Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

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

10.30am, WEDNESDAY 27TH APRIL 2016

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
4-1	To receive apologies for absence	Chairman	Verbal
4-2	To declare interests relevant to agenda items	Chairman	Verbal
4-3	Minutes of the Part 1 meeting of 23rd March 2016	Chairman	1
4-4	To note progress with previous actions	Chairman	2
4-5	Safety moment	Chairman	Verbal
4-6	Chairman's report	Chairman	Verbal
4-7	Chief Executive's report	Chief Executive	3
4-8	Board Assurance Framework, 15/16: year-end review	Trust Secretary	4
4-9	Integrated Performance Report for March 2016 ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-led (workforce)	Chief Executive Chief Nurse Medical Director Dir. of Infect. Prevention and Control Director of Finance Chief Operating Officer Director of Workforce	5
	Quality items		
4-10	Progress with the Quality Improvement Plan	Chief Nurse	6
4-11	Planned & actual ward staffing for March 2016	Chief Nurse	7
4-12	Trust Board Members' hospital visits	Trust Secretary	8
	Planning and strategy		
4-13	Confirmation of the Trust's final planning submissions, 2016/17	Director of Finance	9
4-14	Approval of the OBC for additional Radiotherapy LinAc bunker capacity at Tunbridge Wells Hospital	Director of Finance	10
	Other matters		
4-15	Response to the national staff survey 2015	Director of Workforce	11
	Reports from Board sub-committees (and the Trust Management Executive)		
4-16	Quality Committee, 13/04/16	Committee Chairman	12
4-17	Trust Management Executive, 20/04/16	Committee Chairman	13
4-18	Finance Committee, 25/04/16	Committee Chairman	14 (to follow),
4-19	**To consider any other business**		
4-20	**To receive any questions from members of the public**		
4-21	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 25th May 2016, 10.30am, Education Centre, Tunbridge Wells Hospital		

Kevin Tallett,
Vice-Chairman of Trust Board
(on behalf of Anthony Jones, Chairman of Trust Board)

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 23RD MARCH 2016, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Coralle Baillie	Member of Integrated Discharge Team (for item 3-10)	(CB)
	Lynn Gray	Associate Director of Nursing, Emergency Services (for item 3-10)	(LG)
	Dawn Hallam	Operations Manager (Discharge) (for item 3-10)	(DH)
	Richard Hayden	Director of Workforce	(RH)
	Stephanie Line	Member of Integrated Discharge Team (for item 3-10)	(SL)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Sara Williamson	Member of Integrated Discharge Team (for item 3-10)	(SW)
	Russell Woodruff	Member of Integrated Discharge Team (for item 3-10)	(RW)
Observing:	Hannah Alland	Digital Communications Officer	(HA)
	Claire Barnett	Assistant Trust Secretary	(CBa)
	David Bennett	Member of the Public / Member of the Trust's Patient Experience Committee	(DB)
	Bernard Brown	Member of the Public	(BB)

3-1 To receive apologies for absence

Apologies were received from Sylvia Denton (SD) and from Glenn Douglas (GD) who was unable to attend due to an urgent commitment.

AJ noted that this was RH's first Trust Board meeting since his appointment as Director of Workforce. AJ also explained that members of the Integrated Discharge Team would be attending, for item 3-10, to give a presentation.

3-2 To declare interests relevant to agenda items

There were no declarations of interest.

3-3 Minutes of the Part 1 meeting of 24th February 2016

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

3-4 To note progress with previous actions

The circulated report was noted. Verbal updates were given on the following actions:

- **Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director").** PS reported that the Medical Rotas were being reviewed, but progress had stalled because of the new (national) Consultant contract, for

which guidance would be issued in April. PS elaborated that the primary aim was to review the rationalisation of rotas, but there was a need to optimise the rotas in light of the new contract.

KT remarked that he would find it useful to see the spread of rotas i.e. the basic range, plus details of Consultants who performed at the extreme ends. PS replied that the intention was to collate a booklet, to describe the on-call rota, and queried whether this would serve KT's purpose. KT clarified that he was mainly interested in Job Planning issues. PS suggested that this would therefore be more appropriately discussed at the Workforce Committee. The point was acknowledged. It was however agreed that PS would provide a verbal update on the latest situation regarding the review of Medical rotas at the Board in May 2016.

Action: Provide a verbal update to the Trust Board, in May 2016, on the latest situation regarding the review of Medical rotas (Medical Director, May 2016)

- **Item 1-12 ("Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis".** AG reported that the issue was complex, but the required data should be able to be reported to the Board in April 2016.
- **Item 1-19ii ("Revise the Reservation of Powers and Scheme of Delegation to reflect the amendments made at the Trust Board on 27/01/16").** KR reported that the action would aim to be completed by the end of March.
- **Item 2-15 ("Circulate, to all Trust Board Members, the 'straw man' that has been developed to aim to improve flow/discharge, and address the capacity gap within the West Kent health and social care system**"). JL reported that he intended to share a 'straw man' of a proposal to work with an external third party, and he had yet not circulated this as the issue had developed further. JL continued that he would however share the initial proposition after today's meeting, and then share a more developed iteration in due course.
- **Item 1-19i ("Arrange for the Workforce Committee to review the current list of authorised car and mobile phone users at the Trust")**. KT asked for the outcome of the discussion at the Workforce Committee. RH replied that the small number (i.e. less than 10) of lease car owners had been reviewed, and an action was agreed for he and SO, which related to the application process. RH added that the Trust had however now introduced a salary sacrifice scheme for lease cars.

  KT asked whether lease car owners were given allowances. RH replied that this was the case for a small number of individuals, but the number had reduced markedly.

- **Item 2-7iii ("Arrange for a list of the main individuals undertaking fundraising activity for the benefit of the Trust to be reported to the Trust Board").** AJ highlighted the list in Appendix 1, but noted that this did not include the contribution from the Leagues of Friends at both hospitals.

3-5 Review of the Trust Board's Terms of Reference

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

- The Terms of Reference were due their annual review, and a number of minor / 'housekeeping' changes had been proposed
- The proposed changes were shown as 'tracked', and should be self-explanatory

The Terms of Reference were approved as circulated.

3-6 Safety moment

AJ referred to a previous 'Safety moment' that had been raised regarding traffic, and stated that he wished to highlight two associated issues. AJ continued and stated that the traffic flow at the front of Maidstone Hospital (MH) had involved some near misses, in terms of accidents. AJ therefore asked AG to arrange for the road signage at the entrance to MH to be reviewed, to confirm this was adequate from a safety perspective.

Action: Arrange for the road signage at the entrance to Maidstone Hospital to be reviewed, to confirm this was adequate from a safety perspective (Chief Operating Officer, March 2016 onwards)

AJ also referred to the previously raised issue of staff using unofficial pathways in the exterior to the Tunbridge Wells Hospital (TWH) site, and asked for an update. AG replied that no concerns had been reported recently, and Security undertook patrols to ensure compliance. AG added that observations of staff had been discussed at the Health & Safety Committee, and this had been beneficial.

AJ then asked about parking at TWH. AG reported that additional spaces for staff had been secured at the adjacent Mercure Hotel, and the 'Parking spaces available' display Board directed patients to available spaces. SDu noted that the display board was not functioning as intended when she entered the TWH site that morning. AG agreed to check the functioning of the Board.

