (ODP) x 1
- Scrub Practitioner (either ODP or RN) x 2
- Runner x 1 (may be a CSW)
- Recovery RN x 1

A theatre suite may consist of several theatres, and as such there is a degree of flexibility in requirements for recovery personnel. However these fundamental principles need to be met for each theatre with a theatre suite to ensure safe delivery of care.

Tunbridge Wells Hospital has a theatre suite comprising of 8 theatres (including 8 anaesthetic rooms), 2 dedicated obstetric theatres, ophthalmic (11 theatres in total) and 3 recovery areas.

Obstetric Theatres are staffed to the same principles with an additional recovery RN for elective lists. This has been put in place by the team in response to learning from previous incidents and Serious Incidents (SIs).

For out of hours obstetric theatre cover the minimum staffing set for 1 theatre is on-call on site.

Theatres at TWH is budgeted for 129.5 WTE staff
Theatres at MH is budgeted for 76.34 WTE staff.

Maidstone Hospital has 11 theatres but not contained in a full suite. The theatre complex comprises of:

4 main theatres (1 suite)
2 ophthalmic theatres
2 short stay surgery theatres
2 procedure rooms (chronic pain and brachy therapy)
1 Orthopaedic theatre (MOU)

The theatres are staffed to the same principles as Tunbridge Wells Hospital in line with AfPP recommendations.

The Maidstone Hospital theatre case mix is predominately elective however the staff also provide cover to a range of satellite services including electrophysiology studies, interventional radiology, line insertion and cover to Priority House for electroconvulsive therapy.

Each theatre is led by a Band 6 and is overseen by the Theatre Coordinator.

The Theatre Coordinator is supernumerary.

Quality Indicators:

The generic indicators used for in-patient care do not transpose well to theatres.
The key issue for theatres is maintaining flow through the recovery room. On both sites there are often delays in transferring patients to a ward bed. This is an operational/capacity challenge rather than a staffing challenge.

Never Event(s)
1 - Wrong Route Medication (MGH) (declared as an SI 2020/1250) - Oral oxycodone was given IV instead of orally post-surgery in recovery.

Serious Incidents
Main SI's declared = 11 (7 TWH / 4 MGH)

Safeguarding SI declared = 1 (MGH)

Themes and Trends

- The quality of documentation needs to be improved, it needs to be legible and include dates and times
- Improvement in completion of patient risk assessments
- Training
- Communication and documented evidence of any communication / conversations

Complaints: are generally related to time delays between admission lounge and theatres, or when one of the recovery rooms is used for escalation.

Summary: budgeted establishment is correct to meet the AfPP recommendations. Challenges have previously been related to recruitment and retention, though improvements in recruitment have been seen and the departments have welcomed the recruitment of oversea nurses. There is a risk this may change if utilisation of theatres changes.

There is a potential impact on theatre staff through the colorectal reconfiguration of theatre sessions and speciality activity. Staff are proactively being give opportunity to develop new skills.

Operational flow problems can occur with escalation of beds into SSSU. Staffing for the admission lounge is not included into the TWH theatre budget and remains a cost pressure.

There are 2 Associate theatre practitioners due to qualify, 1 across each site. The ATP course is no longer supported by the training provider but there are proactive discussions in place of an ODP degree apprenticeship. There is consideration for using a TNA programme in place of the ATP pathways.

Recommendation: undertake bi-annual review or as part of the Quality Impact Assessment for any planned service change.

The AFPP Association of perioperative practice national audit is to be undertaken imminently and Anaesthesia Clinical Services Accreditation formal assessment is due to place in March 2020. To review and monitor outcomes / recommendations.

5. Head & Neck

Head & Neck provide discrete services for ophthalmology and ENT across both sites. The service has a satellite eye clinic in Medway.

Eye services provide both outpatient and day surgery services, with their own dedicated theatre/minor operations room. Patients requiring overnight care are cared for from within the main surgical ward bed base, predominantly on short stay surgery.

ENT Services are provided on both sites including an outreach service. Inpatient care is provided from within the main surgical bed base, predominantly on short stay surgery.

Ambulatory services have an establishment of 21.72 WTE with a vacancy of 0.6 WTE
TWH services have an establishment of 10.05 WTE with a vacancy of 1.46 WTE
Ophthalmic OP have an establishment of 19.34 WTE with a vacancy of NIL.
CNS' are at 3.6 WTE currently training in speciality to develop ACP roles.

The ENT Clinical Nurse Specialist Team provide an outreach service and support junior doctors. The ENT CNS provides onsite advice for the management of tracheostomy care and will support accident & emergency with pre-transfer reviews and care planning.
The services are small in terms of whole time equivalents which means there is limited resilience within the team. The key challenge for the Head and Neck team is attraction to the specialty as junior staffs are not routinely exposed to the specialty early in their education pathway. The team are supporting speciality training to develop Advanced Clinical Practice ACP roles within the area and are considering rotation posts through the units to support speciality areas and enhance resilience within the team.

There is no validated tool to support the review of staffing establishments for this specialty, as it is so dependent on location and colocation to other support services.
The professional judgement of the combined sisters and matron suggest that the funded establishment whilst currently meets the need for baseline services there is a need to ensure that staffing is reviewed in line with development of diagnostics, one stop clinics and ability to support WLI.

Quality Indicators:
SI's There were two reported SI's within 6 months at the time of reporting period which are being fully investigated

Falls: despite the perceived risks associate with ophthalmology patients, the number of falls is zero

No other nursing care related incidents

Complaints: 1 complaint reported relating to nursing attitude. Nil related to clinical nursing care.

Friends & Family: With the transition to a new FFT provider for the Trust Head and Neck are now participating with FFT and looking at ways to increase opportunities for patient feedback.

5.1 **Summary:** the budgeted establishment is sufficient to meet the current demands for baseline services however, when there is additional WLI, pre assessment cover or sickness in the team there is minimal resilience to be able to support this which causes an overspend. This establishment and budget will be reviewed annually and as part of the Quality Impact Assessment for any planned service change

The team are considering new ways of working and new roles and recognise the opportunity for technician roles to support increasing technology including the orthoptics team, Audiology health care science and Increasing specialists ACP to include botox.

6. Ophthalmology (OOPD) and Ears Eye Mouth Unit (EEMU)

The OOPD and EEMU is a high volume Out patients area with increasing demand to meet our populations needs of increasing age and sight conditions. The unit consists of 19 consultation rooms, 2 laser rooms, 2 treatment rooms, 1 minor op and 1 virtual room. The average number of outpatient attendances per week are >1000

The department works with colleagues across the Ophthalmic speciality including ophthalmologists, optometrists, orthoptist, technicians, medical photographers and the ECLO (Eye Clinical Liaison Officer – support by Kent Associate for the Blind).

Consultations include diagnostics and treatments undertaken as a one stop clinic whee possible. Intra-vitreal injections (minor op standard of procedure) have increased in demand by 121% in the last 3 years causing capacity and demand challenge
Waiting list activity current demand includes: 3 x Saturdays/ month and 4 x evening sessions/ month. Additional clinic requests between 10- 15 hrs/ week and are managed outside of budgeted establishment.

OOPD and EEMU 22.94 WTE establishment with NIL reported vacancies

Recommendation: Further review to quantify the increase in demand on services through ad hoc / WLI to be included in business planning to ensure staffing levels are considered to meet increasing demand.

6. Oncology

6.1 The Kent Cancer Centre operates services across both hospital sites as well as satellite units at Kent and Canterbury and supporting oncology service provision for Kent. The safe staffing review focused on the oncology outpatients department, the roll out of a haematology ambulatory service, establishment of the Medical Infusion Unit, the Chemotherapy units Charles Dickens Day Unit(CDDU) (MH) and Haematology Oncology Unit (HODU) (TWH). The Trust does not have a specific oncology ward however has an 18 bedded haematology ward which has been included in the ward review section of this report. The service is supported further by a workforce of Clinical Nurse Specialists which are reviewed continuously in line with service delivery.

Oncology OPD: based at MDG consists of 10 rooms with clinics running both AM and PM across 5 days. 1 x treatment room and 2 clinical rooms on Chartwell. Outreach clinics are supported at the TWH main out patients department with support from oncology staffing for these clinics. The unit is run on 2 RN (1 x nurse led clinic and 1 x RN to oversee coordination / management of the department) and supported by CSW. Staff also support the Radiotherapy trolley bay at the MH site. Within the budgeted establishment the Macmillan Information Centre manager and information assistant are included. The information centre is open Monday-Friday

Establishment: 9.81WTE Vacancies: 2.73 WTE

Business planning is reviewing increasing clinical capacity for outpatients which will require additional staffing to be included. Staff support clinical activity including complex dressing, injections and patients who attend “ad hoc”. Plan is for a phased approach to support business

plans however need to ensure sustainability of cancer standards with additional clinics. Current activity Approx 400 outpatients per day go through waiting area.
Approx 300 patients seen in Oncology clinics per day with an Average of 6/7 treatments per day.

Considering new roles and the Nursing Associate within oncology

Chartwell Unit: Provides Ambulatory services on a Monday to Thursday between 08.00 – 18.00 primarily for haematology patients. Activity is run through 8 chairs with a plan to increase to 10. There are approximately 20 – 25 patients who attend per day. The Chartwell unit was opened using existing Lord North Staff and PP budget with the decrease of PP usage. The haematology ambulatory work has increased with the successful implementation of pathways. The unit continues to aspire to "true" ambulatory model including a Ring Fenced bed.

All haematology clinical, consultants, medical team and CNS' are based within the unit to support patient activity and staffing.

Establishment: 5.0 WTE and 0.7 Bank line. Nil Vacancies.
Plan to increase to 7.58

CDDU: based at MH consisting of:

- 16 chairs
- Brachy lists – 2 per week
- Piccs / Ports – 3 – 4 Picc / port lists per week (anaesthetist / nurse)
- side rooms support brachy lists
- Iodine room – 45 per year
- Clinic room – nurse led clinics
- D bay – chemo chats / info session
-

The unit provides chemotherapy treatment, immunotherapies, nurse led clinics, chemotherapy information session, PICC placements and supportive therapies. The unit runs a Mon- Fri service with 9 trained (staggered start and finish times) supported by 2/3 CSW depending on theatre lists running.

Establishment: 21.8 WTE. Nil Vacancies

HODU: based at TWH consisting of 11 chairs, treatment room and provision of nurse led clinic in this space. The unit provides chemotherapy, immunotherapy, and supportive therapies. The unit has increased in size over the last few years in line with service demand. Nursing establishments were set at 1:1 (RN: Chair) space ratio to deliver safe staffing levels however current establishment at 11.05WTE. Rheumatology continues to use HODU for treatment delivery. The unit is staffed Mon – Fri 07.30 – 18.30 with staggered start and finish times delivered by 7 trained nurses and 1 CSW.

Quality Indicators (all units):

Falls: 0 falls recorded in oncology OPD, CDDU or HODU using Q3 data.

Complaints: 1 reported in CDDU regarding a PICC line. No other reported nursing complaints within reporting period.

Friends and Family: FFT has now been recently rolled out to the day unit's and outpatient areas and consistently achieve very high recommended scores.

6.2 **Summary:** There remains no validated tool to support the review of staffing establishments for this specialty, as it is so dependent on location and colocation to other support services. However, anecdotal evidence suggests 1:1 per chair space. Therefore the professional judgement of the combined sisters and matron suggest that the funded establishment is broadly meeting need. Units are utilising skill mix adjustments e.g. – supportive therapies delivered by non-chemo trained and chemo trained for specialist skills. Future workforce planning required with change in SACT delivery. Future mapping of service will need to plan for 6 day working (could be chemo or supportive treatments) and / or evening clinics. This would need to be part of business planning and business cases. Increase in monoclonal treatments. Consider new roles and the role of the TNA and NA to integrate into oncology. Ongoing recruitment and continue to support chemotherapy training.

7. Maternity

7.1 All acute Maternity services across both sites were part of the safe staffing review alongside the Community Midwifery Team, the Maidstone Birthing Centre and Crowborough Birth Centre. These reviews were undertaken with consideration using a traditional model of midwifery through the NICE guideline: Safe midwifery staffing for maternity settings (February 2015). The methodology acknowledged the Birthrate Plus (BR+) framework for workforce planning and strategic decision-making which has been in variable use in UK maternity units for a significant number of years. Continuity of carer has continued to be rolled out throughout England with effect from 2018 over a three year period and will impact on current and future staffing reviews and business case planning.

All Acute Maternity Areas: based at the TWH site and consisting of the 17 bedded Antenatal ward, Labour ward with 2 theatres (emergency and elective), 2 bay recovery area, 26 bed Post-natal / Transitional care ward, 4 couches in Triage and Day assessment unit 3 couches.

Significant work has been undertaken during 2019 to align the budgets with the changes made at the last staffing review. This has included 23 consultations and a full clinical competency review with all band 2/3 staff.

The combined WTE is:

Band	WTE budget	WTE required	WTE vacancy
Band 8a	1.0	1.0	0
Band 7	34.28	34.28	4.32
Band 6	72.59	72.59	8.31
Band 5	20.96	20.96	+8.91*
Band 4	6.95	6.95	3.36
Band 3	17.36	17.36	7.23
Band 2	24.92	25.92	+1.7*

Band 8a is cross charged to the LMS

*Where the WTE vacancy is reported at +8.91 and +1.71 these are over established according to the Banding but remains within the budgeted establishment overall through utilising vacancies from other Banding. For example: B5's over recruited using B6 vacancy (8.31)

Specialists are included in the above and supernumery band 7 coordinators for labour ward. Work underway to convert some band 2 staff to band 3 in line with the recommendations as set out by the RCM and national staffing framework

Current structure:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2
Triage/DAU	3.48	13.38	0.0	0.0	1.0	5.35
AN ward	1.0	7.7	3.0	0.0	1.4	5.35
PN ward	1.6	10.38	7.36	6.35	12.96	0.0
Labour Ward	11.7 (5.35 supernum)	27.45	10.0	0.0	0.0	10.7
Theatre	0.0	0.6	0.6		0.6	
ANC	1.0	7.68	0.0	0.0	0.0	4.52
Specialists	15.5	5.4	0.0	0.6	1.4	0.0
Total	34.28	72.59	20.96	6.95	17.36	25.92

Midwifery / CSW Ratios are as follows:
AN ward 2:1
PN ward 2:3
Transitional care 1:1
Triage 2:0.5
DAU 1:0.5
Labour ward 8:2
ANC – dependant on clinic activity
Theatre 2:1

1:1 Midwife to patient ratio care delivery during labour

Quality Indicators (all units)
Medication errors: We have been recognised for our improvement in medicines management

Falls: Acknowledge risk post epidural / elective surgery however nil reported.

Pressure Ulcers: a known risk to patients post epidural however Nil reported.

Complaints: Complaints managed and compliance of turnaround improving. Themes are predominately staff attitude and failure of good communication.

Friends and Family: Improving compliance with consistently achieving high scores 95%. Q3 data: 16.3% / 98.5%

Community Midwifery Team: establishment covers the full service of community midwifery with current caseloads based on 1:120 and a budgeted 56.26 WTE workforce. Current vacancy of 18.64 WTE. The establishment has the potential to require change with the impact of continuity of care. The recommended caseload is 1:99 for traditional models of care. This uplift has been included in the continuity BC for consideration of safe staffing. Whilst the current profile meets

the demands of the service there is limited capacity for an Out of Hospital Homebirth (OHH) service due to the high caseload demands and current level of establishment.

Crowborough Birth Centre: offers services to women living in the High Weald area and North East Sussex. It is a small unit consisting of 2 delivery room and 3 post-natal rooms. There is potential for converting a Post Natal room into the 3rd delivery room. Current establishment consists of 16.55 WTE with a MW : MSW split of 2:1.

Maidstone Birth Centre: offers services for women to deliver and learn how to care for their baby during normal births for "low risk" women. The unit has 2 birthing rooms and 3 postnatal rooms. 1 postnatal room can be converted to a labour room if required. Current establishment consists of 15.83 WTE with a MW: MSW split of 2:1.

The current profile for the birth centres meet the demands of the service; however there is a focus on the national agenda towards the Continuity of Carer work and this will require a business case to increase the current staffing levels to align with the recommendations.

Increasing the B3 staffing at the birthcentres has the division to improve the LoS based on the improved infant feeding services within the community. This would also align with the Baby Friendly Initiative accreditation and support the recommendations of the BR+ staffing review.

Quality Indicators for both birth centres: No SI's, Falls, Infection Control quality indicators reported.

Friends and Family: both units are signed up and compliance is good based on attendances to the unit. Score included in overarching maternity scores.

7.2 **Summary:** *Acute*: the team have been working on their electronic roster system which has been challenging to manage given the complexity of planning staffing across the whole service. The head of Midwifery has now got to the position where all of the rosters are clinically led and that the accountability sits firmly with each ward manager (currently it is collective). Continued work is being done to align the rosters and ensure these are well managed and hours are managed frequently. The change to the service is to ensure there is a good system in place for succession planning and to ensure safe staffing is prevailed throughout the service.

Community Midwifery: The current profile meets the demands of the service; however there is a focus on the national agenda towards the Continuity of Carer work and this will require a business case to increase the current staffing levels to align with the recommendations.

Crowborough and Maidstone Birth Centre: There is a continued focus on the national agenda towards the Continuity of Carer work which requiring business case investment to increase the current staffing levels to align with the recommendations. There are plans to move towards rostering annualised hours which will be due for consultation.
Hypno birthing – two sessions at Crowborough self-funded business

7.3 **Recommendations:** There is focus on succession planning and consideration of the need for changes to service delivery in line with the National agenda for midwifery care through the Continuity of Carer Model whilst continuing to ensure safe staffing is prevailed throughout the service. Some examples of key initiatives being explored are as follows:

- To ensure apprenticeship schemes are used when developing band 3 and band 4 staff with the backfill required.
- To be aware that with the continued role out of the continuity of care model will require an uplift of midwifery posts within maternity in order to achieve the 20% compliance target. This will be increased to 35% in the forthcoming year. A business Case will be required for proposed changes to align staffing levels with the recommendations of Continuity of Carer

- The Division are working to ensure apprenticeship schemes are being used when developing B3 workforce with the backfill required.

- Uplift for staff is currently 21% and this equates to approx. 2.5 study days per year per member of staff. Midwives currently have 5 mandatory training days to ensure they remain skilled. This is currently a cost pressure for all midwifery staffing. Consideration for the uplift to be increased to 23% will ensure costs pressures are accounted for.

8. Gynaecology Out Patient services:

8.1 The Trust provides gynaecology outpatient services across both sites of the Trust. These are based in the Women's Whitehead department on the Maidstone Hospital site and the Gynaecology OPD based in Women's and Children's, Green zone at the Tunbridge Wells Hospital. The reviews were undertaken with consideration to the following guidance: NICE guidance: Endometriosis (February 2018), Royal College Obstetricians and Gynaecologists (RCOG) Quality care for women 2016, RCOG Hysteroscopy 2011, NHSCSP Colposcopy 2016.

8.2 Both units offer outpatient clinics and procedural clinics to include: colposcopy, uro-gynaecology, fertility, Early Pregnancy Assessment Clinic, Consultant new patient and follow up clinics, Rapid Assessment Clinic and Hormone Replacement Therapy clinic and myosure at the Women's Whitehead Unit. Women's Whitehead delivers services through 2 treatment suites and 3 consulting rooms. TWH GOPD also delivers services through 2 Treatment suites & 3 Consultation Rooms.

8.3 Clinical activity is staffed to a plan of RN/ CSW 1:1 per procedural clinic session with up to 3 sessions to support daily. Mostly there are 2 x clinics for 5 x day's .Colposcopy 1:1 and Best Practice guidance Out Patient Hysteroscopy 1:1. Women's Whitehead unit is currently established at 6.54 WTE whereas Gynaecology OPD at TWH is established at 4.19 WTE.

Quality Indicators (all units)

Complaints: Nil

Friends and Family: Both units now signed up to FFT and will be starting to collect patient feedback.