Action: Arrange for the 'Parking spaces available' display Board at the entrance to Tunbridge Wells Hospital to be checked, to confirm this was functioning as intended (Chief Operating Officer, March 2016 onwards)

3-7 Chairman's report

AJ noted that he had nothing to report.

3-8 Chief Executive's report

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

- The first "Learning from Mistakes League" data had been published, which would be discussed later in the meeting
- The new Acute Medical Unit (AMU) at TWH was now open, and Trust Board Members would be welcome to visit

AJ referred to the latter point, and proposed that a formal visit be arranged. This was agreed.

Action: Arrange for Trust Board Members to visit the new Acute Medical Unit at Tunbridge Wells Hospital (Chief Operating Officer / Trust Secretary, March 2016 onwards)

AG also reported that the 12 beds at Tonbridge Cottage Hospital would be available for patients from acute beds that had continuing rehabilitation needs. AG added that Kent Community Health NHS Foundation Trust (KCHFT) would also commission 8 beds at Sevenoaks Hospital, which had previously been used for Neuro-Rehabilitation.

AJ stated that it was worth reflecting that if the Trust had not taken the decision to increase its bed base, which was not the norm in the NHS, the Trust would be in a far worse position. AG agreed, and noted that circa 50 additional beds had been introduced into the local health economy.

KT asked how the introduction of the new beds had been communicated with staff, noting that he had heard some negative comments from staff (in the local cafeteria) regarding the fact that the beds in the new AMU would not have single rooms. AG stated that the single/non-single room environment issue had been discussed at length, and the non-single room environment had been selected as evidence had shown that single rooms were not conducive to the model of care the Trust wished to introduce. KT suggested that a focused communications exercise be undertaken. AJ replied that lots of communication had already been undertaken on the issue, and she was unaware of any negative views.

JL then continued, and highlighted that the implementation of the new Patient Administration System (PAS) would be a very significant undertaking in the coming months.

KT then referred to the "West Kent Clinical Commission Group's recent urgent care strategy" on page 1 of 2, and asked whether the Strategy had been seen by the Board. JL stated that the Strategy could be circulated, but highlighted that it was not yet finalised. It was agreed to circulate the document to Trust Board Members.

Action: Circulate West Kent Clinical Commission Group's draft Urgent Care Strategy to Trust Board Members (Deputy Chief Executive, March 2016 onwards)

3-9 Integrated Performance Report for February 2016

JL referred to the circulated report and highlighted that the single largest issue facing the Trust was the effectiveness by which patients flowed through the Trust's hospitals. JL elaborated that the flow affected almost every part of the Trust's operations, not just A&E performance i.e. elective care, Cancer care, financial performance etc. JL added that although much more needed to be done by the Trust, the importance of working with external partners could not be emphasised enough, and the Trust's future prosperity was dependent on this.

AJ noted the 21.8% increase in A&E attendances was unprecedented. JL agreed this was extraordinary.

ST asked whether the reasons for the significant increase were known. AG confirmed the reasons were unknown. PS noted that similar increases had been experienced by other organisations. AG elaborated that the change that had been seen in the winter months had continued into March, but there had been no particular change in disease pattern or condition. AJ remarked that all of the hospitals in the South East were operating at with bed occupancy levels exceeding 90%. AG confirmed this was the case, and noted that bed occupancy of 85% was the ideal.

KT queried whether an analysis of patients' originating location had been carried out. AG replied that some increases had been identified from the East Sussex and Medway areas, but this did not account for the aforementioned surge. KT asked whether GP workload had increased. AG answered that West Kent Clinical Commissioning Group (CCG) had confirmed that record numbers of patients had been seen. JL also confirmed this was the case.

ST opined that there appeared to be a systemic problem, and therefore the Trust needed to plan for increased capacity and flow throughout the whole system. AJ concurred with ST's assessment. AG added that there was a need to ensure that elective capacity was more resilient. JK noted that West Kent CCG would soon be modelling the area's capacity needs over the next 20 years, although much of this need was being modelled outside an acute hospital environment, which led to questions as to who would fund care that did not fit within traditional boundary distinctions.

AJ then invited AB, PS, SM, SO, AG, and PB to highlight any key points.

Safe / Effectiveness / Caring

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

- Information regarding Falls had been included in Attachment 6
- There was an error on the dashboard regarding the "% complaints responded to within target": the "Prev Yr", "Year to Date" figure should be 67.9%, not 75%. This meant that the year to date performance was an improvement when compared to the previous year. The response for March was also above 65%
- The Trust was performing to plan in relation to the scores for the Friends and Family Test (FFT), but the response rate performance had been challenging. The recent dip in response rates was due to problems in providing the A&E data to the external provider used by the Trust ("iWantGreatCare") but this issue had now been addressed. However, although the rates were behind the Trust's internal plan, they were still in accordance with the national average

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report and highlighted that the latest Hospital Standardised Mortality Ratio (HSMR) was 100.08, but he was not aware of any particular issues of concern.

ST then referred to a report from the Royal College of Obstetricians and Gynaecologists that had been subject to recent media coverage, and asked how the Trust fared in relation to the issues raised. AJ proposed that PS review the report and provide an appropriate response to the Trust Board. This was agreed.

Action: Review the "Patterns of maternity care in English NHS trusts 2013/14" report published by the Royal College of Obstetricians and Gynaecologists in March 2016, and provide an appropriate response to the Trust Board (Medical Director, March 2016 onwards)

Safe (infection control)

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

- There were no concerns regarding Clostridium difficile or MRSA bacteraemia
- There had been some cases of Norovirus at MH, but these had been sporadic, and there had been no Ward to Ward spread. The cases had been managed very well.

Well-Led (finance)

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

- The financial position in February had been adversely affected by non-elective pressures. The conversion rate was lower than in previous years, but significant levels of escalation capacity were in use, and there were a large number of Medical outliers
- Escalation capacity had placed increased demand on the workforce, which resulted in increased expenditure on Agency staff, particularly for Nurses
- The in-month deficit was just below £2.8m, whilst the deficit for the year to date was £24.8m
- The year-end forecast was for a deficit of £23.5m, and the Finance Committee had discussed the efforts being made to ensure this was met

AJ highlighted the oddity of increased WTE, increased vacancies, increased Agency usage and decreased income, and emphasised the importance of achieving an appropriate balance.

AJ then referred to the 36.8% reduction in ""Overtime (WTE)", and asked for an explanation. SO and RH agreed to provide an explanation.

Action: Provide an explanation for the 36.8% reduction in "Overtime (WTE)" reported on the Trust Performance Dashboard for month 11 (Director of Workforce / Director of Finance, March 2016 onwards)

ST remarked that with the new capacity from the AMU at TWH, performance against the A&E 4-hour waiting time target might be expected to improve dramatically, and asked whether this was the case. AG replied that it was difficult to gauge the impact of the AMU after only 1 week, as performance on that target was largely affected by Length of Stay (LOS) (which was known to need a reduction by an average of at least 1.1 days), as well as Delayed Transfers of Care (DTOCs), which were currently at 6%.

ST then referred to Stroke performance, and noted that this was not as good as the Trust wanted, but the Trust was constrained by the Kent and Medway Stroke Services Review. ST continued that he had heard different timescales regarding the associated decision-making process. AG answered that PS would be able to reply regarding the Review, but noted that all of the Trust's improvement targets had been met in relation to current Stroke care. PS then reported that the Kent and Medway Stroke Service Review was continuing, and was entering the next stage, but he was unable to give clarity on timescales. PS added that regardless of the system-wide issues, the Trust's performance was improving. AJ proposed that PS write to NHS England to express the Board's frustration at the lack of progress. PS proposed that he instead contact NHS England, and report the position to the next Board meeting. ST asked what was preventing the Trust pursing its own future direction. PS pointed out that that the Review was commissioner-led. ST asked when the point would be reached that the Trust could not continue with the delay, and therefore propose how a new arrangement could be funded. JL replied that the Trust had already been open with commissioners regarding the outcome of the Review, but pointed out that it was difficult for the Trust to take action in isolation. AJ stated that he was also frustrated by the lack of any decisions. JL agreed to highlight the Trust Board's frustration to NHS England.

Action: Highlight, to NHS England, the Trust Board's frustration at the apparent lack of progress being made via the Kent and Medway Stroke Services Review (Deputy Chief Executive, March 2016 onwards)

AK emphasised the importance of seeking a diplomatic solution. JL concurred with the point.

Effectiveness / Responsiveness (incl. DTOCs)

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

- In 2015, January had seen the re-stabilising of activity after the winter period, and the Trust's current plans had been based on this. However, this situation had not materialised in 2016
- Cancer performance had not yet fully recovered, although more patients had been treated in January, as had been agreed with the NHS Trust Development Authority (TDA). A recovery plan was in place, which should lead to continuous improvement

AJ referred to Cancer performance, and stated that the data did not show any improvement, which was concerning. AJ added that that he did not understand why the problems had occurred. AG explained that the increase in volume of patients, and delays in diagnostics, had led to the problems. AG continued that although the number of treatments carried out had been increased, treating the backlog would also have an impact. AG also reported that each of the Multidisciplinary Team (MDT) Leads had shown responsibility in needing to improve, and gave assurance that the issue was subject to significant focus. PS added that having been to a recent MDT meeting, a range of factors were involved, including disease confusion, patient choice (such as wanting to defer treatment in order to get married etc.). AJ acknowledged the point, but stated that such factors would have also been present for the previous year. AG agreed that such factors had been present, but highlighted that the flexibility for mitigating these had been reduced.

KT asked when it was intended to return to good performance. ST also asked whether the resources were available (in terms of capacity) to manage the activity. AG replied that there were some capacity issues, as well as some diagnostic issues (but not for all tumour sites), and work had been undertaken with SM and her colleagues. AG confirmed that normal performance would be in place by September or October 2016.

KT proposed that future "Integrated Performance Reports" to the Board included additional information on Cancer performance, i.e. beyond the usual level of detail. This was agreed.

Action: Arrange for future "Integrated Performance Reports" to the Board to include additional information on the Trust's performance on the Cancer access targets (Chief Operating Officer, April 2016)

Well-Led (workforce)

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

- February was the eighth month in succession that the Trust's 'headcount' had increased
- Sickness absence had however increased

AJ asked for a comment on the recruitment 'pipeline' for Nursing staff. AB relied that most of the international Nurses that had been recruited had now arrived, and large numbers of local Nurses had also recently joined. AB added that after today's Board meeting, a meeting had been scheduled to discuss the planning for the next year.

KT pointed out that the "Plan/Limit" section of the report relating to workforce indicators had not been populated. RH agreed to include such detail in future reports.

Action: Arrange for the workforce metrics within the "Well-Led" section of future "Integrated Performance Reports" to the Trust Board to include full details of the year-end "Plan/Limit" (Director of Workforce, April 2016)

ST noted that the Finance Committee had expressed continuing concern regarding the relationship between activity (Occupied Bed Days), Whole Time Equivalent worked, and expenditure. SO noted that he had been asked by the Finance Committee to ensure that the relationship between the three elements was reported within the monthly financial information submitted to the Committee.

Presentation from a Clinical Directorate

3-10 The Integrated Discharge Team

AJ welcomed CB, LG, DH, SL, RW, and SW to the meeting. A presentation was then given, highlighting the following points:

- Previously, 3 teams were all working on complex discharges, which resulted in: poor visibility of progress on patient's discharge; lack of knowledge about alternative services; and poor visibility of pressures and any issues effecting discharge
- The Discharge Liaison Team (SL) focused on: Continuing Health Care (CHC); complex discharges (especially issues like homelessness, un-befriended patients etc.); and support for self-funding patients East Sussex patients.
- The Community Liaison Team (SW) focused on: discharges into community hospitals; community pathways for IV antibiotics (although this was work in progress); and the High Impact Team (HIT) in A&E regarding admission avoidance. The Team also purchased commercial beds for non-weight bearing patients
- Kent County Council Social Services (RW) focused on: care packages; long term placements; Enablement (which aimed to get patients back to the baseline in their own homes); and involvement in CHC decisions
- The core principles of the Integrated Team were: to have one single point of referral; one single version of the truth; an openness to alternatives; co-location; transparency about issues within the service; to represent each other; and to provide some internal resilience
- The objectives set were: to reduce LOS; to increase number of discharges per day (and attempt to improve prediction); to move discharges earlier in the day; to deduce DTOCs; and improve awareness of the factors outside the acute hospital that would effect flow (including, for example the Easter holidays)
- In terms of achievements, the integration of the new Team started in November 2015, with a single referral point and contact number. Single referral worked (although there was still some work to do with Wards re giving enough and accurate information). The single contact number worked about 90% of the time. In addition, a Team referral log was in place (which included all patients referred to any Team, to be clear as to which staff were involved); and all referred patients were on update boards, so the Team were aware of next actions
- Other achievements included a single written report back to Site Meetings, with both confirmed and potential discharges for the day. There was a target of 10 per day per site for complex discharges, and this was now being consistently achieved on both sites. There had also been a reduction in DTOCs (although this was still above national target, but not all of the delays were attributable to the Team)
- The benefits of the Team for patients included: less time in hospital; smoother transitions between services; more explanation with clearer choices; and removing the worry as to which service needed to act
- The benefits for staff included: quicker access to each other; less duplication of work; more ideas and options being generated; and improved understanding of what was available (and what the limitations were)
- The benefits for the Trust included: a reduction in DTOCs, leading to a reduction in LOS; improved compliance with pathways; clear accountability; clear visibility of where delays were occurring and the actions needed to resolve issues; and generation of new ideas to improve discharge and reduce delays
- Next steps included: working with 'Newton Europe' to decrease placements with Social Services; a "Trusted assessor" project to be piloted with the new CHC pathway to Darent House (which was previously the Neuro Rehabilitation Unit); cross-organisation 'up-skilling' (especially for Nursing related assessments); increasing the discharge target incrementally (for example, April's target was 11 per day); and to work with enablers such as HILTON (a Social Services funded project to provide 'short, sharp' packages of care for up to 5 days) and CHS (a care home finding service)
- There was also a real focus on the new AMU at TWH, to discharge those patients wherever possible (and clinically appropriate)

AJ thanked DH and her colleagues for the presentation, and highlighted the crucial nature of the work to the functioning of the Trust. AJ added that working an integrated approach was the best way to achieve solutions, so congratulated the establishment of the Team, and encouraged them to continue to develop.

SO asked whether more resources had been required to establish the Team. LG replied that this was not the case, as the same number of staff had been involved as had been involved in the previous disparate teams.