8.4 **Recommendations:** Nursing establishments in Gynaecology OPD should mirror Women's Whitehead to work towards parity across services. Business cases need to consider nursing establishments when increasing clinical activity. Consider within the division using medical hours to offset costs. Need to start considering succession planning and as part of that to

consider the implementation of new roles as part of the annual business planning process in line with service needs.

9. Endoscopy

9.1 The underpinning approach for setting safe staffing levels within Endoscopy is based on a concordance of recommendations form the Joint Advisory Group on GI endoscopy (JAG recommendations). The JAG accreditation is the formal recognition that an endoscopy service has demonstrated competence. The scheme is both patient centred and workforce focused.

Both the Maidstone and Tunbridge Wells Endoscopy units are JAG accredited.

Safe staffing review was completed for the Maidstone unit which consists of 7 Recovery bays, 2 admitting rooms and 3 procedure rooms (one that is lead lined). The establishment is set at 26.72 WTE

Procedures include; colonoscopy, endoscopy, bowel scope, EBUS, EUS and ERCP. On call GI belled service, decontamination and emergency lists.

The staffing requirements are planned as follows:

For 3 rooms running
X 2 RN per endoscopy room for 2 rooms and one RN & x1 CSW for the 3rd room
X 2 RN pre assessing
X 2 RN recovery x 1 CSW for some of the time
X3 CSW in decontamination

For 2 rooms
X 2 RN per endoscopy room
X1 RN pre assessing
X 2 RN or 1rn 1 CSW in recovery
X 3 CSW in decontamination

For 1 room running
X 2 RN in endoscopy room
X 1 RN pre assessing
X 1 RN in recovery
X 3 CSW in decontamination

Quality Indicators:

Falls: 0

Complaints: 0 Nursing complaints at time of reporting period.

Friends and Family: Consistently receive high scores. Most recent 4.82 / 5.0 at time of report Score 99.8% privacy and dignity.

9.2 **Summary:** Staff working increasing hours due to introduction of Saturday working through waiting list initiatives.(WLI) Due to speciality substantive staff are covering these duties. Current staffing overspend correlates directly to the additional lists

Recommendations: To discuss with finance the total cost of WLI / additional list and to consider more sustainable ways in which the service can be staffed in line with the JAG recommended guidance. The team are also looking at how integrating new roles into the team including a training post / apprenticeship to support a more defined career pathway and succession planning. Further staffing reviews required if service is to be aligned to the JAG 24/7 Bleed rota.

10. Cardiac Catheter LABs

10.1 The Trust provides a cross site Cardiac Catheter service led by an 8A cross site manager, Both the Maidstone and Tunbridge Wells Cath Labs provide an average of up to 8 elective day cases and 4 inpatients daily.

The shift profile is staffed by 5 RNs to 1 CSW ration to include:1 X coordinator role, 2 X recovery area, 1 X pre-assessment nurses, 1 X RN in the lab and 1X CSW. The service does not usually run at night although if the unit is used for escalation this becomes a cost pressure to staff for the unit.

Quality Indicators (all units)

Falls: 1 in reporting period – 1 assisted fall

Complaints: Nil

Friends and Family: Consistently receive high scores. Most recent 4.85 at time of report

Summary. The service delivery model has been revised so that staff can cross cover each site. Additionally, they have approached the general manager to ask theatres to support the ODP. Staff support wards when able especially CCU and cardiology

Recommendations:

There is a cost pressure in the budget as the band 5 posts need to be aligned to the budget plan which has been a cost pressure during this financial year.

11. Main Outpatients

11.1 The Trust provides outpatients services across each site. Maidstone Outpatient Department see a demand of 100-400 patients per day. Tunbridge Wells report a demand of 350-400 patients per day.

Clinics operate between 08.00-18.30. Shift patterns are planned to ensure all clinics are covered and support flexible working In addition to long days, there is an early shift 08.00-13.00 and a late shift 13.30-18.30.

Outpatient staffing each site	Maidstone	TWH	Crowborough
Funding	13.86 WTE	18.81 WTE	This is a separate budget which is about to be

			aligned to the TWH budget for 2020/21
	B7 = 1WTE	B7 = 1WTE	
	B6 = 1WTE	B6 = 1WTE	B6 = 0.9 WTE
	B5 = 6.87	B5 = 7 (includes plaster technicians both sites)	
	B3 = 4.93	B3 = 7.09	B2 = 1.16

There is ongoing discussions regarding Health Roster management and the ability to provide a more accurate reflection on the flexibility that is required for planning outpatient staffing according to Clinic utilisation. The annual leave profile is managed in accordance with the needs of the service i.e. more nursing staff take annual leave during school holidays because there is usually also less demand for clinics at that time. Staff ratios will flex and vary to meet the demands of the service required.

Vacancies:
MH 1.0 WTE B6 and 0.85WTE B5 (B5 post under review to consider alternative role potentially a B3 Senior CSW or B4 Nursing Associate NA)
TWH 0.5 WTE B5 consideration being given to convert to NA role.

Staff on each site work flexibly to ensure cover is available for short notice changes to clinics or additional clinics at weekends or evenings. Additionally Staff work extra hours or bank shifts to cover additional activity requested by specialty teams to meet outpatient targets. The MH Clinics are geographically spread over multiple areas which require additional supervision requirements for CSWs supporting clinics away from the main areas.

Active room recycling allows any service to request to use clinic rooms that have been vacated by other teams. This is often at short notice so requires staff to be flexible or work additional hours to support extra activity. Clinics that run outside of normal hours (evenings and weekends) are supported by OPD staff working extra hours or bank shifts.
Currently there is no admin support for OPD so this is carried out by nursing staff.

The Crowborough Outpatients service is a separate service with oversight from the TWH manager; however the budgets are due to be aligned. TWH additional clinics have been added as Waiting list initiatives in the evenings and on Saturdays.

Quality Indicators (Both units)

SI's one reported at MH, an unavoidable pressure ulcer underneath a plaster cast.

Falls: Nil

Complaints: two patient complaints at MH this related to an expectation about treatment, secondly at TWH relating to Accessible information and poor communication, the lessons shared were that all staff was made aware of their responsibilities, the trust policy and expectations for delivering patient care.

Friends and Family: Recently started collation in OPD's, questions still being revised to reflect OPD.

Summary. Both services have a considerable daily footfall of patient's and have a loyal and committed staff base. The cross site service manager post is vacant; the service director is reviewing the role prior to reappointing. This may be an opportunity to review some across site working with a similar model to the pre-assessment surgical outpatient clinics to ensure consistent cover and staffing to all clinics across each site. Nursing staff provision to be included when planning for WLI and additional clinic capacity.

12. Section 2:

12.1 Ward reviews were undertaken using the methodology as described at the outset of this report and in line with National Quality Board Guidance (2016), NICE guidance (2017), Shelford Acuity & Dependency model, Professional Judgement (Telford) model and Carter Model Hospital (CHPPD). The areas reviewed include:

Maidstone Hospital	**Tunbridge Wells Hospital**
Ambulatory Medical Unit (AMU)	Short Stay Surgical Unit (SSSU)
Acute Stoke Unit (ASU)	Surgical Assessment Unit
Chaucer Ward	Ambulatory Medical Unit (TAMU)
Cornwallis	Coronary Care Unit (CCU)
Culpepper / CCU	Ward 2 / Acute Frailty Unit
John Day	Ward 10 Ward 22
Lord North	Ward 11 Ward 30
Mercer	Ward 12 Ward 31
Maidstone ITU	Ward 20 Ward 32
Maidstone Short Stay Surgical Unit (MSSU)	Ward 21 Ward 33
Maidstone Orthopaedic Unit (MOU)	Tunbridge Wells ITU
Peale	
Pye Oliver	
Whatman / Frailty	

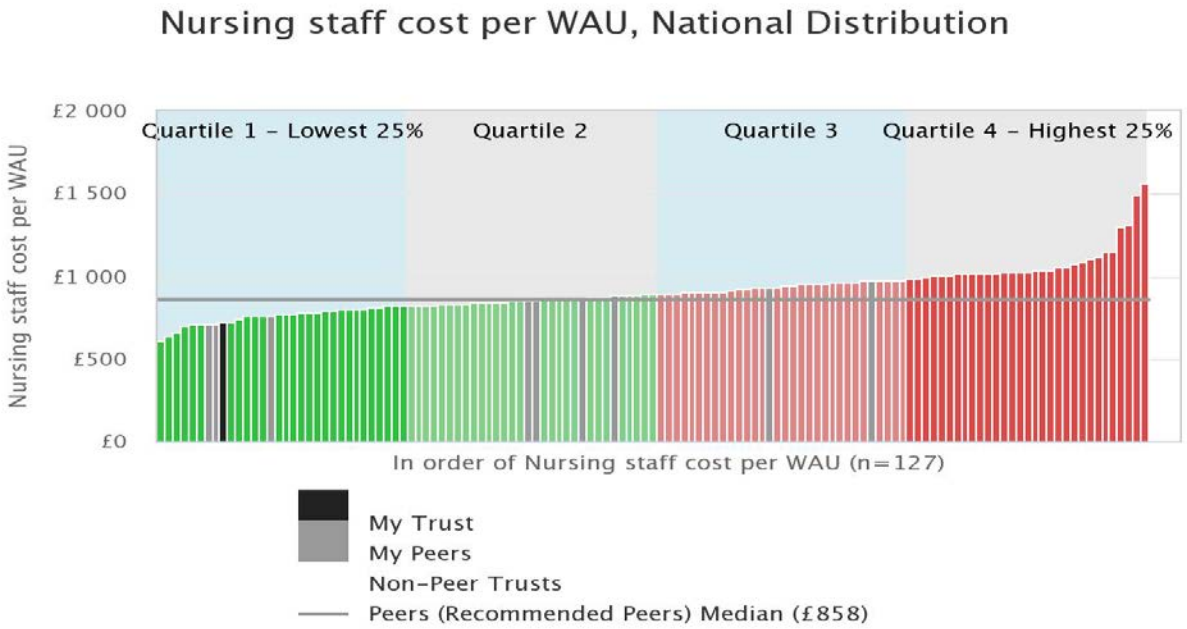
A summary of the outcomes from each ward review are seen in **Appendix 2** of this report. The summary provides details of each ward including the agreed and budgeted establishment, the skill mix for each ward, total number of vacancies on each ward, a summary of the nurse sensitive indicators and some commentary relating to each review.

12.2 Guiding Principles for our ward establishments

Ratios: RN:CSW = 65/35, RN:PT 1:5 – 1:8
Supervisory time for ward managers - 4 days per week for larger wards and 3 days for smaller wards
Ward Clerk – not included in nursing numbers
Headroom allowance 21% (to cover mandatory training, annual leave and sickness)

12.3 Carter Model Hospital comparisons:

NHSI Model Hospital Data: Nursing, December 2019



Nursing Cost per Weighted Activity Unit (WAU) (cost for average inpatient episode) is £ 716 per WAU £176 per WAU below national average. MTW is within Quartile 1: lowest 25%

Care Hours Per Patient Day:

National Median:	8.0
Peer Mean:	8.2
MTW:	**8.8** (Above Average)

Staff retention rate for Nurses 87.9% Dec 2018 (above national median)

12.4 Overview and Conclusion:

- No significant changes to establishments recommended where services remain consistent in their pathways and speciality.
- Safe staffing reviews to be completed alongside development and implementation of any new service redesign or care pathway.
- Minor changes, primarily within budgeted establishments to adjust skill mix. For example increase in band 6 funded from existing Band 5 monies for TSSSU and Surgical Bed flow coordinator role shared across Peale, Cornwallis and SAU (within budget)
- Changes within establishment generally volunteered by Ward Manager & Matron.
- Finance engaged with process, so changes to be included within business planning
- Data set reflect position as at January 2020.
- Staffing establishments are appropriate for ward specialty and layout.
- Wards are safe when nursing levels are at establishment
- Significant overseas recruitment drive which has significantly reduced the vacancy levels across specialities however, has changed the skill mix and level of supervision requirements to support new staff, new learners and integrate new roles within the context of the high operational demands of the acute provider setting
- Capacity and demand impacts on both substantive and temporary fill rates.

- The Vacancy Data for Registered Nursing (based on the 2019-20 Business Plan) is

Values	Total
Actual WTE	1,566.22
Budget WTE	1,765.89
Vacant WTE	199.66
Vacancy %	11.31%

The vacancy data according to Trac showing vacancies being actively recruited to are as follows: CSW (55.6WTE unfilled) RN (69.1WTE unfilled)

12.5 The Trust has furthered its work on Advanced Clinical Practice following publication of the competency framework. The governance for ACP is now in place through the Advanced Practice Assurance Group (APAG) and an initial scoping project has been completed to map the Nursing workforce against the competencies. This work is a key enabler for MTW to move towards a standardised position and definition of titles and competencies for ACP that will influence the development and deployment of new advanced roles that will enhance our patient pathways but also support us in meeting the wider workforce needs.

In summary, the budgeted establishment for the departments is broadly correct when at establishment. The key successes and challenges for this reporting period has been the extensive recruitment activity and appointment of overseas nurses which, whilst has significantly reduced the vacancy levels across specialities, has changed the skill mix and level of supervision requirements to support new staff, new learners and integrate new roles within the context of the high operational demands of the acute provider setting. Staffing skill mix and Quality provision is closely monitored to ensure patient safety

Opportunities are being actively explored as to how new roles and apprenticeships can be incorporated into the nursing workforce to deliver safe, effective and high quality care and in line with workforce recommendations. Where areas have successfully support the Trainee Nursing Associate role, through safe staffing reviews and workforce planning, the Nursing Associate role has been mapped into the nursing structure from December 2020 and onwards. Other areas where this role is not yet established will be supported through the safe staffing review process and workforce planning to introduce and embed the Nursing Associate role within the nursing establishment across the organisation. In addition to integrating the Trainee and Nursing Associate roles further mapping to support a future nursing workforce will include CSW apprenticeships, the Advanced Clinical practice competency framework and potential apprenticeships in development.

As part of any proposed change in skill mix, there will need to be a formal review of skill mix supported by the completion of a quality impact assessment (QIA) undertaken to ensure that any impact on the provision of safe staffing is clearly understood. The Trusts QIA for the introduction of the Nursing Associate role has been approved. Each department / speciality will build on this to ensure the QIA is localised.

13. Summary of Safe Staffing Key Recommendations by Division

Medicine and Emergency care Division:

- Ward 12 – no change to budget / establishment however consider using current vacancies to appoint into a B4 NA role
- A+E TWH – advised of separate business case requirement to increase MRAP 7/7 service to include increase in CSW hours to support.
- A+E MH - The team are keen to trial a band 3 /4 flow coordinator within the department and to employ an ENP to work at nights to support triage as a 'Hello' nurse. This would need to be incorporated into current business planning
- Ward 2 - With the proposed increase in AFU to move to 7/7 service the staffing will require an increase in establishment to support and to be included in business planning / case Aim to have 7/7 service by the end of the year based on 16 going through the unit staffing levels required: 2 RN and 1 CSW mon – sun LD – no change at present unless change in service delivery as proposed
- Ward 20 – currently established for 3 RN / 3 CSW at night however, consistently uses bank / temporary cover for 4th CSW at night due to either enhanced care requirements / dependency of patients. Recommend 4th CSW at night as substantive rather than bank / temporary.
- Whatman / Frailty: There has been no change to the level of skill mix on the ward which was previously mapped for 2 x RN to in patient and 3 x RN to assessment areas however, now with an increase in inpatient areas the change is for 3 RN inpatient areas and 2 RN in assessment areas. There has been a change to provide 7/7 service and extended hours which has required additional staffing numbers rather than skill mix.
    - Current WTE budget for 31.37 inclusive of nursing, care, ward and flow coordinator staff mapped to 14 inpatient beds and 11 frailty spaces
    - Service now provides for 20 inpatient beds and 5/6 frailty spaces - no change in skill mix allocation but requires an uplift in staffing numbers to 37.43 WTE difference of 6.06 WTE inc nursing, care, ward clerk and flow coordinators staff - to be included in business planning to re align budget as will remain overspent.

- Cardiac Cath lab Maidstone B5 posts should be aligned to the budget plan which has been a cost pressure during this financial year.

Women's Children's and Sexual Health:

- No changes to current establishment in gynaecology or paediatric services
- Reviewing Seasonal Pressures establishment for times of "peak" for paediatric service
- Business case for Continuity of Care model for staffing recommendations Maternity
- Implementation of changes following B7 consultation
- EGAU services increased to 24hrs – staffing established not increased at this time. Any additional staffing to support the increase in service activity will need to be included in business planning

Surgery Division:

- Looking at ACP roles across directorate and how this would benefit services – to be presented APAG
- TWH SAU – budget currently does not reflect the surgical coordinator role but should be included as this role is undertaken
- Surgical Bed flow coordinator role shared across Peale, Cornwallis and SAU (within budget)

- Safe staffing reviews will need to be undertaken and included in the surgical reconfiguration business planning.
- Endoscopy - Staffing reviews will need to be undertaken if service aligns to JAG 24/7 bleed rota – no change at present
- MSSU currently supporting WL for urology funded for 2 x early shifts but require long days – to be included in business planning as will continue to be outside of budget to support WLI.
- Support increase in senior nursing representation across the unit using current budget to uplift a B5 to a B6 – this does not reflect a change in establishment but offers career development, retention opportunity and increased senior nursing support on site.

Cancer Services:

- Separate Business case required to support Oncology out patients.
  Additional clinics for sustainability of cancer targets
- Separate business case to increase activity on Chartwell to 6/7 days services

Diagnostic and Clinical Support Services Division:

- Need to quantity the increase demand of ad hoc/ WLI activity within this year's business planning activity. No current recommendations to change staffing levels

14. Key recommendation summary:

14.1 New roles and apprentices to be considered across all areas to include the Trainee Nursing Associate and integrating the Nursing Associate role in further workforce planning. Backfill of CSW workforce to areas supporting apprenticeships, new roles and new learners

- Integrate TNA and NA into nursing workforce structure across the organisation and ensure finance and Healthroster are aligned to incorporate a new nursing line within the workforce structure.

14.2 The ongoing roll out of continuity of care model for maternity will require a significant uplift of midwifery posts within maternity in order to achieve the 20% compliance target. This will be increased to 35% in the forthcoming year.