SO also asked about the use of performance metrics. DH replied that DTOCs were a key metric, as was LOS, but day-to-day monitoring included the number of discharges achieved each day. SL emphasised that there was challenge and competition within the Team, which helped to improve.

SO then referred to the 'next steps', and asked whether there was anything that had not been presented that would lead to over 12 discharges being achieved per day. DH replied that having additional Social Services staff was important, but it would be beneficial to merge the whole team organisationally (i.e. rather than have the 'virtual' integration model that was, in effect, in place).

KT asked for a comment on the Team's use of IT. DH replied that an internal system was currently used, but DH was optimistic regarding the new PAS being implemented at the Trust, whilst a bespoke system solely for discharge would be very helpful. KT opined that there should be some scope to do this. DH noted that there had been some information governance–related problems when this had been mooted previously.

KT also noted that he was meeting with the Chief Executive and founder of the aforementioned CHS Healthcare, so asked DH and the team to let him know, via JL, if there were any issues the Team wished KT to discuss. The offer was acknowledged.

AJ asked RW whether the Trust could do anything different to assist Social Services. RW replied that joint-working had been very beneficial, as was the introduction of HILTON to the team.

AJ thanked the Team, and highlighted the importance of their work to the Trust and the Board.

Quality Items

3-11 Supplementary Quality and Patient Safety Report

AB referred to the circulated report and highlighted that

- There was improving performance on Patient falls. The Quality Committee 'deep dive' on Falls had helped focus attention, and there had been no falls-related SIs for the first time since October 2012
- Pressure Ulcer performance had significantly improved over recent years, and despite the latest performance, AB was confident that rate would (in the next 2 months) revert back to that seen previously
- The Complaints response position had improved for March, and AB was confident this improvement would continue

KT remarked that if the complaints response performance was overly sensitive to recent activity demands, he would be concerned whether this meant the system was the right system for a long-term systematic approach. AB acknowledged the point, but highlighted that the relationship between capacity challenges and complaints response performance was not straightforward.

SDu asked whether it was possible to superimpose the quality report into the "Planned and actual ward staffing" report, as she believed this would make the latter report more meaningful. AB highlighted that data for FTT, Falls and Pressure Ulcers was already included in the "Planned and actual ward staffing" report, and although complaints data was not included, there was no particular correlation between these indicators and the 'planned v actual' metrics.

3-12 The Learning from Mistakes League

AB referred to the circulated report and highlighted that although there was more work to be done, the Trust's rating of "good" was positive. AB highlighted that the Trust had performed relatively well against a number of other large and/or well-known Trusts.

AJ agreed it was better to be rated "Good" than have a rating of "Significant Concerns" or "Poor".

3-13 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted that.

- Capacity issues had already been discussed
- An Equality and Diversity Lead had now been appointed
- There was one outstanding action for Compliance Action 14
- A new in-house monitoring process was to commence soon, which would focus on Critical Care and Paediatrics in the first instance. Both of these areas were also scheduled to be subject to Quality Committee 'deep dive' meetings in the near future

It was agreed that future reports should continue to be submitted each month, but only include details of the Compliance Actions that were rated 'red', or regarded by AB as an area of concern.

Action: Ensure that future "Quality Improvement Plan" reports to the Trust Board only included details of the Compliance Actions that were rated 'red', or regarded as an area of concern (Chief Nurse, April 2016)

3-14 The process for ensuring institutionalised learning following Serious Incidents

AB referred to the circulated report and highlighted that it had been produced in response to query at a previous Board meeting.

KT referred to the statement on page 2 that "Key messages and learning from Serious Incidents are shared at the Trust Clinical Governance Committee with an expectation that Directorate representatives take and share the information at more local and staff meetings, disseminating learning through the Directorates", and queried whether "expectation" was a strong enough sentiment. AB acknowledged that a stronger word could have been used, but explained that there was evidence that such dissemination occurred.

KT queried how effective the Governance Gazette was, and highlighted the potential use of in-house social media such as "Yammer". SDu asked how it could be tested that, for example, staff had time to read the Governance Gazette; and also queried how the aforementioned "Learning from Mistakes League" tested how the Trust learned, beyond the number of incidents reported. AB replied to the latter query that the aforementioned "Learning from Mistakes League" was also informed by the responses to 3 key questions on the NHS staff survey. AB then referred to the Governance Gazette, and noted that this was visible in staff rooms, but the only way to test whether this was read was to query the knowledge-base of staff. AB added that she undertook such testing by asking questions of her key staff, and she expected this to be repeated.

AB then referred to KT's query regarding social media, and noted that such use would be considered in the future.

A discussion was then held regarding the circulation of the Governance Gazette, and AJ proposed that this be routinely circulated (as an attachment) via an all-users email, when published. This was agreed.

Action: Arrange for the Governance Gazette to be routinely circulated (as an attachment) via an all-users email, when published (Chief Nurse, March 2016 onwards)

3-15 Planned and actual ward staffing for Feb 2016 (incl. comparison of the Nursing establishment for each Ward with the actual staff employed, for 2015/16)

AJ referred to the circulated report and stated that the data needed to be part of the planning discussions regarding future establishments. ST agreed, and noted that the Finance Committee had been heartened by the review of establishments referred to on page 4 of 7.

AJ stated that the assumptions used should also be circulated. SO pointed out that high-level assumptions had been included in the report.

AB then highlighted that the requirement to continue to submit "Planned and actual ward staffing" reports may change, following the Lord Carter-led review of NHS efficiency.

3-16 Updated declaration of compliance with eliminating Mixed Sex Accommodation

AB referred to the circulated declaration, and explained that an annual declaration was required.

Questions or comments were invited. None were received.

The declaration was approved as circulated.

Planning and strategy

3-17 Update on the Trust's planning submissions, 2016/17

SO referred to the circulated report and highlighted the following points:
- Further work was required before the submissions would be made
- The Plan intended to address some of the issues that had already been discussed in the meeting, including the plans regarding reconfiguration of the existing Wards, newly-opened capacity and potential de-escalation

KT asked SM, as a representative of the Trust's Clinical Directors, whether she had been fully involved in the planning process. SM replied that each Directorate had its own plans, and had received updates on the plans of other Directorates, which had been helpful.

The Trust Board agreed to consider the planning submissions in more detail in the 'Part 2' meeting to be held later that day, and duly delegated its authority to approve the planning submissions to the 'Part 2' meeting.

Assurance and policy

3-18 Update from the Senior Information Risk Owner (SIRO) (to include approval of the Info. Governance Toolkit submission for 2015/16

AB referred to the circulated report and highlighted that 95% of staff needed to be trained annually, and the Trust's performance at present was in the high 70%/early 80% range. AB added that the Trust may therefore have to submit an action plan to address any shortfall when the year-end submission was made.

AJ stated that he hoped all Trust Board Members had completed the training. KT reported that he would complete his training w/c 28/03/16.

The Information Governance Toolkit submission was approved as circulated, noting the caveat highlighted by AB.

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

3-19 Charitable Funds Committee, 22/02/16

ST referred to the circulated report and invited comments or questions. AJ noted that Wendy Maher had left the Trust, and commended Wendy for her contribution during her time at the Trust.

3-20 Audit and Governance Committee, 22/02/16

KT referred to the circulated report and highlighted the issue listed in section 5 (regarding the outcome of the Internal Audit review of the "Use of Nurse Specials"), would be expected to be addressed as part of the aforementioned review of Nursing establishments.

3-21 Quality Committee, 02/03/16 (incl. SIs)

SDu referred to the circulated report and highlighted the following points:
- Clinical Directors had expressed concern at the reduced levels of elective activity, and the potential adverse impact on trainee medical staff
- The Trust's PACS system had had been unavailable for 40 minutes, and it had been agreed that PS would provide a report to TME

3-22 Workforce Committee, 03/03/16

AK referred to the circulated report and invited questions or comments. AJ remarked that it was quite clear that the new Junior Doctor contract was intended to be imposed.

3-23 Patient Experience Cttee, 07/03/16 (to include approval of revised Terms of Reference)

In SD's absence. AJ referred to the circulated report and highlighted that there was nothing of significance to report, but the revised Terms of Reference needed to be approved.

The Terms of Reference were approved as circulated.

3-24 Trust Management Executive, 16/03/16

JL referred to the circulated report and invited questions or comments. None were received.

3-25 Finance Committee, 21/03/16

ST referred to the circulated report and highlighted that the points that had agreed to be highlighted at the Board had already been discussed under other agenda items.

KR then stated that it had been agreed that he should submit a brief report to the Board outlining the benefits and implications of changing the dates of Trust Board meetings Finance Committee, and duly tabled a report (Attachment 21). AJ proposed that comments be provided to KR outside of the meeting, and that the issue then be discussed at a future Board meeting. This was agreed.

Action: Arrange for the scheduling of Finance Committee and Trust Board meetings to be discussed at a future Trust Board meeting (Trust Secretary, March 2016 onwards)

AJ clarified that the current scheduling arrangements should continue for the present time.

3-26 To consider any other business

There was no other business.

3-27 To receive any questions from members of the public

AJ invited questions or comments. DM commended the presentation from the Integrated Discharge Team, and queried whether this could be given at the Patient Experience Committee. It was agreed this should be arranged.

Action: Arrange for the Patient Experience Committee to receive a presentation from the Integrated Discharge Team (Trust Secretary, March 2016 onwards)

DM added that he was Chair of a local Patient Participation Group (PPG), referred to the discussion of the Kent and Medway Stroke Services Review discussed under item 3-9, and gave assurance that West Kent CCG was under pressure to resolve the uncertainty regarding the future of Stroke services.

BB then stated that he had sent a series of questions to the Chief Executive's office, and reported that he had been a patient of the Trust over the last 15 months. BB continued that although the treatment he had received had been excellent, he had recently had an elective procedure cancelled, and since that time, his experience had been awful.

AJ invited BB to elaborate. BB therefore reported that the appointment for his procedure had been offered 20 weeks previously, but had been cancelled at 20 hours' notice, even though BB later discovered that it was known by the Trust that it was highly likely that the cancellation would occur. BB continued that the Trust's media statement regarding cancelled procedures stated that "Each patient, whose operation has been cancelled, is individually reviewed to see if it would be appropriate for the patient to be offered the procedure at another hospital (usually with a local private provider)", and "despite all the challenges, the Trust continues to be compliant with the 18 week standard". BB stated that he wished to know who undertook these reviews, when these were

done, how many patients were referred to another provider, and how many patients had another date booked. BB noted that he had been given another date with another provider, but emphasised that it took an inordinate length of time before someone at the Trust was willing to speak to him, which he believed was his right.

AJ asked AG to respond. AG responded the Theatre list containing BB's procedure had been risk-assessed, and it was believed that it would be possible for the list to proceed, but this proved not to be the case, and therefore the list had to be cancelled at short notice. AG continued that it normally took 2 days for patients subject to a cancellation to be reviewed. AG added that the review considered whether the patient should be transferred to another provider, and the patient should be informed of what was planned within 1 week.

BB asked who carried out the review. AG confirmed this was the Consultant, with a member of the administrative team. BB stated that his case had not been reviewed after 9 days, and his Healthcare Records had been returned to the Trust's Records store at Paddock Wood. BB highlighted that the cancellation had caused him significant inconvenience and loss of earnings.

AJ asked whether the Trust had an 'amber' warning in place, which enabled patients to be pre-warned that their treatment may be cancelled. AG replied that the system included a 'forward look' and daily review, but pointed out that it had been accepted that there had been insufficient resilience that year, and if such a warning process was needed, this could be introduced. BB remarked that staff under pressure were at risk of issuing provocative messages, and elaborated that he had been told that the reason he had not been informed of the likelihood of his procedure being cancelled, was that there was a risk that he would ask for the procedure to be rescheduled, which would cause inconvenience to the schedulers. AG apologised for the inconvenience the cancellation had caused BB.

AJ thanked BB for raising the issue, and asked AG to review the communication the Trust provided to patients subject to (or at risk of) cancellation of their elective procedure.

Action: Review the communication the Trust provided to patients subject to (or at risk of) cancellation of their elective procedure (Chief Operating Officer, March 2016 onwards)

ST stated that he supported the introduction of an 'amber' warning system, and noted that the future of elective activity would be discussed in the 'Part 2' Board meeting to be held later that day.

3-28 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2016

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

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	It was agreed at the Board on 23/03/16 that the Medical Director would provide a verbal update to the Trust Board, in May 2016, on the latest situation regarding the review of Medical rotas (see action 3-4 below)
1-19ii (Jan 16)	Revise the Reservation of Powers and Scheme of Delegation to reflect the amendments made at the Trust Board on 27/01/16	Trust Secretary	January 2016 onwards	The amendments have not yet been able to be made, but will be done in the near future
2-15 (Feb 16)	Circulate, to all Trust Board Members, the 'straw man' that has been developed to aim to improve flow/discharge, and address the capacity gap within the W. Kent health and social care system	Deputy Chief Executive	February 2016 onwards	A verbal update will be given at the meeting
3-8i (Mar 16)	Arrange for Trust Board Members to visit the new Acute Medical Unit at Tunbridge Wells Hospital	Chief Operating Officer/Trust Secretary	March 2016 onwards	A visit is being arranged (with the intention that this takes place on the day of the Trust Board in May 2016)
3-9i (Mar 16)	Review the "Patterns of maternity care in English NHS trusts 2013/14" report published by the Royal College of Obstetricians and Gynaecologists in March 2016, and provide an appropriate response to the Trust Board	Medical Director	March 2016 onwards	A verbal update will be given at the Trust Board on 27/04/16
3-9v (Mar 16)	Arrange for the workforce metrics within the "Well-Led" section of future	Director of Workforce	April 2016	The requested "Plan/Limit" data will be

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

Ref.	Action	Person responsible	Original timescale	Progress [1]
	"Integrated Performance Reports" to the Trust Board to include full details of the year-end "Plan/Limit"			added from month 1, 2016/17 (which will be reported to Trust Board in May 2016)
3-14 (Mar 16)	Arrange for the Governance Gazette to be routinely circulated (as an attachment) via an all-users email, when published	Chief Nurse	March 2016 onwards	This will be implemented from the next published edition, which is due w/c 25/04/16
3-27i (Mar 16)	Arrange for the Patient Experience Committee to receive a presentation from the Integrated Discharge Team	Trust Secretary	March 2016 onwards	A presentation is being arranged (for the Patient Experience Committee meeting in either June or September)