14.3 Business cases to increase clinical activity MUST include nursing establishment reviews.

14.4 Any change to service redesign or development of new pathways of care MUST include a Safe staffing review of the nursing workforce to deliver safe, effective and high quality care and in line with workforce recommendations

14.4.1 The 2020 / 21 safe staffing forward work plan will focus on the continued move towards compliance with the recommendations set out the NHSi Developing workforce safeguards to include;

- Consideration to new roles and integrating these into workforce plans,

- Implementation of Safe Care through Healthroster which will provide evidence based method of acuity measurement through collecting patient numbers, acuity and dependency data that is real time and can be used for the optimum deployment of substantive staff.
- Further collaborative working with other healthcare professionals to ensure a multi professional approach to safe staffing

SAFE STAFFING REVIEWS SEPTEMBER 2019

Data period to cover last 6 months

Date:

Site:

Ward:

Review team:

	Detail
WTE Establishment: **WTE Vacancies**	
Budget **YTD** **Variance**	
Beds/Rooms:	
Shift Profile: **Early:** **Late:**	

Night:	
Ratios: **RN/CSW split** **RN/Pt:** **Current Staffing:** **CSW** **Apprentices** **Trainee Nurse Associates** **Nursing Associates**	**Planned v Actual**
E-Roster KPIs over last 6 months to include: **Sickness/Annual leave profile** **Staff turnover**	
Safe Staffing Acuity & Dependency (AUKUH) requirements:	
Activity/Turnover of patients (admits/discharges/escorts average per day – should be included in Acuity & Dependency)	
Quality and Safety Dashboard: **Last 6 months**	
Number of : SI's **Number of : MSSA Bacteraemia** **Number of : E.coli** **Number of : C - Diff**	
Pressure Ulcers:	
Falls:	
Nursing Care Complaints:	

FFT: Percentage response rate and positive responses	
AHP / Therapy contribution to ward:	

Discussion:

Conclusion/recommendation:

Staffing Review by ward					Ratios		New Roles	Nurse Sensitive Indicators (Q3)									Comments	Recommendation	UPDATE Triangulation Review May 2019
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	TNA / NA	Number of : SI's	Number of : MSSA Bacteraemia	Number of : E.Coli	Number of : C-Diff	P'Ulcers (cat2+) Q3	Falls Q3	Nursing Care Complaints (6 months)	FFT (resp/%positive)				
Maidstone	AMU	37.18	35.18	2	60/40	1:4.5, 1:4.5, 1:5.5	No	0	0	0	1 RCA - UA	0	4	2	5.0% / 100%	Falls relates to three months. Consideration given that during seasonal variation AMU is escalated + 8 trolleys consistently requiring 1+1 at night Approximately 25 admissions, discharged transfers, ambulatory and 15 AEC every day. Treatment suite days will have additional 2RN/ 1 CSW to run the unit.	No change to establishment if reamins at 14 beds. Encourage Band 2's to recruit to TNAs next cohort and backfill with CSW	5 x RNs 0700-2000 4 x supervisory days Treatment suite early - 1 x Rn mon - fri 0800-1600 1 x tr 10 - 1800 3 rntrained on night will need to request additional tr for escalation trolleys CSW 3 x long days and 1 x 8-1800 1 x csw at night - will need to request additional fro escalation Matron 8a 1 x WTE 2 x admin and clerical mon - fri 9-5 and 1 sat and sunday
	ASU	42.32	32.78	9.54	60/40	1:5 5, 1:5.5, 1:7	2 TNA's and planning to support a further 2	0	0	0	2 RCA - A	0	21	4	32% / 95%	Continue to work collaboratively with recruitment. Actively recruited junior nurses and are developing these nurses in their expertise within stroke.RN:PT ratio assumes Thrombolysis nurse in numbers. When this role is off the ward ratios increase to 1:6 and 1:9 Stroke assessors. Actively supporting and considering new roles including TNA's – additional CSW support would be beneficial to help with transitioning new structures within workforce. Awaiting outcome of judicial review re: HASU. Awaiting outcome of second RCA at time of review. Themes from complaints include discharge planning Plan to move EC to Chaucer will then review staffing moving between both stroke wards to increase knowledge and experience in preparation for HASU/ASU in Autumn/Winter 2020. Lead CNS working closely with STP on developments and patient pathways and Competency Booklet Pathway for TW and IP and walk in patients being reviewed currently	No Changes to current establishment Students – currently have 3 students on the unit – about to increase to 5 students Discussion about 'therapy associate' type roles and whether the team had considered such roles as part of their workforce plans The view is that the culture on the unit is very much that of rehab. competency framework – part of an internal programme	standard shifts LD / E / L / nights 5 tr (1 of which is stroke assessor) 4 tr 3 LD and 1 early and 1 late 3 tr nights and 1 x outreach 4 x CSW AM and 3 x Late and 2 x night 1 x flow coorindator and 1 ward coorodiante Monday to Friday 4 x supervisory
	Chaucer	22.92	16.4	6.52	50/50	1:8, 1:8,, 1:8	No	0	0	1	0	2	10	EC x2, W22 x2	57% / 92%	Chaucer became stroke rehab in September 2019. Ward 22 staff and service moved from TWH and Edith Cavell staff moved to Chaucer. There are 33 beds including 3 side rooms. Band 5 vacancies are now filled with overseas recruitment programme. Chaucer will have a weekly MDT meeting with a daily board round at 09.30 with 14.00 catch ups. There is a flow coordinator in post. The matron is planning an innovation for supporting families following a recommendation from a patient complaint. Staffing is now over long days 5/5, 5/5, 4/4	Staffing levels agreed with change in service to plan: 5/5, 5/5, 4/4	Chaucer accomodating stroke during tranistion works for HASu - 33 beds 4 tr (3 LD 1 e and 1 Late) 4 tr night and 3 csw 5 e and L csw (3 LD 2 e and 2 lates) supervisory 4 shifts 1 flow coordinator and 1 ward clerk
	Cornwallis	26.36	22.52	3.84	50/50	1:6, 1:6, 1:6	2 x TNA's	0	0	2	0	0	3	0	37.4%/91.2%	Following 2018/19 winter escalation team remained in Cornwallis location.Band 7 and 6 covering surgical beds 3 times a week. Currently only 3 supervisory days within the budget. Potential to increase to 5 or 6 remaining within budget as money moved from Peale to support this. This would enable Cornwallis to support 2 days beds and then remaining supervisory time as unit support. 2 x Ecoli RCA outcome: unavoidable	Increase supervisory days to 5 remaining within allocated budget this will incorporate the PDN aspects of the role within the directorate. 2 bed days Cornwallis, 2 bed days Peale Safe staffing discussion with a divisional plan as this will impact across other surgical units	19 beds with Hilary ward manager 3 x tr 7 (2 x LD 1 early and 1 late) 2 x csw 3 x supervisory days 3 x tr 1 x csw 1xb7 3x 6 11.4x 56.5 B2's wte 27.37
	Culpepper/CCU	33.08	29.15	3.93	50/50 65/35	1:6.5 Culp, 1:3 CCU	No	0	3	0	2 RCA's - UA	0	6	0	59% / 94%	RN:CSW ratio reflects CCU dependency. CCU and med combined (6 CCU beds, 13 medical. No changes in establishment previously. Establishment consistent with case mix unless escalation into Cath Lab recovery.	No change to establishment Consider introducing TNA's / NA's into establishment and other new roles Will need to support workforce review pedning discussions for cardiology services within the Trust.	CCU: 2tr xLD 1 x CSW LD - 2 tr xN 0 xCSW Culpepper: 2 tr x LD 2 x CSW LD - 2 tr x N - 1 x csw N WTE 34.1 1 x ward clerk 9-5
	John Day	44.12	31.48	12.64	60/40	1:6, 1:6, 1:6	No	4	0	0	2 RCA - A RCA-UA	8	11	5	42% / 97%	Trachy training days for staff successful and encouraging recruitment to area. When staffing levels and new starters stabilise will review ability to support apprenticieships. Plan to review BTS guidance, escalation policy used in respiratory ward at TWH / previous JD policy alongside staffing levels. Plan to meet again to review when additional information available.	No change to establishment.	5 tr LD (4 LD 1 early and 1 late) 4 x CSW LD 5tr x Nights 2 x CSW x nights 1 x ward clerk and 1 x flow coordinator. WTE 45.72
	Lord North	29.67	27.2	2.47	75/25	1:3.5, 1:4.5, 1:6	No	1	1	8	2 RCA - UA	2	3	0	59% / 91%	High ratio of RNs to cover chemo regimes. RN:CSW ratio reflects chemo requirements. Increase incidence of E.Coli - being investigated by Infection control and ward manger to find trends/causes. Action plans already in place, Fans removed) New treatment 7 correlation to be explored. Awaiting panel for 2nd RCA C-Diff.	No change to establishment. Consider new roles within budgeted establishment and how to support new roles / apprentices. Considering ACP role for directorate.	3 supervisory days. 1.35 / 1.45 /1.6 B3 ward clerks 0.67 x 2 shifts:7-12 and 12 - 2(5 hr ward clerk shifts) not covered at weekend no leave cover
	Mercer	36.72	33.66	3.06	55/45	1:6.5, 1:6.5, 1:8.5	1 TNA	0	0	1 RCA - UA	0	2	11	0	50% / 100%	Acuity of patients changed with an increase in the MFFD. With B5 leaving plan to recruit to B6 role as a secondment until firm plans re: all secondments impacting on ward. This is to support skill mix and senior support 24/7	No change to establishment To consider opportunities to look at new roles and ways of working including TNA's and apprentice CSW's when working with recruitment Look to place a 1 WTE B4 line to support TNA / NA Future staff plan:E- change to 3T, 1NA, 4 CSWS L-change to 3T, 1NA, CSWs N- keep same 1x flow co coordinator	4 trained ealry and late (3 1 1) 4 x CSw early and 3 on the late Nights 3 x trained and 2 x CSW supervisory day x 4 days 1 x ward clerk - 15% head room Dementia Key worker - 1 WTE - no head room
	MITU	43.97	43.97	0	90/10	Patient acuity of level3 then 1:1 level 2 is 2:1	No	0	0	0	0	2	0	0	N/A	Planned staffing levels are mapped to safe staffing according to dependency. Sickness and supporting new starters have caused some gaps. Minimal agency usage Escalation will impact on dependency levels – may rely on outreach Query apprenticeship role how would this be supported for training ITU staff by having the B6 available this would support apprenticeship pathway - Career planning growing / developing staff	AHP – Psychology / OT / SALT would be valuable addition to team to proactively manage patients rather than reactive referral when issue has arisen – GPIC recommendations – to be included in workforce plan 50 % of staff must have ITU qualification – then eligible to apply for B6 Consider increasing WTE of B6's to reflect 50% of overarching level of establishment. To include in central workforce planning as a potential request – this is recommendation against GPIC but will also support career development and future proofing workforce / retention. Supports 3-4 nurses training on ITU course @ Brighton – consider training post / apprenticeship Recommendations will be dependent on decision for surgical reconfiguration and dependency will need to be reviewed. If dependency levels move consider CSW support 24/7 to support flow across the unit (5 areas)	No change
	MSSU	15.65	14.51	1.14	65/35	1:6, 1:6, 1:9	0	0	0	0	0	0	1	3	97.70%	Establishment generally good. Increased activity noted, particularly in relation to additional waiting list initiative for urology, however not funded for 2 long days, Saturdays are funded for 2 early shifts but HR agreed 2 long days. Have implemented the twilight shift from 14.00-22.00 to support demand recommended in the last safe staffing review. Average of 25 admissions per day and 20 discharges per day 18 beds (2 x bays of 5 beds and 2 x bays of 4 beds)	No change to establishment. Need to consider options within budget / business planning to support WL initiative and cost pressure of 2 unfunded long days.	0700-2000 1930 - 0730 3 x tr LD mon - fri and 2 x csw 2 trained at night.mon - fri sat 2:1 LD- not budgeted for sat or Sunday night and should be closed on a sunday
	MOU	19.1	17	2.1	50/50:AM/PM 100 / 0 : Nocte	1:6 1:6 1:6	0	0	0	0	0	0	4	1	98.52%	Establishment generally good. New ward manager started in June, proud of patient safety record to date	No Change to establishment	
	Peale	22.28	20.44	0	60/40	1:6. 1:6, 1:8	2 x 0.6 WTE TNAs	0	1	0	0	0	3	1	57%/97%	1 bay of 6 beds plus 7 side rooms. 6 side rooms are for barrier nursing, but only 1 has en-suite bathroom, this is a challenge for nursing patients. MSSA RCA showed this was unavoidable. Average 2-5 admissions/ discharges per day, dependency average is 7x 1b, 6x0-1a. Consideration being given to colorectal services which may result in the ward expecting to see more urology and gynae surgery . Plan is to change shift to have 1 trained per day as ward coordinator and bed days to be supernumerary.	No change to establishment Will need repeat review pending ward any change in surgical services.	Peale 13 beds 3 x supervisory days Trained 2 xld, 1 xearl and 1 xlate CSW days 1 x early, 1 x ld and 1 x late 2 x trained and 1 csw night Reduction on a satruday and Sunday due to lower elective active 1 csw early, 1 long day and 1 night 22.56 WTE shift patters
	Pye Oliver	38.97	33.98	4.99	50/50	1:7, 1:7, 1:9	No	0	1	0	2 RCA's - UA	4	9	4	19.4% / 76.9%	RN:CSW ratio reflects the client group (gastro). Discussed staffing levels at night and if there is a need to consider additional supportstaff. Plan to review enhanced care requirements for the ward at night to see if this supports a review of establishment at night .	No change to establishment CSW's actively supported to consider TNA roles. Active recruitment and supporting overseas recruitment programme.	LD 0700-2000 / L 1330 200, E 0700 - 1500 / Night 1930 - 0730 SPN 0700-1500 4 tr and 4 csw E 4 tr and 4 csw - E 1 x flow coorodinator 1 x ward clerk - needs 15% head room 3 tr and 3 CSW Expecting 3 x SPNs WTE 40/97

	Whatman / Frailty	29.94	26.94	3	65 / 35	1:6.5 / 1:6.5 / 1:6.5 Frailty 1.4	1 x TNA	1	0	0	2 Com. acq. 2 post 72 hours RCA - UA	1	10	0	60.3% / 90.2%	Whatman changed 3 years ago to provide in patient and a mon - Friday 9-5 frailty patient service and was budgeted according to this. The frailty service was increased to 7/7 extended hours 0800 - 2000 and 9-5 at weekends. This is mapped to 14 in patient beds and 11 assessment trolleys. With this change an additional B6 and B2 were agreed from frailty budget and are reflected in current budget settling. On top of the 29.94 is 1.85 ward clerk and 1.0 flo coordinator. Since the introduction of frailty the service has been persistently in escalation >12 months including throughout increase service. Divisional plan to map to 20 in patient beds and 5 / 6 assessment areas which will not change the skill mix requirements but will increase the staffing numbers for the ward establishment. Currently ward is staffing to this level and therefore need to change budgeted establishment to reflect requirement as consistently over spent.	Recommendation: Whatman / Frailty: There has been no change to the level of skill mix on the ward which was previously imapped for 2 x RN to in patient and 3 xRN to assessment areas however, now with an increase in inpatient areas the change is for 3 RN inpatient areas and 2 RN in assessment areas. There has been a change to provide 7/7 service and extended hours which has required additional staffing numbers rather than skill mix. Current WTE budget for 31.37 inclusive of nursing, care, ward and flow coordinator staff mapped to 14 inpatient beds and 11 frailty spaces Service now provides for 20 inpatient beds and 5/6 frailty spaces - no change in skill mix allocation but requires an uplift in staffing numbers to 37.43 WTE difference of 6.06 WTE inc nursing, care, ward clerk and flow coordinators staff - to be included in business planning to re align budget as will remain overspent.	5 RN early and 3 CSW 5 tr and 3 CSW late 2tr and 2 csw nights. Based on 14 in patient beds and 11 assessment trolleys open mon - Friday 9-5
Tunbridge Wells	SSSU	27.18	27.18	0	60/40	1:6, 1:6, 1:7.5	No	0	0	1 RCA UA	0	0	1	4	No score	Discussed current workforce structure and senior level support currently 1x B7 and 1 x B6, still to implement the change of up banding a band 5 to create an additional band 6 form the last review. Ward is staffed for 25 beds for 23 hour stay. Beds 1-9 day cases and not staffed overnight, 10-25 should be elective and radiology but often escalated. very rare to canel elective beds and see about 20 elective patients per day. Staffing ratio established according to original plan of 12 beds and 9 trolleys – permanently escalated to 15 which increases as escalation increases to a potential total of 41 spaces therefore often difficult to establish definitive levels. Increasing the CSW support at night has helped significantly to reduced risk of falls in addition, SSSU does not have housekeeping support and the additional care to refreshment and dietary needs can be met with the CSW support FFT still needs to be addressed, complaints relate to managing expectations of single rooms, lost property and communication not nursing care Need to increase FFT and suggested using a nominated named nurse per shift or ward clerk	No change to establishment Recommend and support an additional B6 post to offer further senior nursing level support within budget. 2 x CSW rostered at night has reduced risk of falls and if remains escalated at 15 +9 or more then this is additional care requirements and need to be part of planned numbers. Previous discussion included: Consider current workforce structure and how new roles and apprentices could be Possibilities to include: CSW supported as TNA Backfill CSW with Apprentice CSW Advertise now for NA as other areas will have qualified NA's Consider implementing "Always Event" "Hello my name is" to help with privacy and dignity issues / communication themes arising Have used B2 vacancies over recruited to B5 establishment	5
	SAU	18.01	16.48	1.53	75/25	1:4, 1:4, 1:4 *Variable*	Support placement	0	0	0	0	0	2	0	Average score 97% positive	Capacity is 3 x 23 hr beds and 6 assessment trolleys. Takes GP and A&E referrals. Covers surgical assessment clinic and day cases. *Variable* RN:Pt ratio depending on demand and escalation. Attendances - Average of 100 Converted as (admissions)– 120 per week Discharges – 3-6 Inpatients - Days cases (returners) in addition Turnover of approx 30 mixture of 0 length of stay per day but with differing complexities .200 + attendances of which approx. 50% will be admits and 50% returners planned	No change to establishment Consider New Roles? Potential for ACP roles/advanced assessment roles within the unit Surgical coordinator role taken from staffing numbers should be incorporated into budget setting	
	TITU	53.81	52.81	1	90/10	Patient acuity of level 3 then 1:1 level 2 is 2:1	No	0	1	0	1 RCA - UA	1	1	0	N/A	Consider role of Nursing Associates in the future –will be dependent on developing local competencies due requirement for IV competencies. Would be happy to support a placement on ITU to support TNA training AHP – Psychology / OT / SALT would be valuable addition to team to proactively manage patients rather than reactive referral when issue has arisen – GPIC recommendations – to be included in workforce plan Correct level of staffing for dependency. Due to continued escalation and planned surgical reconfiguration Dependency 8.5 needs to be mapped against the GPIC Escalation will impact on dependency levels – may rely on outreach	Currently 1 x WTE clinical educator and 0.5 WTE x clinical audit lead would need to review hours of clinical educator / audit if increase in dependency and pending any changes from a surgical reconfiguration if this increases dependency With increase number of patients would need to increase level of audit support Currently Support 4 staff per year at Brighton for ITU course 50 % of staff must have ITU qualification – then eligible to apply for B6 Consider increasing WTE of B6's to reflect 50% of overarching level of establishment. To include in workforce planning as a potential request – this is recommendation against GPIC Query apprenticeship role how would this be supported for training ITU staff by having the B6 available this would support apprenticeship pathway - Career planning growing / developing staff. This would need to be included in business planning.	
	TAMU	58.7	54.92	3.78	70/30	1;6	2 x TNA's	4	0	0	2	2	21	1	10.6% / 100%	Capacity is 28 beds across 7 bays (4 beds per bay). Ambulatory - 4 spaces and 2 x SR. AEC - 4 spaces. Average 30 patients per day ambulatory and AEC 17 patients per day. AMU approx turnover of 10 patients transfer / discharge per day. Plans to extend AEC to 8 spaces through moving Ambulatory location. Have recruited actively to vacancies supporting apprentices, new roles including: TNA's and Drs Assistants and unit coordinators.	No change to current establsihment. Recommend staffing review on relocation of services / change in patient flow Build in training post for CSW and TNA / NA's	9 x Long days x trained 1 x supervisory day (ward manager) 4 x csw long days 6 x trained on nights 7.30 - 7.3- 3 x night csw Drs assistant now in post B3 mon - fri budgeted establishement 61.14
	CCU	18.32	13.47	4.85	75/25	1;2.5 / 1;2.5 / 1;2.5	No	0	0	0	0	0	3	0	90.9% / 100%	Capacity is 8 rooms.Fast band 5 turnover over the last few years due to career progression additional band 6 role to support career progression within budgeted establishment.	No Change to establishment Consider new roles to support career progression within the unit. Such as ACP role. Consideration for TNA next cohort	3 x trained early and 3 trained, CSW x 1 LD 3 trained x 0 CSW night supervisory shifts 2 shifts ward clerk .46 19.57 WTE
	2 / AFU	45.31	37.31	8	50/50	W2: 1;6.5/1;6.5/ 1;8.5 AFU: 1;4	1 x TNA	5	0	0	2 -RCA UA	0	32	2	41.3% / 89.5%	Ward 2 - 26 beds all single rooms. AFU 8 assessment areas. Recruited actively into vacancies and continue to support new roles and apprentices.	No Change to current establishment however, With the proposed increase in AFU to move to 7/7 service the staffing will require an increase in establishment to support Aim to have 7/7 service by the end of the year based on 16 going through the unit staffing levels required: 2 tr and 1 csw mon – sun LD	Long days Nights and earliess and lates 1 x tr in AFU 1 and 1 x late 1 x CSw early and late Ward 2 - 4 tr (3 long days 1 early 1 late) x 4 csws 3 trained ward 3 x csw full time ward clerk and flow coordinator 48 WTE in budget
	10 now 32 Moved October 2019	40.02 / 22.22	31.3 / 19	3	65/35 50/50	1:4, 1:7.5, 1:10	1 x TNA	2	1	0	2	2	6	1	14% / 92%	Skill mix adjustment at night a considered risk by the ward team in line with a high dependency and moderate acuity.Ward moved to ward 32 with 20 beds so recruitment has been halted as they will require staff for 20 beds and supporting PPU which will have separate staff and 10 beds, have had 6 RN's leave in 6 moths for relocation, promotion, work life balance and career progression but have welcomed overseas nurses	No change to establishment but skill mix in shift pattern might require review following move	3 x tr long day 3 x tr early 4 csw 1 x tr late 4 csw 3 x trained at night 3 x csw 5 x supervisory admin and clerical 1 x wte b3 wte requirement 42.8
	11 now 10 moved October 2019	35.38	31.08	4.3	65/35	1:5, 1:6 1:7.5	1 x TNA	0	2	0	2	0	9	0	2% / 100%	Majority of patients come from A&E, Specialise with patients with tracheostomy and tracheostomy changes, airway problems and from ITU. Tna will take up a band 5 vacancy as a band 4. Both MSSA and Cdiff were non-ward attributable, although had PII twice. Daily ward rounds with therapists. Average of 5 admissions daily and 40 discharges per week. TNA works Monday-Friday with CSW shift pattern but not Wednesday/Thursday as in school or placement. 6 staff nurses resigned in last 6 months to other areas ITU, HODU and renal dialysis. 1 CSW transferred to X-ray department, sickness is low and AL managed well not above 15% . Have welcomed overseas nurses to team	No change to establishment . Team have now moved to ward 10 but remain at 30 beds.	4 x tr long day 2 x tr early 1 x tr late 4 tr night 5 x supervisory days CSW 4 , 3 , 2 2 x LD , 2 eary, 1 late and 2 night WTE 42.81 (increase in 2 wte)
	12	43.6	29.95	13.65	60/40	1:6, 1:6, 1:10	1 x TNA	3	1	0	1 RCA - UA	1	27	4	47% / 93%	Current Plan staffing levels satisfactory when vacancies all filled however, whilst the numbers look much improved there are currently a high percentage of new starters, learners and SPNs requiring support to embed into the ward. Cosnider recruiting to NA post.	No change to total establishment. Consider New roles including TNA / NA	5 X TR EALRY 5 x trained late (2 x long days 3 early and 3 late) csw x 4 ealry 3 x csw lates 3 x trained nights - 4 x csw supervisory (Wednesday off) ward clerk 1.0 wte and flow coordintaor 1 wte
	20	35.56	35.56	0	40/60	1:10, 1:10, 1:10	No	2	1 RCA - UA	0	3 A/W Panel	5	33	3	81%/83%	RN/PT ratio reflect MFFD case mix. With recent change to stroke services at MTW W22 staff relocated to W20 with new unit manager therefore staffing levels fully recruited to. Working with Falls lead re NHS collaborative programme.	Staffing requirement changes according to dependency requirements on ward. Establishment includes a flow coordinator to be captured on A+C line of roster. Increasing B6 – 3 x WTE within funding to support senior cover 24/7 within budget PvA has consistently shown over fill rate at night for CSW over last 12 months due to dependency needs of the ward therefore support recommendation to have additional CSW at night to be included in business planning	
	21	41.4	37	4.4	70/30	1:5, 1:6, 1:6	2 x TNA's	2	0	0	0	2	16	4	21.7%/100%	RN:CSW ratio reflects acute respiratory care. Ward accommodates patients from all specialities requiring NIV and tracheostomy care. Specific SOP for staffing regarding L" patient. Ward capacity is 3 L2 patients. For each further 2 L2 patients and additional RN is required Use band 5 vacancy and consider having a band 4 1.0 WTE and B3 TNA WTE line Discussion of potential ACP role across directorate	No change to establishment Supporting TNA	tr x 6 early 5 x trained late CSW x 3 early and late tr x 5 night and 2 x csw ward clerk 1.0 wte 8-4 flow coordintor 1.0 8-4 supervisory time 30hrs 44.2 WTE
	22 Moved from ward 32	47.37	32.74	14.63	60/40	1:6.5,1:6.5, 1:10.5	1 TNA	0	0	0	3	1	29	1	44%/89%	Change in ward speciality from acute stroke to general medicine ward working to frailty pathway. LOS increased – complex patients part time consultant – impacting on decision for patients - escalated. Discharge profile 3-7 per week 3 x C-diff: 1 due to panel 1 x unavoidable and 1 x avoidable (locum consultant not followed process re: microbiology) no lapses in nursing care	Informed that the current safe staffing levels were agreed within the Division at the time of ward move from ward 32 to 22 with an increase to 32 beds therefore, the triangulation data by which the budget was set is out of sync as this was aligned to "old" W22. Ade to take lead on budget setting with staffing levels as agreed by division 5/4, 5/4,3 / 4. Georgina and Fay to take a lead on evidence enhanced care requirements / specialist above / beyond the pva of current establishment setting. Need to quantify the level of need above plan before being able to make formal recommendation. Advised always to ensure safe staffing levels and even if not planned, undertake enhanced care risk assessment if additional resource required to staff ward safely.	