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-12 (Jan 16)	Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis	Chief Operating Officer	April 2016	The requested information has been included in the Integrated Performance Report submitted to the April Board (and will be included in the new performance dashboard, when developed)
2-13 (Feb 16)	Submit a report to the Trust Management Executive, in the first instance, providing an explanation for, and response to, the inability to obtain the clinical details of patients subject to alerts within the 'Dr Foster' IT system	Director of Finance / Medical Director	April 2016	A report was submitted to the TME in April 2016 (although an explanation was provided at the 'main' Quality Committee on 02/03/16)
3-6i (Mar 16)	Arrange for the road signage at the entrance to Maidstone Hospital to be reviewed, to confirm this was adequate from a safety perspective	Chief Operating Officer	April 2016	The signage was reviewed as part of a Disability Discrimination Act' compliance report that the Director of Estates and Facilities commissioned in 2015. The report identified that some improvement was required, and this will be included within the backlog maintenance budget when issued.
3-6ii (Mar 16)	Arrange for the 'Parking spaces available' display Board at the entrance to Tunbridge Wells Hospital to	Chief Operating Officer	April 2016	The display Board has been turned off, following a number of complaints (when the car park spaces

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	be checked, to confirm this was functioning as intended			setting was correct, the display always showed as "FULL", but when the setting was altered to show that there were spaces, complaints were received that there were no spaces (and that the signage should show this)). It was therefore considered appropriate to turn off the display, as there would continue to be problems until the space issue is resolved. To that effect, the General Manager Facilities (Contracts) is liaising with Notcutts Garden Centre to explore whether it is possible for the Trust to lease car parking spaces.
3-8ii (Mar 16)	Circulate West Kent Clinical Commission Group's draft Urgent Care Strategy to Trust Board Members	Deputy Chief Executive	24.03.16	The document was circulated on 24/03/16
3-9ii (Mar 16)	Provide an explanation for the 36.8% reduction in "Overtime (WTE)" reported on the Trust Performance Dashboard for month 11	Director of Workforce / Director of Finance	April 2016	The matter has been investigated and the reduction is due to a decrease in the use of overtime within Estates and Facilities, as a result of compliance with their financial control total for 2015/16
3-9iii (Mar 16)	Highlight, to NHS England, the Trust Board's frustration at the apparent lack of progress being made via the Kent and Medway Stroke Services Review	Deputy Chief Executive	April 2016	The Board's frustration has been conveyed
3-9iv (Mar 16)	Arrange for future "Integrated Performance Reports" to the Board to include additional information on the Trust's performance on the Cancer access targets	Chief Operating Officer	April 2016	Further information on Cancer performance has been included in the "Integrated Performance Reports" submitted to the April 2016 Trust Board (and will be included in subsequent such Reports)

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
3-13 (Mar 16)	Ensure that future "Quality Improvement Plan" reports to the Trust Board only included details of the Compliance Actions that were rated 'red', or regarded as an area of concern	Chief Nurse	April 2016	"Quality Improvement Plan" reports have been amended accordingly w/e April 2016
3-25 (Mar 16)	Arrange for the scheduling of Finance Committee and Trust Board meetings to be discussed at a future Trust Board meeting	Trust Secretary	April 2016	The item has been scheduled for consideration at the Trust Board meeting on 25/05/16
3-27ii (Mar 16)	Review the communication the Trust provided to patients subject to (or at risk of) cancellation of their elective procedure	Chief Operating Officer	April 2016	The letter has been reviewed and re-drafted

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
3-4 (Mar 16)	Provide a verbal update to the Trust Board, in May 2016, on the latest situation regarding the review of Medical rotas	Medical Director	May 2016	The item has been scheduled for the Trust Board in May 2016 (although a written report will actually be submitted)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-7	Chief Executive's update	Chief Executive

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

1. We have ended the (2015/16 financial) year with the lowest rate of Clostridium difficile (C. diff) of any NHS acute trust in the South of England. This is an excellent achievement for our patients and represents a consistently high standard of infection control within our hospitals.

   We had 18 cases of C.diff in the 12 months up to 31st March. This is a reduction of 36% on last year's figure (28). In achieving this reduction, we have more than halved the All England rate of 15.23 cases per 100,000 bed days at a time when hospital-attributable C. diff infections have increased as a whole in England. Our challenge is to work towards zero avoidable cases.

   To put this achievement into context, our hospitals saw over 400,000 people in 2015/16. Around 90,000 people required treatment that resulted in a planned or emergency hospital admission for medical or surgical care.

   We had one hospital attributed MRSA bacteraemia over the same period and achieved a 44% reduction in hospital-attributable E. coli bacteraemia. This has again been achieved on a background of rising levels nationally and in our local community.

2. We are continuing to work closely with our partners to improve the flow of patients coming through our hospitals. Our ability to admit patients to, and discharge patients from our hospitals efficiently, has impacted on our elective and emergency performance in 2015/16 and our financial position.

   While we saw 11,000 more A&E attendances in 2015/16 than the year before, our actual emergency admissions are down. While many patients over the age of 70 have had longer stays in hospital as a consequence of coming to us acutely unwell, delayed transfers of care (DTOCs) have increased markedly from 4.2% in 2014/15 to 6.2% in 2015/16. DTOCs remain a key challenge for the local health economy as a whole.

   Positive improvements have occurred recently with 10 beds we vacated at Tonbridge Cottage Hospital being funded by West Kent Clinical Commissioning Group for stepdown care for patients who do not need to be in an acute hospital environment. A further eight beds are also being made available to us at Sevenoaks Hospital for a similar purpose.

   Our own schemes are also delivering positive improvements for our patients. We are now discharging more patients at weekends, for instance, following the introduction of our Pharmacy Seven Day Service. This is a major benefit to our wards and patients. We can also expect to see further improvements in patient flow following the recent opening of our new £3 million Acute Medical Unit at Tunbridge Wells Hospital.

3. I have continued to support trust-wide learning from incidents, and improvements in patient care, by openly discussing key clinical issues with staff. This month I have helped draw the Trust's attention to key issues and our patient experience around:

- Ensuring our staff check for allergies so that patients are not given drugs they are allergic to
- Ensuring policies are followed in theatres around equipment counting and modifications
- Ensuring our patients have robust referral pathways and appropriate follow up care

4. We have officially opened our new phlebotomy room in the Outpatients department (OPD) at Maidstone. This new facility has been designed to provide a more comfortable environment for patients who are waiting for, and having, blood tests. It has three private rooms, with improved access for wheelchairs, and a pleasant seated area for patients waiting to be called.

5. We have submitted a planning application for a 145-space patient and visitor car park at the rear of Maidstone Hospital. The new car park will be a welcome and positive development to address capacity issues with patient and visitor parking. We are exploring options regarding how we can manage capacity issues at the Tunbridge Wells site.

6. We have introduced a new role within our maternity service to enhance the care we are able to provide women with perinatal mental illnesses (such as anxiety, depression and postnatal psychotic disorders).

   Our perinatal mental health nurse will be carrying out training for colleagues to make them aware of the impact of perinatal mental health and how it affects women and their families, as well as acting as a source of advice and support for both midwives and families.

7. We have held the first course of its kind nationally to provide advanced training for therapeutic radiographers. The course, which is approved by the Society and College of radiographers, attracted specialists from cancer centres across the UK.

8. I have met with residents with learning disabilities from day centres in Sevenoaks and Tonbridge, in our A&E at Tunbridge Wells. The event was set up after some residents provided feedback through one of our 'Meet the Matron' sessions to say that their previous experiences of A&E had left them scared to come back. The aim was to make those with learning disabilities, who do have to attend the emergency department, feel more comfortable with the environment and happier to come in should they need to.

- Congratulations to our Lord North Ward team, who recently received an award honouring local unsung heroes. The team were nominated for a Celebrate Maidstone Star Community award. Three ward staff, Ward Manager Sylvia Want and Junior Sisters Hayley Geere and Amanda McLoughlin, attended the Celebrate Maidstone gala ceremony at the Kent County Showground. Their nomination, which was received from a patient, mentions how all members of the team are professional and care about people and their job, and that the team is making a massive difference in the lives of people, who are going through an extremely tough journey.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2016

4-9 Board Assurance Framework (BAF) 2015/16: Year-end review — Trust Secretary

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, and ensures that adequate controls and measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met. The status of the BAF was reviewed by the Trust Management Executive, Finance Committee, Audit and Governance Committee, and Trust Board at regular intervals in 2015/16.

The enclosed report describes the year-end status of each of the objectives, in terms of whether they were "Fully achieved", "Partially achieved" or "Not achieved". Explanations are provided for any objectives not considered (by the Responsible Director) to be "Fully achieved".

The Board is invited to review and critique the content of the enclosed, by considering the following questions:

- Does the year-end rating reflect the situation as understood by the Board?
- Does any of the content require further explanation?

The enclosed report was discussed at the Trust Management Executive on 20/04/16, and will be reviewed at the Audit and Governance Committee on 05/05/16. The content of the enclosed report will also be reported (in a different format) within the Trust's Annual Report for 2015/16 (which will be submitted to the Audit and Governance Committee and Trust Board in May 2016).

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/04/16
- Finance Committee, 25/04/16 (objective 4.a. only)

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? [2] *Main risk*

1 "Quality i.e. failure to provide care and treatment within the upper quartile (as recognised by patients, staff & the CQC); & the need to improve the standard of the Trust's clinical governance arrangements"

What did the Trust want to achieve? *Objective*

1.a To provide care & treatment within the upper quartile (as recognised by patients, staff and the CQC)

1.b To improve the standard of the Trust's clinical governance arrangements

Responsible Director/s	**Committee/s responsible for oversight**
Chief Nurse / Medical Director	Quality Committee / Trust Board

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [3]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☒ ☐	☒ ☒ ☐

Explanation of any "Amber" or "Red" rating (at February 2016):

1. The "amber" rating reflects the fact that "upper quartile" performance has not been demonstrated as a whole (1a), and the fact that the CQC's view will not be known in detail until a further inspection is undertaken
2. The "green" rating reflects the improvements that have been made to the clinical governance arrangements (1b)

Year-end position: Was the objective achieved by the end of 2015/16?

☒ Fully achieved ☒ Partially achieved ☐ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

Objective 1.b has been "fully achieved", as the standards of the Trust's clinical governance arrangements were improved. This was primarily manifested in a revised Committee structure and the establishment of a new Trust Clinical Governance Committee.

Objective 1.a. was "partially achieved". The Quality Improvement Plan (QIP) developed in response to the Care Quality Commission (CQC)'s inspection in October 2014 was monitored monthly by the Trust Management Executive and Trust Board, and significant progress was made (the majority of Compliance Actions are now closed). The implementation of new, broader, CQC-style reviews is well underway, and this will continue into 2016/17. However, the objective is not considered to be "fully achieved" as the Trust's care and treatment will not be judged to be "upper quartile" by the CQC until the CQC have undertaken a further inspection.

[2] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

2 Capacity i.e. the need to increase inpatient capacity to cope with rising non-elective demand

What did the Trust want to achieve? *Objective*

2.a To increase inpatient capacity to cope with rising non-elective demand

Responsible Director/s	**Committee/s responsible for oversight**
Chief Operating Officer	Trust Management Executive / Trust Board

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [4]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☒ ☐	☒ ☒ ☐

Explanation of any "Amber" or "Red" rating (at February 2016):

The new Ward at Tunbridge Wells Hospital will be open by the year-end (albeit later than planned), but this will not make a difference to the capacity in the system in 2015/16

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

Capacity was increased, but not by the year-end. The new Ward at Tunbridge Wells Hospital has 38 beds. In addition, Whatman Ward was open during 2015/16, and the Trust's escalation plan was fully utilised. However, the overall level of capacity was insufficient, as Length of Stay and Delayed Transfers of Care contributed to the Trust's ability to cope with non-elective demand (which increased beyond the higher limit that had been set).

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

3 Staffing i.e. the need to reduce reliance on temporary staff and have the appropriate skill-mix

What did the Trust want to achieve? *Objective*

3.a Reduce the reliance on temporary staff

3.b To ensure the appropriate skill-mix of staff across the Trust

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce	Workforce Committee

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [5]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☐ ☒	☐ ☐ ☒	☐ ☒ ☐	☐ ☒ ☐

Explanation of any "Amber" or "Red" rating (at February 2016):

The national shortage of qualified Nursing staff; Home Office visa restrictions / government drive to reduce immigration; and system-wide failure to reduce increasing demand on acute services constrain the Trust's ability to eradicate the risk in 2015/16.

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

Whilst the Trust has been successful in increasing the number of substantive staff employed during 2015/16, the reliance on temporary staff has been high and above the planned utilisation which is primarily attributed to the number of escalated beds open, number of delayed transfers of care, pressure on A&E on both sites and use of specials. The Trust is continuing to implement the NHS Improvement Agency Rules and Price Caps, adopt best practice identified by Lord Carter and drive recruitment to reduce reliance on temporary staff.

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

4 Finances i.e. the need to deliver the financial plan for 2015/16

What did the Trust want to achieve? *Objective*

4.a To deliver the financial plan for 2015/16

Responsible Director/s	**Committee/s responsible for oversight**
Director of Finance	Finance Committee / Trust Management Executive

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [6]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☒	☐ ☐ ☒

Explanation of any "Amber" or "Red" rating (at February 2016):

1. The financial position remains behind plan at the end of Quarter 3. The Trust is forecasting not to achieve its financial plan, despite the introduction of an Integrated Recovery Plan
2. The trend on temporary staffing was being partially offset by increased income, in Quarter 1. This has not continued through Quarters 2 and 3

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

The Trust delivered a deficit of £23.4m against a planned deficit of £14.1m. The main drivers for the variance against plan were as follows

- Agency staffing costs over substantive for Nursing (£4.0m) and Medical (£2.6m) staff
- Staffing costs due to escalated areas (£2.3m)
- Ability to deliver elective activity, due to increase in non-elective activity, Length of Stay, and Delayed Transfers of Care

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

5 Culture i.e. the need to enhance and sustain a high-performing culture

What did the Trust want to achieve? *Objective*

5.a To enhance and sustain a high performing culture

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce	Workforce Committee

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [7]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☒ ☐	☒ ☒ ☐

Explanation of any "Amber" or "Red" rating (at February 2016):

Culture change takes 5 to 10 years to materialise. The Trust has an ambitious Workforce Strategy and supporting implementation plan which will drive improvements in the culture over the next five years – dependent upon resources being made available

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

Culture change takes 5 to 10 years to materialise. The Trust has an ambitious Workforce Strategy which has been approved by the Trust Board. The Workforce Strategy defined the ambition of the Trust to construct an organisation where people deliver excellence each day and feel engaged, enabled and empowered to work for the Trust. The Strategy has 6 interrelated workforce priorities and programmes of work have been identified which will drive improvements in the culture over the next 5 years. The 2015 Staff Survey results show that Trust had improved results when compared to its performance on the 2014 survey, and also when compared against the benchmark of acute Trusts in England. The Trust was also rated "Good" in the newly published "Learning from Mistakes" League Table by NHS Improvement.