	30	38.74	38.74	0	60/40	1:5, 1:7, 1:10	1 x TNA	4	2	6	0	2	19	2	23%/100%	With full recruitment current staffing level appropriate. Acuity depends on A&E admissions vs electives as well as outlying medical/surgical patients, turnover has been high but ward welcomed 9 overseas nurses. Approximately 3-4 discharges a day but variable the ward is well supported by 3 physios and 2 OT's.	No change to establishment	Correct for trained mon to Friday 4 csw on all shifts. 1 wte ward clerk 8-4 mon to Friday Due to appoint flow coordinator within vacancies. 42.27 WTE shigft pattern
	31	45.12	43.94	1.18	60/40	1:6, 1:7.5 1:10	2 x TNA's	3	1	0	0	6	16	0	Nil response rate	PDN between ward 30 & 31 to support new staff, also supports working clinically when under pressure. Have welcomed overseas nurses, but have previously been dependent on bank/agency. There are 6 nurses on an early which includes a supervisory role making it difficult to ensure 2 RNs to a section Monday to Friday, ward manager and matron identify need to return to funding/staffing the extra shift as to maintain safety. Well supported by AHPs	To consider increasing an extra RN each day for an early shift, a business case would be required to change the establishment To consider new roles to fill vacancies such as AHP physio, twilight shift, TNAs	5 trained + 1 supervisory 4 days per week 4 trained late and night. CSW's 5 early 4 late 3 night 1 wte band 3 8-4 Band 3 flow coordinator 8-4 mon - fri wte 45.82 shift pattern
	33	23.6	23.48	1.12	80/20 Mon-Fri 60/40 Sat-sun	1:7, 1:7, 1:7	No	0	0	0	0	0	2	There is a deep dive into the number of compliants on the ward, could not provide numbers at time of review	50% / 100%	Ratios for RN:Pt reflect the 10 in-patient beds. The staff also cover the 5 clinic beds for EGAU which is separate to ward 33. There are 4 trained in the day and 1 at night 8.03 WTE are needed to provide the service but team operates on 7.6 WTE. Business case recommended in the last safe staffing review has not been been actioned. 15.88 budgeted but we require 18.73 to run the ward as planned with 2 trained in the day and 1 trained at night on EGAU and 2 trained on day and night on ward 33. This is a shortfall of 2.85WTECSW requirement are 2 during the day across the floor and 1 during the night. Currently budgeted for 7.6WTE and require 8.03WTE. This will mitigate for any addition support required for chaperone facilities which will offset the requirement for the sonography team.	Business case will be required to increase staffing levels according to activity based on the introduction of a 24hr EGAU service	10 in patient beds 5 rooms EGAU 4 trained in total for the day Monday- Friday Weekend 3 x trained at weekend Long day 0700 - 2000 x 2 0700-1500 RN'sTrained 2 13.30 - 2000 Tr x 2 Night 19.30 - 19.30 3 trained CSW's

Staffing Review by non ward areas					Ratios		Nurse Sensitive Indicators (Q4)					Comments	Recommendation
Site	Non Ward Areas	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
Maidstone													
	Endoscopy	23.4	21.4	2	X 2 RN per endoscopy room for 2 rooms and one RN & x1 CSW for the 3rd room X 2 RN pre assessing X 2 RN recovery x 1 CSW for some of the time X3 CSW in decontamination		0	0	0		4.9 score	Saturday list was not part of the previous safe staffing reviews or mapping Current overspend of 42K directly correlates to Bank / agency / overtime to support lists and is a cost pressure. Staff are consistently working increased hours to support additional work. Due to area of speciality	To discuss with finance total cost of WLI / additional list and need to map additional staffing levels according to the JAG recommended guidance If uplift required will need to also consider new roles to develop staff, offer career structure and succession planning. To include in Business planning
	Womens Whitehead Unit	7.02	6.54	0.48	50:50 proceduarla clinical	1;1 during procedure	N/A	0	0	0	To start FFT now	Clinical activity and services subject to increase in March 2019. RN/ CSW 1:1 per clinic session with up to 3 sessions to support Mostly 2 x clinics for 5 x days Coloposcopy 1:1 (Best Practice in Out Patient Hysteroscopy 1:1 would not achieve best practice guidance	Business case needs to ensure nursing establishment is reviewed in line with increase in services. Services likely to grow small initially with minimal impact to nursing however, as clinics become full will increase on nursing establishment requirements. To consider new roles in business planning in line with service needs ? TNA ? medical support
Tunbridge Wells													
	Gynae OPD	3.51	4.46	Band 5- 1.90 (actual 1.73 in post (dual role to include 0.27 endo CNS))(0.17vacancy) Band 3- 0.68 (actual 0.64)(0.2 vacancy) Band 5- 1.90 (actual 1.73 in	50:50 per clinic session	RN/ CSW 1:1 per clinic session with up to 3 sessions to support	N/A	0	Specialist drugs such as HRT	0	To start FFT now	Band 8a – Across site Colposcopy not on budget but support mainly at TWH) Clinical activity and services mirror level as that provided at Women's Whitehead however staffing levels significantly different. Vacancy factor in previous budget setting has impacted on staffing level. Band 8A Colposcopy lead often helps clinically if needed. Within her current role is the BSCCP lead – strict criteria	Need to mirror whitehead Band 8a – National Guidance cites it should have accountability of 8B level to undertake BSCCP role for reporting cancer figures therefore currently outside guidance. Need to start considering succession planning - what role would this be? Band 7 to manage unit and specialise To work towards parity across services Consider using medical hours to offset costs Business case requirements

Review of the Board Assurance Framework 2019/20	Chair of the Audit and Governance Committee

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 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 objectives are met. The BAF is managed by the Trust Secretary, who liaises with the persons responsible for empowering our staff 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 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 objectives took into account the risks faced by the Trust.

Objectives for 2019/20, and summary of year-to-date position

The objectives in the BAF were approved by the Trust Board on 23/05/19. The latest summary rating of the 12 objectives from the person responsible for empowering our staff (in terms of the confidence of achievement by year-end is as follows):

Objective (measure of success)	Confidence[2]
1. Reduce our falls rate while in hospital to 6 per 1'000 bed days	Amber
2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020	Red
3. Improve complaints performance to 75% across all divisions and directorates by March 2020	Amber
4. Improve our vacancy rate to 9% by March 2020	Green
5. Achieve staff engagement score of ≥ 7.2 within 2019/20	Red
6. Implement the planned surgical reconfiguration by the end of 2019/20	Green
7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019	Green
8. Ensure that 85% or more of cancer patients are treated within 62 days	Green
9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment	Green
10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours	Green
11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care	Green
12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100	Green

Revised process for oversight

In November 2019, the Trust Board approved a proposal that the 12 objectives within the BAF should be devolved for oversight by one or more Trust Board sub-committees, and that reports on the objectives be submitted to each sub-committee. The proposals noted that after each sub-committee had considered its objectives, the full BAF would then be considered by the Audit and Governance Committee[3], and then be considered by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team).

When the proposals were approved by the Trust Board, it was noted that objectives 6 and 7 were both strategic objectives and should therefore be overseen by the same sub-committee. Both objectives have therefore been allocated for oversight by the Finance and Performance Committee (instead of also the Patient Experience Committee, as was originally proposed for objective 7). None of the objectives have been allocated to the Trust Board's other sub-committees (the Charitable Funds Committee and Remuneration and Appointments Committee).

The proposals did not involve any changes to the format of the BAF document. However, the increase in the frequency of oversight by the Trust Board's sub-committees has meant that the BAF has to be updated more frequently (including the ratings of the "Confidence that the objective will be achieved by the end of 2019/20").

[1] HM Treasury: Assurance frameworks

[2] This is the latest confidence rating of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20

[3] However, as the Audit and Governance Committee only meets each quarter, it was expected that each sub-committee's deliberations on the BAF would feature in the summary report from that Committee to the Trust Board i.e. before the Audit and Governance Committee was able to the report to the Board.

Submission to other forums
The BAF has been submitted to the following forums prior to being submitted to the Trust Board:

- The Executive Team Meeting on 21/01/20, 18/02/20 and 10/03/20 (the full BAF)
- The 'main' Quality Committee on 15/01/20 and 15/03/20 (objectives 1, 2, 3, 8, 9, 10 and 12)
- The Trust Management Executive (TME) on 22/01/20 (the full BAF)
- The Finance and Performance Committee on 28/01/20, 25/02/20 & 24/03/20 (objectives 6 to 11)
- The Workforce Committee on 30/01/20 (objectives 4 and 5)
- The Patient Experience Committee on 04/03/20 (objective 3)
- The Audit and Governance Committee on 19/03/20 (the full BAF)

Review by the Trust Board
Given the revised process noted above, this is the third time during 2019/20 that the Trust Board has seen the populated BAF. Trust Board members are asked to review and critique the content, by considering the following prompts:

- Are the 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?

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

Year-end review of the BAF
As is the case each year, the year-end review of the BAF for 2019/20 is scheduled for consideration at the Trust Board on 30/04/20. That review will report the year-end status for each objective, in terms of whether they were "Fully achieved", "Partially achieved" or "Not achieved".

Additional aspects relating to the Risk Register
A summary of the status of the Risk Register is also enclosed in Appendix 1. Having reviewed the current list of red-rated risks, it is considered that the substance of each is 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?

- The Executive Team Meeting on 21/01/20, 18/02/20 and 10/03/20 (the full BAF)
- The 'main' Quality Committee on 15/01/20 and 11/03/20 (objectives 1, 2, 3, 8, 9, 10, and 12)
- The Finance and Performance Committee on 28/01/20. 25/02/20 and 24/03/20 (objectives 6 to 11)
- The Trust Management Executive (TME) on 22/01/20 (the full BAF)
- The Workforce Committee on 30/01/20 (objectives 4 and 5)
- The Patient Experience Committee on 04/03/20 (objective 3)
- The Audit and Governance Committee on 19/03/20 (the full BAF)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [4]
Review and discussion (taking into account the prompts listed on page 1)

[4] 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 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients experiencing a fall while in hospital

Objective (measure of success) *Objective*
1 Reduce our falls rate while in hospital to 6 per 1,000 bed days

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Increased demand and escalation of beds resulting in patients nursed in inappropriate areas.
2. Staffing; vacancies, unfilled shifts (although this is expected to be a reduction problem due to success in overseas recruitment)
3. Staff training on falls prevention and associated equipment

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Revised pathways of care and improved patient flow (1)
b. Recruitment strategy: overseas and open days (2)
c. All patient facing staff have access to falls prevention training (3)
d. Bespoke training has been arranged for overseas nursing staff (3)
e. Falls prevention is a Commissioning for Quality and Innovation (CQUIN) target for 2019/20 (which is raising awareness of falls prevention) (3)
f. September 2019 was Falls Awareness Month, so actions were taken during that month (3)
g. A new member of staff has been recruited (who will report to the Falls Prevention Practitioner), to support efforts regarding falls and moving & handling (3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Continuous monitoring of incidents to identify themes and trends and implement learning.
2. KPIs for Falls report to the divisional dashboards
3. Monthly performance report submitted to 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 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"

Person responsible for empowering our staff: Chief Nurse

Trust Board sub-committee responsible for oversight: Quality Committee

Confidence that the objective will be achieved by the end of 2019/20[5]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The year to date rate (at month 10, January 2020) is 6.11 per 1,000 occupied bed days

[5] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients acquiring an E. coli infection while in hospital

Objective (measure of success) *Objective*

2 Reduce E. coli bloodstream infections to 21.5 per 100,000 bed days by March 2020

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

1. A national heatwave causing an increased risk of dehydration and subsequent increase risk of Urinary Tract Infections (UTIs)
2. Non-compliance with antibiotic therapy for UTIs
3. Urinary catheters being inserted inappropriately and managed incorrectly
4. Non-compliance with antibiotic therapy for Endoscopic Retrograde Cholangiopancreatographies (ERCPs)
5. Poor compliance with Infection Prevention & control precautions
6. Increased number of infections on the Haematology Ward (Lord North) following a change to the use of a particular recommended form of chemotherapy

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

a. A hydration project has been introduced Trust-wide, to ensure that patients drink enough fluid to reduce the number of UTIs (1)
b. UTI Commissioning for Quality and Innovation (CQUIN) target being supported by the Infection Prevention and Control (IPC) Team reviewing antimicrobial prescribing for UTIs (2)
c. Root Cause Analysis (RCA) investigations are undertaken on E.coli bacteraemia related to catheters and ERCPs to identify any lapses in care for shared learning (2, 4)
d. Audit of compliance with the HOUDINI[6] protocol and catheter related UTIs with actions identified to improve documentation & reason for insertion (3)
e. A UTI reduction working group is in place, supported by a Consultant Urologist (1, 2, 3)
f. Urinary catheter passport re-launched (3)
g. Audit of ERCP prophylaxis completed with action to improve the administration of prophylaxis. Re-audit to be undertaken in 19/20 (4)
h. Mandatory IPC training is provided (face to face training includes hand hygiene training) (5)
i. Triangulation audits are undertaken by the IPC Team (5)
j. Ad hoc training focusing on key issues related to IPC, such as commode cleaning (5)
k. Attendance and participation in the Kent and Medway IPC improvement collaborative (1, 2, 3, 5)
l. 'Focus on' posters for promoting Hydration and avoiding Catheter Associated AUTIs (CAUTIs) / UTIs developed and shared (3)
m. A deep dive review of infections on Lord North Ward has agreed the actions to be taken (6)

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

1. Directorate performance reports presented to the Infection Prevention and Control Committee (IPCC) highlighting rates of infection, IPC issues and actions taken within each Directorate
2. Audit reports and action plan are presented to the IPCC and monitored through the governance team
3. Monthly board report from the Director of Infection Prevention and Control (DIPC)

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

If "No", what other data is needed? N/A

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

Details: E. coli data is reported on the national data capture system (DCS) & by the laboratory through the Telepath IT system. The IPC Team also collects the data which are reported through their ICNet system (which comes via Telepath). All these systems can be accessed in order to validate the data.

Person responsible for empowering our staff: Director of Infection Prevention and Control (DIPC)

Trust Board sub-committee responsible for oversight: Quality Committee

[6] Haematuria; Obstruction/Retention; Urology surgery; Damaged skin; Input/output, fluid monitoring; Nursing care end of life/comfort care; Immobility

Confidence that the objective will be achieved by the end of 2019/20[7]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
The rate of E. coli per 100,000 occupied bed days at the end of January 2020 was 31.6. The rate of January alone was 32.0.

The further actions planned include:

- The "Safety moment" for February 2020 focused on reducing the risk of UTIs (which included details of when to dip / not to dip and advising not to use this as an indicator to treat UTIs)
- Further promotion of the HOUDINI criteria through the distribution of staff information cards
- Promoting patient hydration again around May/June 2020 in collaboration with the Kent and Medway Healthcare Acquired Infection improvement collaborative.
- Focused interventions on Lord North ward where higher rates of infection have been seen (patients receiving octenisan washes, daily changing of bed linen and nightclothes and promoting good personal hygiene)
- Promote improved antimicrobial prescribing in line with the Trust policy for treatment of UTIs – following the finding of the UTI CQUIN
- Continue to promote the urinary catheter passport and monitor use

[7] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will respond to complaints in a timely and consistent manner

Objective (measure of success) *Objective*
3 Improve complaints performance to 75% across all divisions and directorates by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Divisional performance failure to respond to complaints in a timely manner
2. Resource within complaints team (particularly in relation to unplanned absences)
3. IT issues - age of computers (slow to respond)
4. Transition to Datix IQ Cloud, potential issues with functionality
5. Delays in the timely completion of Serious Incident (SI) investigations, which adversely affects complaint responses

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Review of timeframes for each step of the complaints process (1)
b. Exception meetings were held with Directorate leads by the Chief Nurse and Assoc. Dir., Quality Governance (1)
c. Complaints closely monitored at Divisional Performance Reviews (DPRs) and Governance meetings (1)
d. A Business Case was approved for a Deputy Complaints Manager, and they will start in post in February 2020 (2)
e. Discussion with IT re timing of replacement of older computers (3)
f. Datix implementation group established to work through introduction of new system (4)
g. Concerns escalated to Executive leads (5)
h. A Business Case was approved for the Patient safety team to improve on timeliness of SI investigations, and the recruitment to the team is almost complete (6)
i. Review of pathway for complaints that are also SIs to identify key responsibilities/actions required (6)
j. Improvement trajectories have been developed for complaints responses that have exceeded the response date, and these trajectories will be monitored with the Divisions

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Monthly Key Performance Indicators (KPIs)
2. Regular reports/updates to Directorates/Divisions
3. Complaints report to Patient Experience Committee

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details: However, reviews undertaken by the Parliamentary and Health Service Ombudsman (PHSO) assure the quality of responses (for the complaints escalated to the PHSO), whilst the Trust also undertakes a complaints satisfaction survey.

Person responsible for empowering our staff: Chief Nurse

Trust Board sub-committees responsible for oversight: Quality Committee / Patient Experience Committee

Confidence that the objective will be achieved by the end of 2019/20[8]

June 2019	August 2019	January 2020	February 2020	March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The overall response rate at the end of month 10 (January) was 80.4%

[8] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☒ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will reduce the number of vacant posts we have in the Trust

Objective (measure of success) *Objective*
4 Improve our vacancy rate to 9% by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to 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 capacity from professional groups to be able to support interviewing and professional development support of candidates at scale
4. If there was inefficiency of recruitment processes
5. If there was insufficient focus placed on retaining existing staff
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. Agreement of a qualified nurse recruitment plan for 2019/20 (2)
c. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (3, 5)
d. Recruitment KPIs derived from the TRAC IT system identify areas where process can be improved (4)
e. New Roles and Apprentices group within the Workforce workstream of the Best Care Programme identifying additional apprenticeship roles within divisions (1)
f. Establishments and workforce requirements have been reviewed and agreed as part of the Business Planning process for 2019/20 (5, 6)
g. 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)
h. 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
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? N/A

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

Person responsible for empowering our staff: Director of Workforce

Trust Board sub-committee responsible for oversight: Workforce Committee

Confidence that the objective will be achieved by the end of 2019/20[9]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The vacancy rate at the end of month 10 (January 2020) was 9.0%. However, once the additional winter pressure posts are excluded, the rate was 7.79%

[9] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☒ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will improve how involved, motivated and satisfied our staff are

Objective (measure of success) *Objective*
5 Achieve staff engagement score of ≥ 7.2 within 2019/20

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to implement local staff engagement plans
2. Insufficient resource to deliver staff amenities programme
3. Lack of visibility of senior leaders on shop floor
4. Insufficient communication of actions and information to staff
5. Insufficient investment in clinical leadership
6. Staff are not empowered to influence or implement service changes

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. All divisions have a staff engagement plan for 2019/20 reviewed within DPRs (1)
b. Trust engagement plan for 2019/20 agreed (1)
c. Executive and divisional leaders to have shop floor engagement identified in appraisal objectives (3)
d. Staff Amenities delivery group in place along with associated plan (2)
e. Retention and Engagement group set up chaired by Director of Workforce (1, 4)
f. Trust 'Thank you ' events (2, 3)
g. Senior leadership programme commissioned (5)
h. 'Exceptional People Outstanding Care' programme agreed by Trust Board (6)
i. The communications programme for the 2019 staff survey will commence in August (4)
j. Staff have been provided with a range of benefits and rewards/recognition over the year (2, 3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. National Staff Survey data
2. Divisional Performance reviews
3. Updates to the Workforce Committee
4. Minutes of the Engagement & Retention group

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:

Person responsible for empowering our staff: Director of Workforce

Trust Board sub-committee responsible for oversight: Workforce Committee

Confidence that the objective will be achieved by the end of 2019/20[10]

June 2019	August 2019	January 2020	February 2020	March 2020
				

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The staff engagement score in the 2019 national NHS staff survey (which was published in February 2019) was 7.1. This was a statistically significant improvement on the score from the 2018 survey (7.0), but is still below the score in the objective.

[10] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☒	Delivery ☐	Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will optimise the care across our two hospital sites

Objective (measure of success) *Objective*
6 Implement the planned surgical reconfiguration by the end of 2019/20[11]

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit staff in time
2. Failure to adequately identify and protect bed space

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Triangulation with Stroke move to ensure bed availability
b. Configuration timeline created with the Deputy Chief Operating Officer and Divisional Director of Operations for Medicine & Emergency Care to ensure that both original and mitigation plans do not affect winter planning
c. Agreement with Chief Operating Officer on a series of measures to protect digestive diseases bed stock

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Surgical reconfiguration steering group (Chaired by the Clinical Director for General Surgery)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details:

Person responsible for empowering our staff: Director of Strategy, Planning and Partnerships

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[12]

June 2019	August 2019	January 2020	February 2020	March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The service is confident this will be delivered before the end of 2019/20 and has a current 'go live' date of 30/03/20

[11] On 27/02/20, the Trust Board approved a request to amend the title of the objective from "Establish functioning Digestive Diseases Unit by October 2019"
[12] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☒	Delivery ☐	Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will work with partners to develop the best possible models of care across the region

Objective (measure of success) *Objective*
7 Build new Acute Medical Unit (AMU) to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Capital funding to be released from NHS Improvement (NHSI)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Following discussions and the Finance and Performance Committee and Trust Board in May and June 2019, it has been confirmed that the Trust will a hire (revenue-based) arrangement for the modular AMU building, and not a capital purchase.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The reports submitted to the May 2019 Finance and Performance Committee and Trust Board ('Part 2') meetings
2. The minutes of the May 2019 Finance and Performance Committee and Trust Board ('Part 2') meetings

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

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

Person responsible for empowering our staff: Chief Operating Officer

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[13]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The AMU build is now completed and the Unit is scheduled to be operational in mid-March 2020.

[13] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☒ Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will ensure that our cancer patients receive their treatment as quickly as possible

Objective (measure of success) *Objective*
8 Ensure that 85% or more of cancer patients are treated within 62 days

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Oncology capacity shortfall due to workforce shortages.
2. Confirmation of Clinical Commissioning Group (CCG) funding into cancer to ensure we have sustainable plans in place
3. Increased service demand (higher than national average)
4. Pathway issues in Upper GI, Lung, Haematology and Head and Neck
5. Sustainable diagnostic capacity
6. Pension issues impacting additional sessions for clinicians and there flexibility to respond to increased demand

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Daily Patient Tracking List (PTL) meetings in place with all services
b. Weekly executive performance meeting in place
c. Cancer pathway transformation plan is now in place
d. Further support from NHSI on weekly issues
e. Additional funding currently in place for key services
f. Daily review of performance from executive level
g. A Cancer performance General Manager has been appointed

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Monthly reports to the Finance and Performance Committee and Trust Board
2. Weekly report to 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? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 62-day Cancer waiting time target and gave a conclusion of "Reasonable assurance". The report stated that "The figures reported to the Trust Board for Cancer 62 Day Wait, were found to be accurately reported based on the data available from the source data system"

Person responsible for empowering our staff: Chief Operating Officer

Trust Board sub-committees responsible for oversight: Quality Committee / Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[14]

June 2019	August 2019	January 2020	February 2020	March 2020
				

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The year to date performance (at the end of December 2019) was 87.3%

[14] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will carry out elective treatments as quickly as possible

Objective (measure of success) *Objective*
9 Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. RTT data quality programme could impact the total size of the waiting list.
2. CCG funding still relied upon to ensure we can achieve 86.7%.

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Data quality programme has been set up and is tracking progress on a weekly basis
b. On-going meetings with commissioners to track need for additional funding in place.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The monthly reports 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? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 18 Weeks RTT Incomplete Pathway and gave a conclusion of "Reasonable assurance".

Person responsible for empowering our staff: Chief Operating Officer

Trust Board sub-committees responsible for oversight: Quality Committee / Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[15]

June 2019	August 2019	January 2020	February 2020	March 2020
				

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- Year to date performance (at the end of month 9, December 2019) was 85.0%

[15] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☒ Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will review and treat patients in our accident and emergency room as quickly as possible

Objective (measure of success) *Objective*

10 Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

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

1. Increased demand on services. For example May was our busiest every month as an organisation
2. Workforce shortages
3. Brexit

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

a. A flow programme is in place to transform same day emergency care (SDEC), Length of Stay (LOS) and out of hospital capacity, with a number of positive results so far (1)
b. Workforce group in place, and is focussing on international recruitment (2)
c. A Retention group is in place to ensure organisation supports current staff and any new ones joining (2)
d. A Brexit programme is in place working through all potential issues of a no-deal Brexit (3)

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

1. The monthly reports 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 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" and 2 "Routine" priority recommendations were made, which have been monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Person responsible for empowering our staff: Chief Operating Officer

Trust Board sub-committee responsible for oversight: Quality Committee / Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[16]

June 2019	August 2019	January 2020	February 2020	March 2020
				

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

- Year to date performance (at the end of month 10, January 2020) was 90.6%, and was 91.1% for that month

[16] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☒ Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will spend the taxpayers money wisely to ensure that we can invest as much as possible into patient care

Objective (measure of success) *Objective*
11 Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

What could prevent this objective being achieved? (including external factors) *Risks to 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 2019/20 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
8. If the Trust is unable to access the CCG RTT risk reserve
9. If the Private Patient Income does not meet the level expected in the plan

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

a. The Trust has signed up to its control total, and submitted a plan to achieve this (1)
b. Agreed Directorate budgets have been set (2)
c. A number of 'Grip and Control' measures have been implemented to ensure delivery (1, 2, 5)
d. The Performance Management Framework is now embedded (2, 3)
e. Engagement with external stakeholders, including agreeing an Aligned Incentives Contract with West Kent CCG, which now includes Kent Community Health NHS FT (5, 6, 7)
f. Delay investment to keep costs within CCG funding (8)
g. The 2019/20 CIP will be delivered by directorates, supported by the Best Care Workstreams (1, 3, 4)
h. If unable to access risk reserve, discussions will continue with the CCG (although there is increased confidence of receipt) (8)
i. 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)
j. The Trust has provided External Support to the Divisions to assist identification & delivery of CIP (4)
k. Working with private patient management to understand shortfall & develop recovery plan (9)
l. Monthly variance analysis with Divisions (2, 4)
m. Control totals have been set for all areas (2, 4)
n. Fortnightly Financial Recovery Plan (FRP) meetings with Divisions are being held from January 2020

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

1. The Monthly financial performance reports to the Best Care Programme Board, Finance and Performance Committee and Board
2. Monthly detailed Best Care Programme report to the Finance and Performance C'ttee & Trust Board
3. Monthly Divisional Performance Reviews

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 Board each May. In addition internal controls are in place to ensure financial reporting is accurate & complete. This is assured through an Internal Audit process which audits the components of finance reporting & underlying transactions

Person responsible for empowering our staff: Chief Finance Officer

Trust Board sub-committee responsible for oversight: Finance and Performance Committee

Confidence that the objective will be achieved by the end of 2019/20[17]

June 2019	August 2019	January 2020	February 2020	March 2020

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

- At the end of January 2020, the Trust's year to date surplus (including Provider Sustainability Fund (PSF)) was £5.987m which was £0.1m favourable to plan

[17] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☒

How will we deliver on this value in 2019/20?
We will consistently go above and beyond for our patients to deliver the best care possible

What will success look like?
We will ensure that the number of patients that die in our hospital is as low as possible and remains below the level that would be expected

Objective (measure of success) *Objective*
12 Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit Medical Consultants to support the achievement of 7-day services
2. Failure to learn from mortality reviews
3. Weekend-related mortality worsening

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Business planning – Medicine & Emergency care (1)
b. Review of Medical rotas to enhance 24/7 site cover of services (1)
c. Investment in a Mortality Module (2)
d. Close monitoring of crude mortality is undertaken at the Mortality Surveillance Group (MSG)
e. Mortality reports to include shared learning (2)
f. Implementation of Medical Examiner and Medical Examiner Officers roles (2)
g. The MSG is actively monitoring the weekend-related mortality situation (3)
h. Increasing Structured Judgement Reviews (SJRs) are being completed, with SMART actions passed on to Divisions (2)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Minutes and reports for the MSG
2. HSMR (& Summary Hospital-level Mortality Indicator (SHMI)) data reported the Trust Board
3. The mortality update reports to the 'main' Quality Committee and Trust Board
4. Actions taken by Learning from Deaths working group

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: Monthly assurance reports re quality of coding submitted

Person responsible for empowering our staff: Medical Director

Trust Board sub-committee responsible for oversight: Quality Committee

Confidence that the objective will be achieved by the end of 2019/20[18]

June 2019	August 2019	January 2020	February 2020	March 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The HSMR at the end of month 10 (January 2020) was 91.7

[18] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "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 two months. The full Risk Register is submitted to the Audit and Governance Committee. Red-rated risks are also subject to detailed review at Executive Team Meetings each quarter, whilst Divisional and Directorate-based red-rated risks are discussed as part of the report that Divisions give to the ‘main’ Quality Committee (previously such reports were given by Directorates).

The latest review of red-rated risks at the Executive Team Meeting took place on 21/01/20, resulting in an initial downgrading of a number of risks. Additional red risks have subsequently been added. The status of the Risk Register as of 12/03/20 was as follows:

- 16 red-rated risks
- 80 amber-rated risks
- 5 green-rated risks

The issues covered by most of the 16 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:

- The cost pressures associated with the use of temporary staff
- Risk associated with failing to learn from incidents
- Inability to fulfil national standard of 20% of women cared for by Continuity of Carer teams in maternity units
- Shortage of consultant grade oncologists
- Radiotherapy CT has exceeded recommended lifetime and formal support from manufacturer ended in December 2019
- Lapses in service contract for maintenance of scopes
- Risk associated with the age of the Toshiba 64 slice CT scanner
- Backlog of typing Orthopaedics outpatient clinic letters
- Shortage of senior staff in Radiation Physics
- Interventional imaging equipment Philips Eleva lifecycle
- No back up oxygen supply in the event of primary and secondary failure
- Unavailability of End Tidal CO_2 monitoring in recovery bays in Theatres
- Risk of having one glaucoma consultant in the Ophthalmic services
- Insufficient capacity for stable glaucoma patients in community optometrist clinics
- 400v cleaning cupboard at Maidstone Occupational Health serving as the cleaning cupboard
- The effect of the COVID19 outbreak on the Trust’s ability to carry out its functions

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 is either accounted for in the BAF or are being considered by an appropriate forum.

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

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

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

This report is based upon the Trust's most recent data, published by Dr Foster for the period of December 2018 to November 2019.

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

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

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

Mortality Surveillance Report

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months December 2018 to November 2019 show our HSMR to be 91.8, which is unchanged when compared to last month's position of 91.8.

Figure 1. Rolling 12 Month view

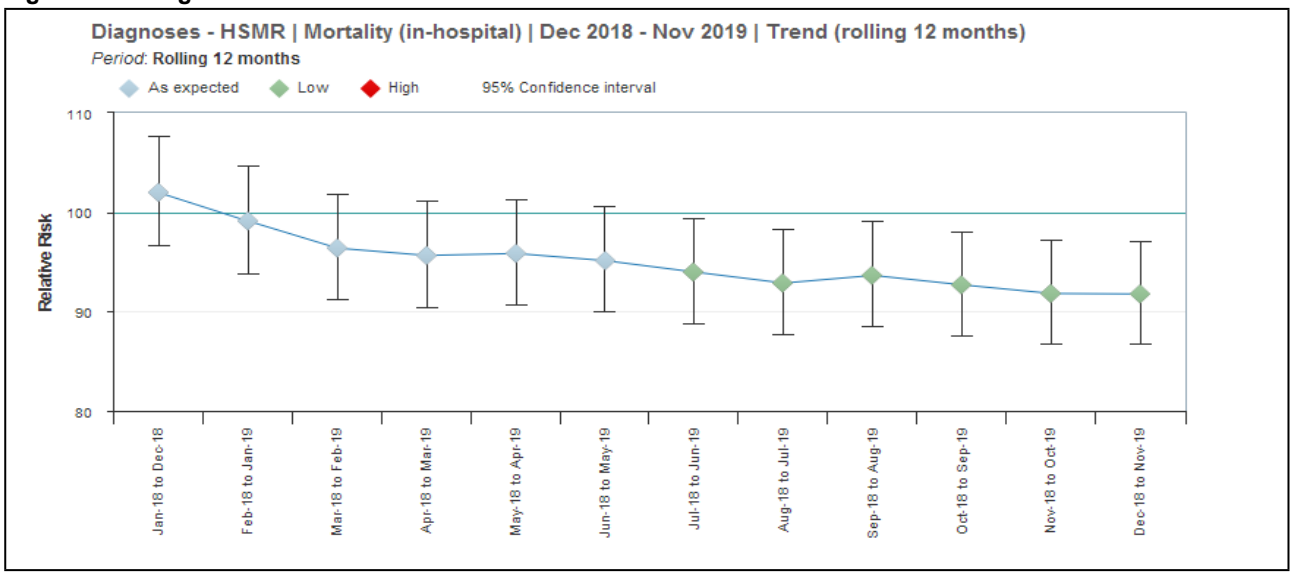
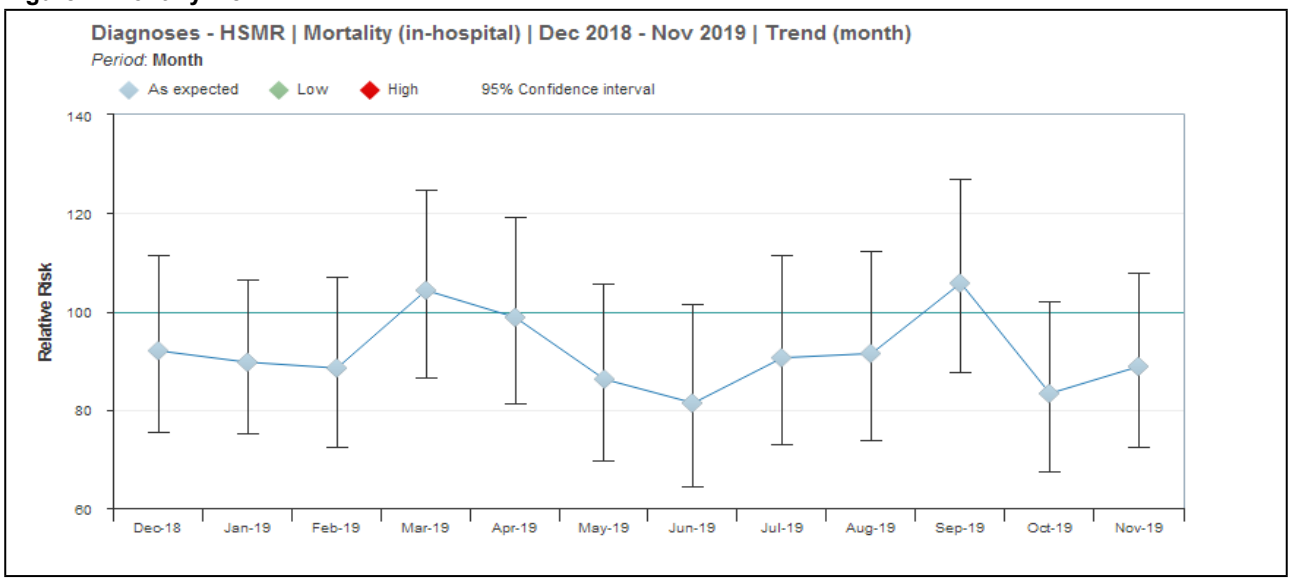


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so October 2019 in this case, shows that the Trust's position has decreased to 83.3 from 105.7 in September 2019.

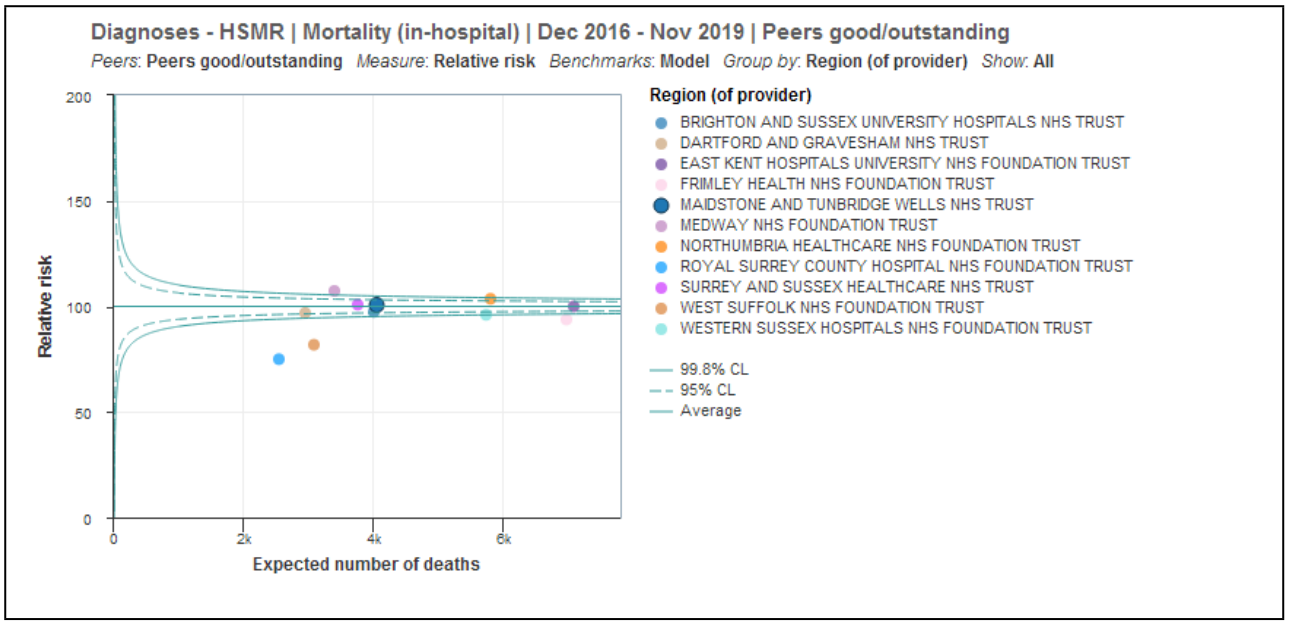
Figure 2. Monthly view

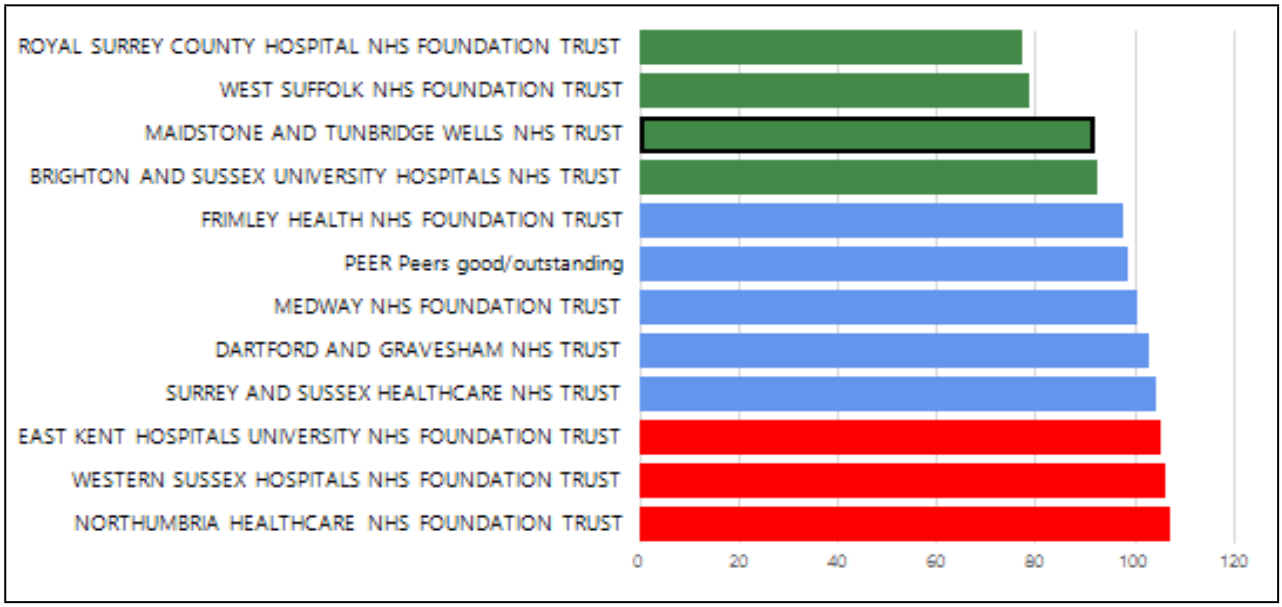


Benchmarking

Dr Foster enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups. Figures 3a, b & c demonstrate that the Trust is in a good position amongst comparable organisations with Good or Outstanding CQC status.

Figure 3a, b & c. Benchmarking against good/outstanding acute non-specialist trusts (Dec 2018 – Nov 2019)





Performance	Site	Trust	Peer	National
HSMR		91.8	98.7	99.2
SMR		89.7	98.5	99.4
Elective (HSMR)		85.9	102.6	103.1
Non-elective (HSMR)		91.8	98.7	99.2
Weekday, non-elective (HSMR)		91.1	97.5	97.6
Weekend, non-elective (HSMR)		93.8	102.0	103.9

Coding / Casemix	Site	Trust	Peer	National
% Deaths in HSMR basket (elective)		88.2%	72.1%	63.1%
% Deaths in HSMR basket (non-elective)		84.4%	83.5%	83.3%
% Non-elective deaths with palliative care		40.5%	35.7%	33.3%
% Non-elective spells with palliative care		4.2%	4.3%	4.1%
% Spells in Symptoms & Signs chapter		8.4%	7.9%	6.8%
% Spells with Charlson comorbidity score = 0		56.8%	49.8%	47.4%
% Spells with Charlson comorbidity score = 20+		7.4%	9.6%	9.6%

Understanding and Improving upon HSMR

It is evident from figures 1 – 3 that the Trust has made a sustainable reduction in our HSMR and are now in a healthy position amongst our peers, having moved from a position of high relative risk

to low relative risk has been the main objective of the Mortality Surveillance Group (MSG) during 2018/19 and 2019/20.

This is also borne out by the significant improvements that can be evidenced in the downward trend of relative risk rates and crude rates since October 2017. In addition the volume of spells has continued to rise in the same period due to the change in casemix as demonstrated in Figures 4a & b.

Figure 4a HSMR – Relative Risk

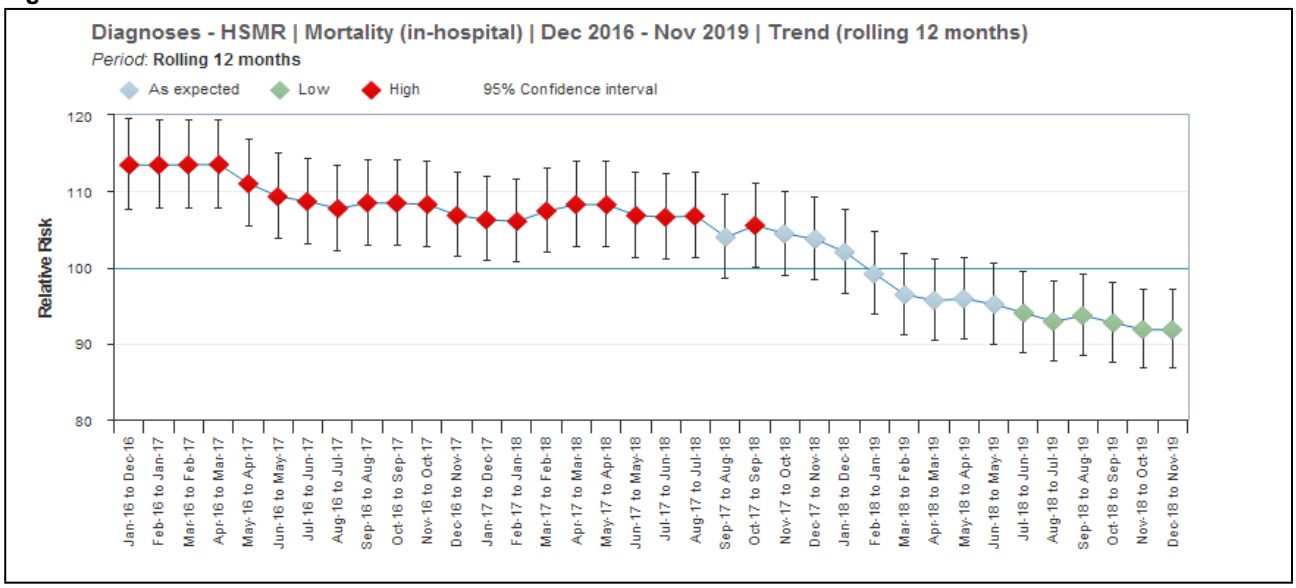
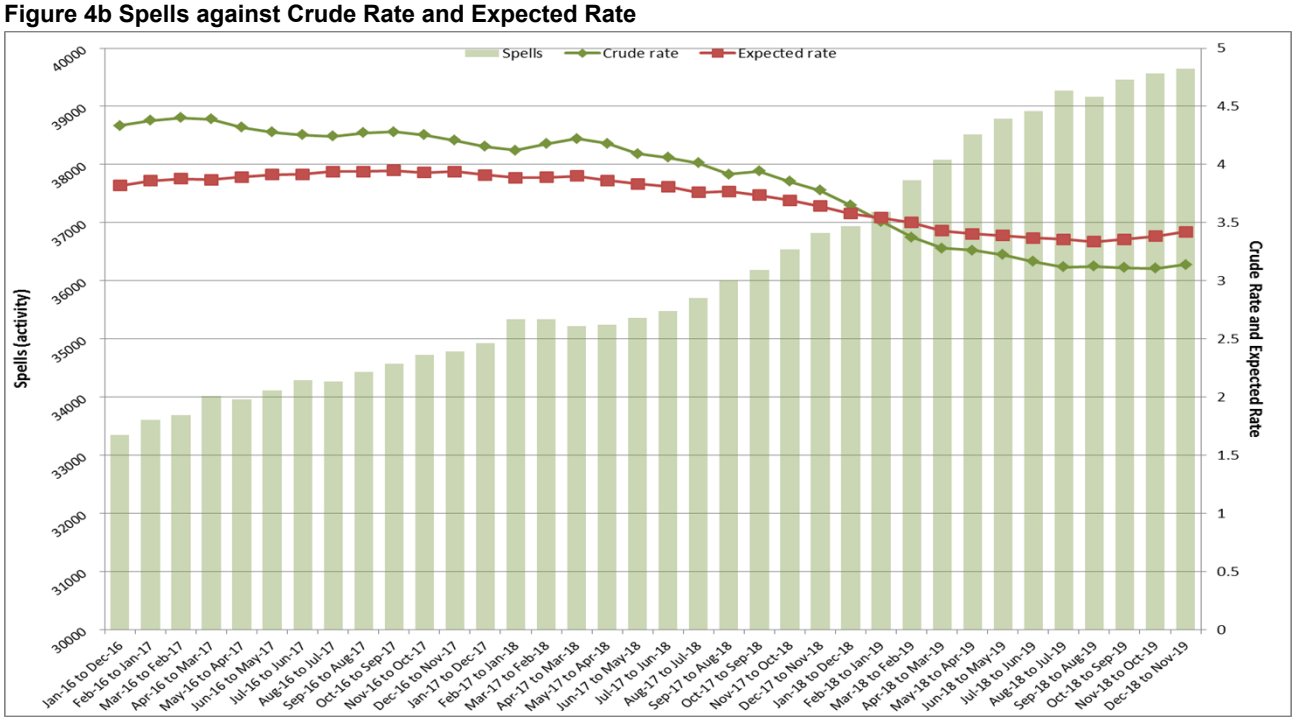


Figure 4b Spells against Crude Rate and Expected Rate

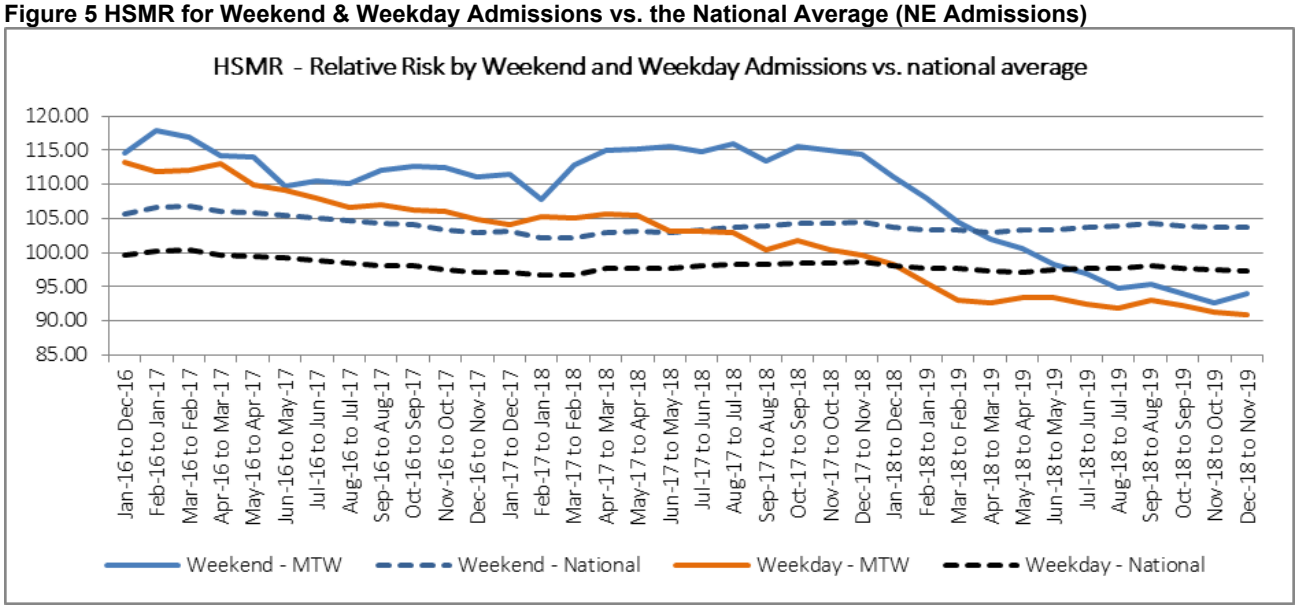


Weekend vs Weekday Admissions

A further concern that the MSG have been monitoring has been in regard to a previous anomaly between weekday and weekend admissions and a raised HSMR for weekend admissions. This has subsequently resolved but remains under active monitoring.

The Seven Day Services programme is focused around reducing variation in performance and mortality forms part of the scope of this work. The latest period (Figure 5) has a HSMR of 93.9 (92.6 last month) for weekends and 90.8 (91.3 last month) for weekday admissions, both the weekday & weekend rates are significantly lower than where the Trust was at the beginning of the year.

Figure 5 HSMR for Weekend & Weekday Admissions vs. the National Average (NE Admissions)



The site split of the Weekday deaths for December 2018 – November 2019 is Maidstone – 86.1 (a decrease from last month of 86.4) & TWH – 94.7 (a decrease from 95.2 last month).

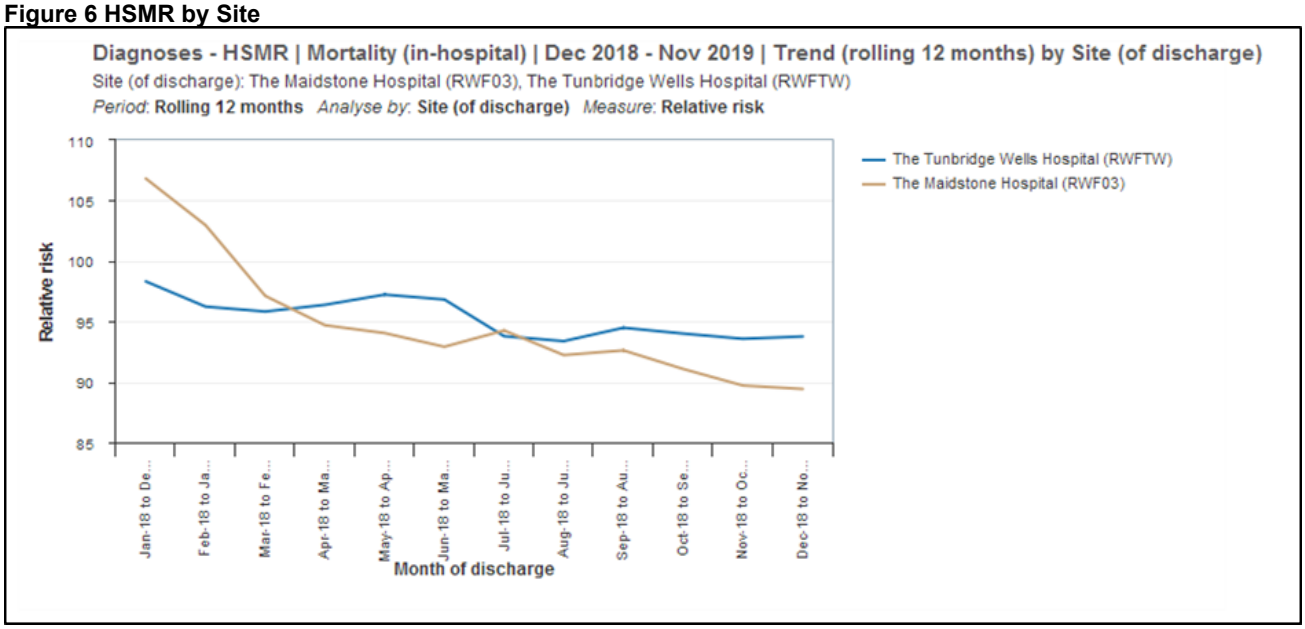
The site split of the Weekend deaths for December 2018 – November 2019 is Maidstone – 97.9 (a decrease from 98.1 last month) & TWH – 90.5 (an increase from 88.4 last month).

Latest analysis shows that patients admitted to the Trust on any day of the week have an 'as expected' or 'low' level of relative risk of death, previously Saturdays has a high relative risk.

HSMR by Site

Figure 6 shows the HSMR split by site. The HSMR at the Maidstone site has decreased to 91.5 from 91.8 last month; the Tunbridge Wells site has increased to 93.6 from 93.1 last month.

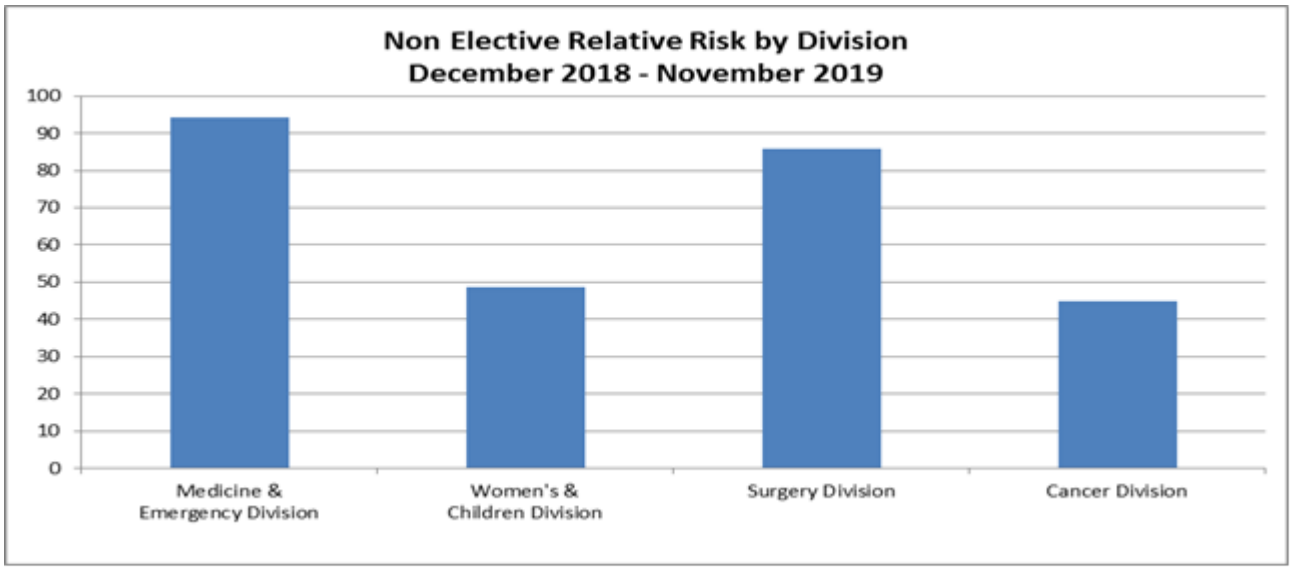
Figure 6 HSMR by Site



HSMR by Division

All four Divisions within the Trust have a non-elective relative risk within the expected range.

Figure 7 Divisional Non Elective Relative Risk

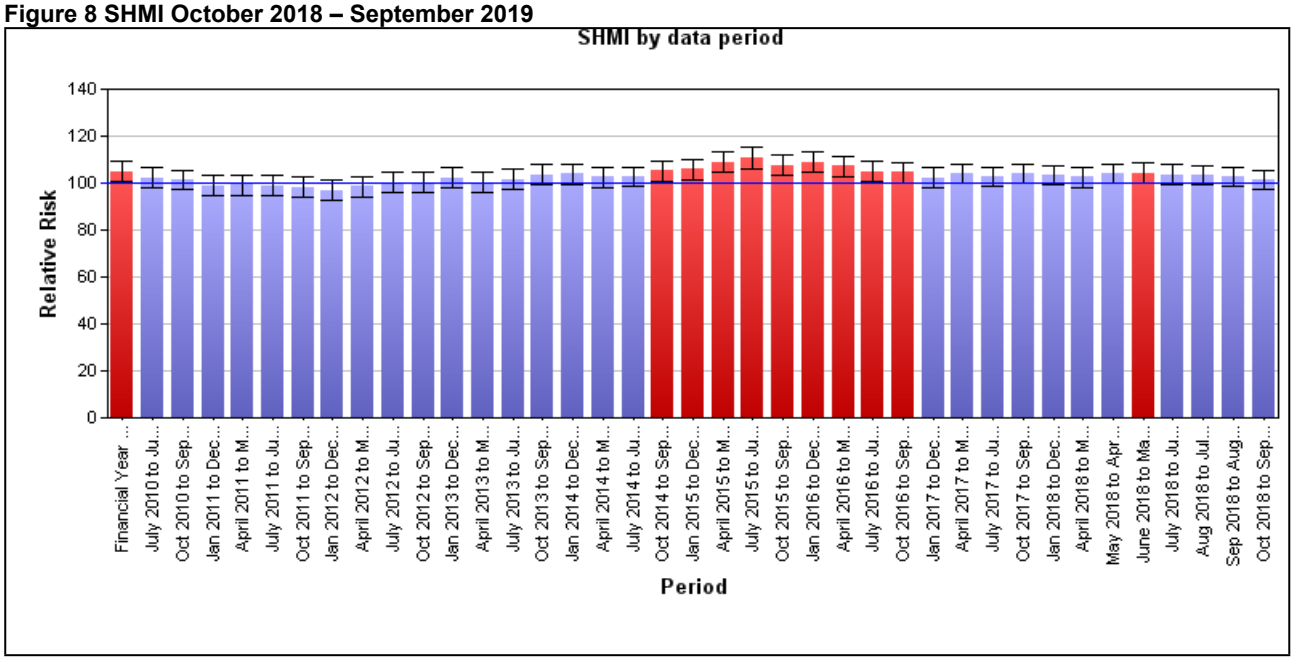


All four divisions within the Trust have a non-elective relative risk within the expected range.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI (Figure 8) is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital.

Figure 8 SHMI October 2018 – September 2019



SHMI published by HSCIC for the period October 2018 – September 2019 shows SHMI as 1.0132 which is banded as level 2 “as expected”.

There is now greater ability to interrogate the SHMI data, similar to how the HSMR data has been used. This new focus will be supportive to the objectives of the Mortality Surveillance group and it is anticipated that this will provide further insight into any anomalies or concerns with the mortality data and support further depth of analysis and focus as needed.

CUSUM (CUmulative SUM control chart) Alerts

A further element of the work undertaken by the Mortality Surveillance Group is to review the CUSUM alerts. This is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The chart below (Figure 9) demonstrates the

diagnosis groups where the Trust has received negative alerts when using A ‘high’ (99%) detection threshold over the past 12 months.

Figure 9 Diagnosis with negative CUSUM Alerts

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	1 5	118076	1462	1629.0	1.2	89.7	
HSMR (56 diagnosis groups)	3	39507	1240	1351.2	3.1	91.8	
Acute and unspecified renal failure	1	477	71	51.0	14.9	139.3	
Acute bronchitis	1	1162	26	21.2	2.2	122.8	
Multiple sclerosis	1	36	2	0.2	5.6	931.7	
Other endocrine disorders		281	10	4.5	3.6	223.2	
Parkinson's disease	1	86	4	2.0	4.7	204.6	
Peritonitis and intestinal abscess		32	8	3.0	25.0	262.4	
Sprains and strains	1	92	1	0.1	1.1	1646.2	
All Procedures	2	77393	952	1032.2	1.2	92.2	
Rest of Miscellaneous operations	2	4769	42	22.2	0.9	189.0	
Therapeutic endoscopic operations on larynx	1	6	1	0.1	16.7	1316.7	

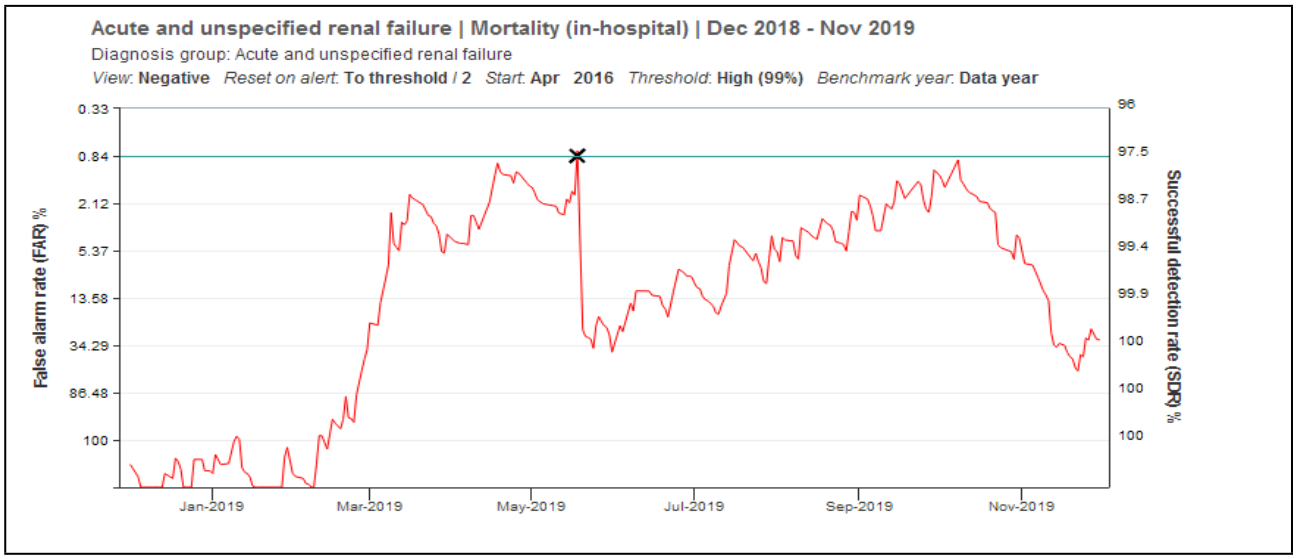
Health Record audits have been completed for Acute and Unspecified Renal Failure and Acute Bronchitis due to the number of observed deaths and the fact that two alerts have been triggered in the 12 month period (as per MTW local rule).

The coding team have also reviewed the records for the following diagnosis groups when a CUSUM alert has been assigned, but the number of observed deaths is low (<5 deaths):

- Multiple Sclerosis
- Parkinson’s
- Sprains and strains

.

Figure 10 shows the CUSUM alert point for Acute and unspecified renal failure which has shown as having a red relative risk of 139.3 in December 2018 – November 2019, the patient level backing data for these alerts has been supplied to the coding department for further analysis.



The Mortality Surveillance Group (MSG):-

The Trust is required to review all in-hospital deaths following the Mortality Review Process. The results of these reviews are then collated and reported to ensure that any learning from deaths is identified and shared.

The percentage of mortality reviews has remained consistent since the process was changed in October 2017 with a current position of 79.5%. The MSG have recently revised the benchmark with the intention of improving on the current standard to reach 95% in preparation for the introduction of the Medical Examiner system. It is the aspiration that once the service is established that 100% of deaths should be confirmed as having been reviewed.

Trust	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD
No of Deaths	1600	142	121	95	128	114	135	132	137	142	162	1308
No of Completed Reviews	1363	121	98	83	112	99	113	112	121	118	63	1040
%age completed reviews	85.2%	85.2%	81.0%	87.4%	87.5%	86.8%	83.7%	84.8%	88.3%	83.1%	38.9%	79.5%
No of Un-reviewed Deaths	237	21	23	12	16	15	22	20	16	24	99	268

%age completed reviews	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD
Specialist Medicine	88.9%	88.5%	80.0%	100.0%	84.2%	83.3%	81.8%	90.9%	93.8%	75.0%	45.5%	82.8%
Acute Medicine	84.5%	84.6%	81.4%	85.3%	90.6%	87.8%	86.4%	82.1%	87.0%	87.0%	40.7%	79.8%
Surgery	90.6%	100.0%	80.0%	80.0%	66.7%	60.0%	71.4%	78.6%	83.3%	55.6%	20.0%	69.7%
Trauma & Orthopaedics	40.7%	33.3%	0.0%	66.7%	66.7%	83.3%	50.0%	80.0%	66.7%	40.0%	0.0%	50.0%
Urol, Gonc, Breast, Vasc		100.0%	100.0%	100.0%			100.0%				50.0%	85.7%
A&E	74.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	93.7%
Cancer & Haematology	90.9%										100.0%	100.0%
Children's	100.0%											
Head & Neck	100.0%							200.0%				100.0%
Women's & Sexual Health	100.0%											100.0%
Trust Total	85.2%	85.2%	81.0%	87.4%	87.5%	86.8%	83.7%	84.8%	88.3%	83.1%	38.9%	79.5%

The table above shows the results for 2018/19 & April – February 2020 as at 10th February 2020.

Of the 1600 deaths between April 2018 – March 2019, 2.9% (47) were referred for an SJR. During 2018/19, 60 deaths actually had an SJR completed; this is 3.8% of the trust deaths. During April – February 2020, 37 deaths have had an SJR completed which is 2.9% of the total deaths to date

The Mortality Steering group is responsible for supporting the Trust in providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated. In addition it is to ensure that lessons are learned and actions implemented to improve outcomes.

Each Directorate has a nominated Mortality Lead with the key objective of ensuring that the Mortality review process is embedded locally and that deaths that have raised concern are fed-back to the Group from the Directorate and in addition that learning from the Directorates to the MSG and vice versa is sustained.

Learning from Mortality Reviews includes the need for:-

- Use of the Amber care bundle, currently being trialled, when it is unknown whether the patient will survive or not, this will help to guide you through the difficult conversation with the relatives re worst case scenario, DNACPR and ceilings of care
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Sensitive DNACPR discussions with relatives should be carried out by senior members of medical team who are responsible for making the decision and not delegated to juniors.
- When a patient is considered for End of Life Care the requirement to use the end of life plan of care.
- Consent for high risk surgical procedures must include the risk of death and the content of this discussion documented.
- Documentation of best interest discussions.
- Importance of contemporaneous and legibility of documentation.
- Improved documentation with particular records of thought processes leading to decision making, including elimination of possible diagnoses.

Medical Examiner Process Implementation Working Group

In addition to the Mortality Surveillance Group there is also a requirement for all Acute Trusts in England to begin setting up medical examiner offices, as such this Working Group became instrumental in July 2019.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- To ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

The Working group to date have:-

- Mapped the current roles of the Bereavement services team to prevent duplication of work
- Developed Job Descriptions for the Medical Examiner and Medical Examiner Officer roles
- Worked with PMO and Deputy Medical Director to determine number of PA's that would be required to undertake the role of Medical Examiner
- Liaised with Chief Coroner and Regional Medical Examiner to ensure key requirements are understood
- Worked with the Deputy Director of Finance to consider funding options in regard to Part 2 monies
- Worked with Estates to consider options to create further desk space to support additional staff
- Developed business case to introduce the service, outlining central funding
- Commenced the recruitment process with roles offered for Medical Examiner Officers and advert out for Medical Examiners.

Next Steps for both MSG and Medical Examiner project groups:-

- Further interrogation of the SHMI data to investigate any anomalies detected.
- Implementation of the Mortality Module – this will be delivered by the Datix Implementation Group and is envisaged to automate the mortality review process and become the repository for all documentation. In addition Datix IQ will be able to generate performance reports which will support the lessons learned agenda.
- Implementation of the Medical Examiner process and introduction of Medical Examiners and Medical Examiner Officer Roles. These roles are anticipated to support the relatives and loved ones of those who die in the care of MTW and improve their overall experience whilst supporting the critical review of the care being provided. These are expected to be in place from the 1st April 2020.
- Work with KCHFT to discuss future plans on the investigation of community deaths which is anticipated to be introduced in 2021/22.

NHS Maidstone and Tunbridge Wells NHS Trust

Proposal to temporarily extend the delegated expenditure limits for members of the Executive Team — **Chief Finance Officer**

Summary

This report outlines a proposal to temporarily extend the current delegated expenditure limits within the Reservation of Powers and Scheme of Delegation for members of the Executive Team to provide sufficient resilience during the COVID-19 pandemic.

Proposal

The existing arrangements within the Reservation of Powers and Scheme of Delegation for the authorisation of payments, orders and non-pay spend are set out in sections 3.1 ("Planning and Budgetary Control") and 3.3 ("Non Pay Revenue and Capital Expenditure – Requisitioning of Goods and Services"). The main pattern of authorisation is as follows:

a) Up to £50,000 (£50k)	• Budget holders and specific officers e.g. Deputy Directors: up to specific limits (e.g. £1k, £5k, £15k etc.) • All members of the Executive Team (being budget holders): up to £50k (except the Chief Executive and Deputy Chief Executive / Chief Finance Officer)
b) From £50,000 up to £250,000	Deputy Chief Executive/Chief Finance Officer
c) From £250,000 up to £500,000	Chief Executive
d) £500,000 and over	Trust Board

These authorisation levels are incorporated in key system controls on the Purchasing and Payments system ("Integra") and therefore purchasing and payments of larger supplies, services and capital equipment cannot take place without appropriate sign off, whether directly within the system through electronic means, or by manual sign off of documents or email authority, and then processed on the Trust's systems.

Therefore there is a risk that if key members of the Executive Team become incapacitated by COVID-19 that the Trust would be unable to maintain its ability to order and pay for key operational requirements within the existing governance arrangements, especially given the current need to source supplies and equipment to support COVID-19 resilience. It is therefore proposed to adjust limits for a temporary 6 months period (from now until September 2020) to address this risk. The limits would be increased for the Executive Team members as follows:

- Members of the Executive Team: from £50k to £250k;
- Chief Finance Officer / Deputy Chief Executive: from £250k to £500k;
- Chief Executive – retained at £500k.

Capital approvals of orders and/or invoices are currently restricted to the Chief Executive and Chief Finance Officer / Deputy Directors of Finance (two) (limit up to £50k). The proposal is that in the event that neither the Chief Executive nor Chief Finance Officer were fit for work, then other members of the Executive Team would be authorised to approve capital up to £250k in conjunction with advice from the Deputy Directors of Finance (to ensure capital resource limit compliance).

It is further proposed to review the arrangements at the Audit and Governance Committee meetings in May and July 2020, to monitor use, effectiveness and determine whether they are still required. Authority to extend beyond September 2020 would be required to be sought at the Trust Board meeting in September, subject to the recommendation of the Chair of the Audit and Governance Committee.

Administrative contingency arrangements have already been put into place to enable specific Procurement managers and the Deputy Directors of Finance to technically authorise requisitions on the Procurement system (beyond their own departmental cost centres) to ensure that the governance arrangements can be enacted if authorisation needs to be given remotely (e.g. by email). This is primarily aimed at covering absences of cost centre managers and budget holders to avoid undue delay from escalation of approvals, but will also support any absences among members of the Executive Team. Reports of pending requisitions will be monitored daily by the Procurement team to identify any particular delays suggesting staff absences and followed up expeditiously.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 19/03/20 (verbal notification of proposal)
- Finance and Performance Committee, 24/03/20 (written notification of proposal)

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

Approval

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Update from the Senior Information Risk Owner (SIRO) (incl. approval of the Data Security and Protection Toolkit submission for 2019/20, and Trust Board annual refresher training on Information Governance)	**Chief Nurse (SIRO)**

The Trust Board will recall that in 2015 the Information Governance Alliance (IGA) published guidance for NHS Board members highlighting that ultimate responsibility for IG in the NHS rests with the Board of each organisation.

The enclosed update report aims to provide assurance of the work done in the last six months of this year in relation to the six key areas of responsibility.

The Board is asked to authorise the submission of a 'standards met' Toolkit year-end submission prior to 31 March 2020.

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

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

[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

In 2015 the Information Governance Alliance issued guidance for Boards entitled Information Governance Considerations for NHS Board Members. This guidance document identified a number of key points for NHS Boards and is used as the basis for this report:

Key points for NHS Boards to note are that:

- An annual IG performance assessment[1] using the IG Toolkit (IGT) must be published for review by commissioners and care partners, citizens, CQC and the Information Commissioner. Used appropriately the IGT is a proven change management tool that can be used to monitor performance and drive improvements in policy and practice.
- A Senior Information Risk Owner (SIRO) must be appointed to take responsibility for managing the organisation's approach to information risks and to update the Board regularly on information risk issues.
- A Caldicott Guardian, a senior clinician, must be appointed to advise the Board and the organisation on confidentiality and information sharing issues.
- Appropriate annual IG training[2] is mandatory for all staff who have access to personal data with additional training for all those in key roles.
- Details of incidents involving cyber security, loss of personal data or breach of confidentiality must be published in annual reports and reported through the HSCIC Serious Incident Requiring Investigation (SIRI) reporting tool[3]

NHS Board members should seek assurance on the following:
1. Is the duty to share information for care introduced by the Health and Social Care (Safety and Quality) Act 2015 and promoted by the National Data Guardian[4] being effectively addressed? Are arrangements for integrated care working effectively?
2. Is the organisation's IG Toolkit assessment satisfactory? Is it a true reflection of performance? Has it been independently audited? Are there any known weaknesses or auditor recommendations and if so, how are they being addressed? Does the organisation have the capacity and capability to guarantee that plans for improved IG can be implemented?
3. Are the Board satisfied with the indicators of IG performance reported to it, e.g. are key roles filled? Are all staff trained in the basics? Are levels of missing or untraceable case notes acceptable etc?
4. Are IG staff – IG managers, SIRO, Caldicott Guardian - trained appropriately? Are IG staff encouraged to participate in regional Strategic IG Network (SIGN)[5] meetings, contributing to and receiving support from the IGA[6]?
5. Are all significant IG Risks being managed effectively and considered at an appropriate level? Have there been any serious incidents requiring investigation reported? How confident is the organisation that all such incidents are reported? How many cyber-attacks have occurred and were they all successfully prevented?
6. Do the organisation's IG arrangements adequately encompass all teams and work areas, including hosted activity and contracted work that the organisation is legally accountable for?

1 This must be provided via the Information Governance Toolkit (IG Toolkit),
2 This may be provided through the Information Governance Training Tool (IGTT) or equivalent local resource, supplemented where appropriate by additional role specific local training
3 The SIRI reporting tool is accessed from within the IG Toolkit
4 Dame Fiona Caldicott, the National Data Guardian conducted a review of care sector information governance available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf
5 SIGN groups meet regionally with their chairs meeting bi-monthly in a national meeting chaired by the IGA.
6 The Information Governance Alliance (IGA) was established in July 2014 at the request of the National Data Guardian to support the Care Sector with authoritative advice and guidance on information governance issues, more details at IGA@nhs.net

The guidance document is used as the basis for this report which aims to provide assurance in relation to the six key areas detailed above.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisation to measure their performance against the National Data Guardian's 10 data security standards and replaces the Information Governance Toolkit.

The 10 standards are as follows:

1 Personal Confidential Data
All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

2 Staff Responsibilities
All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

3 Training
All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

4 Managing Data Access
Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

5 Process Reviews
Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

6 Responding to Incidents
Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

7 Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

8 Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the IT estate.

9 IT Protection
A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually

10 Accountable Suppliers
IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

The 10 Data Security Standards detailed above are devolved into mandatory and supplementary 'assertions' that widen the scope of the previous toolkit requirements.

In order to achieve a fully compliant DSP Toolkit, all 44 assertions must be achieved by the organisation.

These standards address modern data security threats as well as inherent information governance processes operated at NHS organisations.

All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Board are advised that the Trust is continuing to work towards providing the 116 mandatory evidence requirement of the Toolkit. We currently have complete 113 of the 116 requirements and aim to have the remaining 3 completed by 28 March.

In order to provide assurance that the organisation has in place effective data security and information governance controls and processes as directed by the DSP Toolkit, TIAA have conducted a review of a sample of these Standards.

The review tested a sample of four of the 10 Data Security Standards for completeness and validity of evidence and statements supporting the assertions and mandatory evidence items associated with those standards.

The TIAA review adopted a two stage approach and the final audit report has been received. The Trust achieved 'Reasonable Assurance'. The overall conclusions contained within the report state:

> **The audit covered a sample of 41 mandatory evidence items from a total of 116 that the organisations must complete for the final submission.**
>
> - **Forty evidence items sampled had statements and/or documentation to support the claimed position of "met".**
> - **One evidence item is yet to be completed. This relates to incident reporting. The Trust will complete this item at the time of submission to ensure that the data for the whole financial year is included.**
> - **At the time of writing, overall the Trust has completed 107 of 116 mandatory evidence items, the remainder to be confirmed by the March 2020 submission.**

The Board are advised that throughout the year the Information Governance Committee has received regular reports on the Toolkit progress. It reviewed the latest Toolkit position on 11 March and received the final Audit report from TIAA. As a consequence the Committee are happy to recommend that a 'Standards Met' year-end submission be made prior to 31 March 2020. The Board are asked to support this position.

In additional to the work undertaken to complete the mandatory evidence requirements for the Toolkit the Information Governance Committee has also received regular reports on the work being undertaken in relation to Cyber Security.

Cyber Security

It is mandatory that all NHS organisations are Cyber Essentials Plus accredited by 2021. Cyber Essentials Plus is a government-backed, industry-supported scheme designed to help organisations protect themselves against common on-line threats. The Trust achieved the accreditation during the Autumn of 2019 and continues to work to improve resilience against a Cyber event.

A business continuity table top exercise was held in November based around a Cyber event impacting clinical services. The event was well attended and a number of areas for improvement to local plans identified. Directorates are working with the Emergency Planning team to ensure actions are completed in a timely fashion.

IG Incidents

In the year to date there have been three incidents, the detail of which triggered the use of the Data Security and Protection Incident Reporting Tool.

Reference	What happened
19209	Staff were notified of the recent death of a colleague. A number of individuals with legitimate access to the medical records systems have accessed the deceased digital medical record without legitimate need. As a result appropriate investigations have been conducted.
17552	A member of staff has, against policy, used their legitimate role based systems access, to access their own record, their mother's record and the record of a colleagues baby.
17467	An excel spreadsheet containing details of internal incident investigators was disclosed in error to a claimant's solicitor.

One of the above incidents met the threshold for notification to the ICO. On reviewing the case the ICO concluded that the Trust had taken appropriate action and the case was closed. Each of the three incidents has been subject to the Trust internal incident investigation process whereby root causes are identified and remedial actions detailed and implemented.

Information Risks

The Board are advised that no new Information Governance risks have been added to the Trust risk register since my last annual report in March 2019.

All Directorates and Departments have reviewed their Business Continuity Plans to ensure they have been updated to reflect to Trust’s ongoing journey to a paper-light environment.

NHS Maidstone and Tunbridge Wells NHS Trust

Six monthly update on Estates and Facilities	Chief Executive (on behalf Director of Estates and Facilities)

The Estates and Facilities Directorate has been engaged on a wide ranging number of developments supported by the Trust Board over the last six months since the previous report was issued. In respect of operational matters the Directorate has been working on providing improved support to Clinical colleagues and departments. Also making improvements in food offerings and environmental improvements to both sites.

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

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

[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

Environmental Improvements

During the last six months the Trust has engaged with both the Tunbridge Wells Borough Council and Maidstone Borough Council on the two respective sites land and its biodiversity.

The Trust is conscious that there has been significant reduction in indigenous insect species and spiders over the last decade due to environmental stress. There has also been a practice in the United Kingdom of introducing non indigenous trees and plants into the UK that have been used in developments for aesthetic effect. On the advice of a member of staff the Trust approached the Kent Wildlife Trust and a series of productive meetings and surveys have taken place at both Maidstone and Tunbridge Wells Hospital land estate.

The contribution of the Kent Wildlife Trust at minimal cost has been significant and plans are now in place to be put forward to the Executive to progressively redevelop the land on both sites to accommodate indigenous species of plants and to introduce natural gardens. The plans also incorporate providing sustainable habitats for insects, spiders and bee populations. During the last quarter a substantial number of foreign plants that are not compatible with natural insect populations have been removed. The Trust has developed a dialogue with the biodiversity officers at both local authorities who have strongly supported the environmental sustainability measures being undertaken by the Trust. This coming summer it is expected that the changes taking place shall considerably assist insect wildlife that have been significantly declining in all areas of Kent.

The internal atria's of the Maidstone Hospital are being progressively improved with rejuvenation of neglected areas. The Maidstone Hospital Charity funded the refurbishment of an atria at Maidstone Hospital. The new garden in the atria is of considerable benefit to patients providing a tranquil environment to reflect in whilst undertaking medical care. The atria garden was opened by David Highton, Trust Chairman on the 16th January 2020.

Construction and Commissioning of the new Acute Assessment Unit (AAU) unit at Maidstone Hospital

The construction and commissioning of the new AMU building at Maidstone Hospital has now been successfully completed. The new building will provide service to patients and assist overall in the emergency medical provisions provided by Maidstone Hospital to the people of Kent.

The new AMU building is to be officially completed on the 20th February. Staff from the A&E offices moved in on the 25th February and the AMU staff have transferred to the new AAU unit which has come into service on the 11th March 2020. (AMU picture)

Rapid Assessment Point (RAP)

The construction of the Rapid Access Point at Maidstone Hospital has now been let to MACS Construction (Essex). Construction works commence on the 11th March, the contract duration period for the works is 8 weeks. Planned completion date is the 8th May 2020. The specific benefits and advantages of the new Rapid Assessment Point is that it enlarges the current RAP from 3 beds to 7 beds+ 1 additional resuscitation bed with full medical piped gas facilities.

Car Parking

The Trust in 2019 vigorously responded to the significant over parking problems that occur at both Maidstone and Tunbridge Wells hospitals. In December 2019 the Trust granted permission following the provision of an outline business case for the procurement and construction of two new car decks at Maidstone and Tunbridge Wells Hospital respectively.

For financial accounting reasons the two projects required to be built in record time in conjunction with planning applications to Maidstone Borough Council and Tunbridge Wells Borough Council. Both local authorities were engaged in detailed consultation and the Chief Executive and Senior Trust Officers met with local councillors to discuss the proposals of the schemes. Both local authorities have been exceptionally supportive and pro-active in development of the new car decks with the planning applications. The two schemes have both been now delegated to minor planning discharge under the delegated authority of each borough councils Director of Planning.

Ballast Nedham, a major Dutch civil engineering contractor where successful in being awarded the contract of the construction of the two car decks. Estates officers and Ballast Nedham have worked in partnership for the delivery of fast track construction programme projected for the end of March 2020. Following the completion of construction work a commissioning phase will be undertaken on both sites re-designating both visitor/staff parking locations across all car parks. Maidstone Hospital shall benefit with the addition of 211 car parking spaces and Tunbridge Wells Hospital 174 additional car parking spaces. It is proposed that a designated number of car parks shall also be available to members of staff who car share. The programme also requires maintenance work carried out on car park paint lining and colour coding designation of parking zones. The anticipated launch of the revised car parks is scheduled for the week commencing the 18th May.

The two local authorities planning directorates have indicated that they shall be seeking stipulations that green walls are planted around the periphery's of the new car parking decks. Also the requirement of new indigenous trees being planted on both sites to assist in the reduction of hospital CO_2 emissions.

A particular challenge that has been taken up most successfully by Trust staff is the interim arrangement of establishing park and ride services at Allington, Maidstone, Hop Farm at Paddock Wood and the Knights Park Retail Centre at Tunbridge Wells. The Park and Ride facility has been provided by Arriva and Streamline Coaches. The Trust has also during this period extended partnership working relationships with Arriva buses and is engaged in ongoing dialogue with introducing additional permanent bus services to the hospitals in line with Kent County Council requirements and the Trust Transport Plan.

Trust Fire Safety

The Kent Fire and Rescue Service shall be carrying out an audit of Maidstone Hospital and Tunbridge Wells Hospital in respect of the Trusts obligations to comply with the 2005 Regulatory Reform Fire Order. The audit at Maidstone Hospital shall be carried out during April 2020. The Estates Directorate is currently updating and revising fire safety documentation. The outcome of the audit shall be of considerable assistance in defining any additional requirements the Trust is required to undertake to meet with compliance of the Act. The programme is being led by Mark Vince, Head of Fire and Safety.

Facilities Management Developments

Staff Amenities Group has benefited staff with initiatives led by Facilities including:-

Free ice creams during hot weather
Free food wraps
Soup kitchens during the day and early evening
Provision of free hot drinks and meals for park and ride users
Picnic areas for staff and improvement to grounds

These provisions have been well complimented by Trust staff.

Care Quality Commission Report

The Estates and Facilities Directorate is carrying out a range of remediation and preparation duties for the forthcoming Care Quality Commission Inspection working under the direction of Claire O'Brien, Chief Nurse and her team.

Grichan Consultancy - Estates and Facilities review

The Grichan Partnership is currently undertaking a performance review of the Estates and Facilities functions within the Trust. The outcome is scheduled for Easter of this year.

NHS
Maidstone and Tunbridge Wells NHS Trust

Confirmation of the outcome of the Trust's 'going concern' assessment

Chief Finance Officer

The enclosed report sets out the Trust's consideration of its status as a going concern for inclusion in the 2019/20 Annual Accounts and Annual Report. This has been agreed by the Executive Team and reviewed by the Finance and Performance Committee on the 24th March.

The Trust Board is asked to approve the statement for inclusion in the Trust's draft Annual Accounts and Annual Report, subject to final confirmation with the approval of the finalised Accounts and Annual Report in May 2020.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee 24/03/20

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

For review and decision

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

The DHSC Group Accounting Manual requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts. In para 4.12 it states:

‘‘For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up”

The Finance and Performance Committee has reviewed and agreed the following statement on the consideration of the Going Concern approach for the 2019/20 Annual Accounts and Annual Report:

“The Trust Management has assessed the Trust’s ability to continue for the foreseeable future in the light of the GAM guidance. The Trust is planning to compile the 2019/20 accounts on a “going concern” basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.
- The Trust has submitted its initial business plan to NHSI in March 2020 setting out its operational plans for the following financial year (2020/21) and its capital plans for five years. The final plan submission is scheduled for the 29th April.
- The Trust exited from financial special measures in October 2018. The Trust is planning in 2019/20 to fully achieve PSF and MRET requirement therefore to deliver a planned surplus of £6.9m.
- The Trust continues to fully participate in the STP planning process including the submission in October 2019 of the forward 5 year financial and operating plans (Long Term Plan) on a going concern basis. The Trust is leading some of the significant Work-stream areas and a key player in consideration of the shape of services in the STP for the future e.g. it is one of the selected sites for Hyper Acute Stroke Unit as part of the STP-wide Stroke services consultation.
- The Trust will have contracts in place for provision of healthcare services for 2020-21. This will include contracts with the newly formed CCGs in Kent, Surrey and Sussex which include: NHS Kent & Medway CCG (the Trust’s main commissioner, representing 71% of clinical income), NHS East Sussex CCG, NHS West Sussex CCG, NHS Brighton and Hove CCG and NHS Surrey Heartlands CCG. It is anticipated that the aligned incentives contract model will be extended to cover the new K&M CCG contract. This provides certainty for income and cash flows in 2020-21.
- The Trust has prepared and submitted cash-flow plans for 2020/21 which does not include any assumptions of additional required working capital finance. The existing working capital loans have been converted to PDC in line with the national changes to the debt regime.
- The Trust does not consider that there are any material uncertainties to the going concern basis. However it will assess and disclose within it 2019/20 accounts challenges to its financial plans for 2020/21 around its cost improvement programme and risks to achieving its financial improvement trajectory within the overall Kent and Medway system trajectory.

For these reasons, the Trust will prepare its Accounts using the going concern basis in line with the GAM guidance.”

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 04/03/20	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 4th March 2020.

The key matters considered at the meeting were as follows:

- Under the update on **actions from previous meetings** it was agreed that the General Manager for facilities would take over ownership of investigating the reported problems in relation to the car parking payment machines and response time to the support call button at Maidstone Hospital (MH), and investigating the concerns raised at the PEC meeting on 02/12/19 in relation to the League of Friends shop staff at MH having to respond to queries arising from the 5pm closure of the main reception desk (and the planned relocation of the security desk).
- The **"Safety moment"** item focused on infection control.
- The Chief Nurse gave an **Update on the PEC's Code of Conduct** based on feedback received from Committee members, it was agreed that the interim Head of Patient Experience should circulate some alternative titles for the PEC's Code of Conduct to Committee members to enable feedback to be provided within one calendar month for discussion at the PEC on 11/06/20. It was also agreed the Deputy Chief Nurse and General Manager for facilities should investigate the current status of the red tray process (to support inpatients that require assistance with their meals).
- The Interim Head of Patient Experience and Chief Nurse gave an **update on the Trust's Patient Experience Strategy (incl. Request for feedback on the Trust's Core Patient Leaflets)** which focused on the work being undertaken to improve the patient experience within the Trust and ensure information was readily available in accessible format.
- The Interim Head of Patient Experience gave a presentation on the **Patient Partners Pilot** which highlighted the scope of the work being undertaken.
- The Complaints and PALS Manager reported the Trust's initial **Response to Healthwatch England's report "Shifting the Mindset – A closer look at NHS complaints"** which included the work being undertaken for the Trust to improve the complaints process in line with the considerations outlined in the report.
- The Interim Patient Experience Lead provided **Feedback from the Friends and Family Test (FFT)** which highlighted the change in provider for the FFT and the new approach being trialled to increase feedback received by the Trust.
- The Trust Secretary gave a **review of the relevant aspects of the Board Assurance Framework** which focused on objective 3 "Improve complaints performance to 75% across all divisions and directorates by March 2020".
- Under the "**To confirm the items and date for the next meeting**" item the Chair reported the approach being taken to optimise productivity of the Committee and it was agreed that the Assistant Trust Secretary should Schedule an item at the June 2020 PEC meeting to discuss and agree the forward programme.
- Under "**any other business**", it was agreed that the General Manager for Facilities should investigate the lack of a mirror in the men's toilets by the League of Friends shop at MH

In addition to the actions noted above, the Committee agreed: N/A

The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Summary report from Quality Committee, 11/03/20	**Committee Chair (Non-Executive Director)**

The Quality Committee met on 11th March (a 'main' meeting).

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

- The **"Safety Moment"** item, which was on infection prevention and control, was noted, but it was acknowledged that the Trust's response to COVID-19 was the most pressing infection control issue.
- The issues raised from the **reports from the five clinical Divisions** included the latest details on incidents, Serious Incidents, staffing issues, duty of candour compliance, the external audit of the aseptic service at Maidstone Hospital, the most recent Never Events, and patient transfer problems. On the latter issue, it was agreed that a report should be submitted to the 'main' Quality Committee in May on the actions being taken by the Trust in response to the concerns raised. It was also agreed that the Deputy Chief Nurse should provide the Quality Committee with details of the Trust's response to the concerns raised by the Medicine & Emergency Care Division regarding the Objective Structured Clinical Examination (OSCE) failure rate of recent overseas nursing recruits. It was further agreed that the Medical Director and Chief Nurse should arrange for a review of the Never Events that had occurred at the Trust to be undertaken, in light of the seeming common themes involved in some of the Events, and submit the outcome to the 'main' Quality Committee
- The Associate Director, Quality Governance submitted a **Update on implementation of Quality Accounts priorities 2019/20**
- A **revised Quality Strategy** was reviewed and agreed (subject to further editing to align the document with the suite of other Trust strategies. The Strategy would be submitted to the Trust Board, for approval, in due course
- The **proposed Quality priorities for 2020/21** (for inclusion in the 2019/20 Quality Accounts) were reviewed and agreed, subject consideration of amendment to the text of one of the objectives (to "Progress with the implementation of Mental Capacity Assessments and Deprivation of Liberties safeguards as part of our commitment to safeguard patients")
- The Deputy Medical Director reported the **latest position on SIs**, which included an update on compliance with the duty of candour & the trajectory for the reduction in overdue incidents
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality,** which included the latest position on the Trust's Hospital Standardised Mortality Ratio (HSMR) & the positive relative HSMR position when compared to peers, including Western Sussex NHS Foundation Trust
- The relevant **recent findings from relevant Internal Audit reviews** were noted
- The Trust Secretary reported the **relevant aspects of the Board Assurance Framework**
- The report of the **Quality Committee 'deep dive' meeting on 06/02/20** was noted
- Reports were received from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit (CLIPA) group; the Infection Prevention and Control Committee; the Joint Safeguarding Committee; and the Drugs, and Therapeutics and Medicines Management Committee)

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

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

- It was agreed that the Chief Operating Officer or Chief Nurse should update the Trust Board on the actions being taken by the Trust in response to the concerns raised by the Diagnostics & Clinical Support Division regarding the patient transport service that was provided under contract to West Kent Clinical Commissioning Group

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