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

6 Strategy i.e. the need for an updated cohesive strategy to deal with the instability and uncertainty in the wider health economy

What did the Trust want to achieve? *Objective*

6.a To develop a cohesive strategy to deal with the instability and uncertainty in the wider health economy

Responsible Director/s	**Committee/s responsible for oversight**
Deputy Chief Executive	Trust Management Executive / Trust Board

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [8]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☒ ☐	☒ ☒ ☐

Explanation of any "Amber" or "Red" rating (at February 2016):

1. The greatest risks lie in factors beyond the Trust's direct control – continuing external engagement and influencing will be crucial
2. The "NHS Shared Planning Guidance 2016/17 – 2020/21" requires a "place-based" five year Sustainability and Transformation Plan (STP) to be produced by the end of June 2016. The geographic scope (the "transformation footprint") of the STP involving the Trust has been confirmed to be Kent and Medway.

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

Good progress has been made on the development of the Strategy, with the document due to be submitted to the Trust Board, for approval, in May 2016. The final process of iteration and engagement with Clinical Directorates continues in advance of that meeting, as do discussions with commissioners to ensure alignment with their intentions.

The Board discussion will be followed by a period of sustained communication within the Trust, building on the substantial work that has already taken place. The document will also provide important context to the STP process described above – effectively setting out the Trust's view. The full implications of the STP are unlikely to be completely clear until after the initial June submission. These will need to be reflected in our rolling process

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

7 Senior workforce i.e. the need to ensure effective succession planning for key critical posts, to ensure the continual development of the Trust and its services

What did the Trust want to achieve? *Objective*

7.a To ensure there is effective succession planning for key critical posts

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce	Workforce Committee

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2015/16? [9]

July 2015	Sep. 2015	Nov. 2015	Feb. 2016
☐ ☒ ☐	☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☒

Explanation of any "Amber" or "Red" rating (at February 2016):

The Trust will have in place a succession plan for critical roles within the organisation. However issues with supply (attraction and existing organisational talent) and development time will mean that the full implementation and assurance against each critical role will take time to deliver

Year-end position: Was the objective achieved by the end of 2015/16?

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

If not "Fully achieved", explanation of why and detailed status of current position:

An overarching plan needs to be developed and with recent changes to critical roles plans need to be revised and updated. A new process will be put in place to review critical roles and existing plans and creation of an overarching plan.

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-9	Integrated Performance Report for March 2016	Chief Executive

Summary / Key points

The enclosed report includes:

- The 'story of the month' for March 2016, which includes the latest position on Delayed Transfers of Care (DTOCs), 18 week waits and cancer target performance
- Quality Exception Report
- Workforce update
- The Trust performance dashboard
- Integrated performance charts; and
- Financial performance overview and Finance pack.

Which Committees have reviewed the information prior to Board submission?

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

Discussion and scrutiny

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

'Story of the month' for March 2016

Within clinical operations the key areas of focus remain non-elective length of stay, non-elective flow, elective activity and cancer performance.

A&E attendances remained higher than plan and much higher than previous years during quarter 4 with non-elective admissions remaining fairly steady. The year-end performance is 87.8% with a small recovery to the March performance at 84.7%. The recovery plan for the emergency access standard is underpinned by improving flow through assessment and ambulatory areas, improving length of stay for all non-elective admissions and delivering the internal professional standards consistently in the Emergency Department. We have an agreed improvement trajectory in place with NHS Improvement with weekly monitoring in place.

The new Acute Medical Unit is instrumental in facilitating improved flow and we have already seen improvements in the numbers of medical outliers, escalation beds used as well as an increase in the number of elective cases taking place at TWH.

Although we have seen a marginal improvement, the level of DTOC remains higher than the limit set and accounted for 1200 lost bed days in March. With the continued work of the integrated discharge team and the engagement of CHS Health Care there is an expectation that further improvement will occur during April.

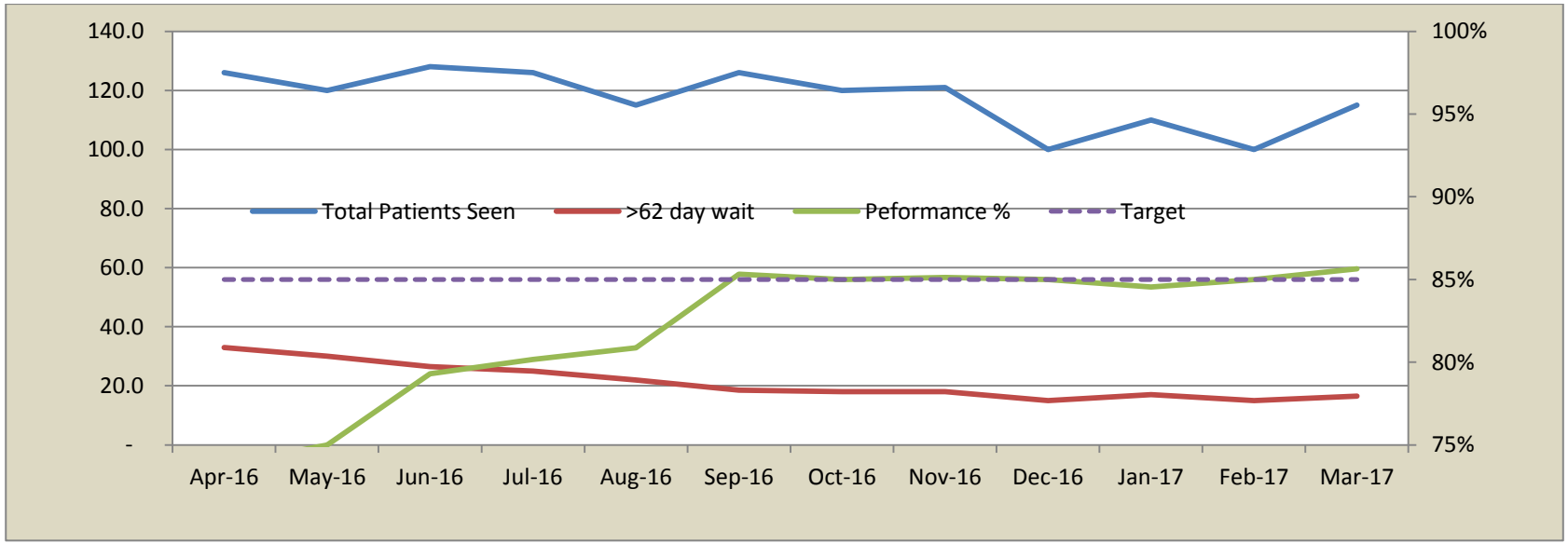
The average non-elective length of stay (LOS) remained high at 8.2 days, but during March the bed occupancy levels reduced to 714 patients a night (excluding Romney Ward).

Count of Hospital ID	Column Labels																								
Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	7	3	8	218
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1			1	59
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	8	15	18	633
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	15	15	27	275
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	53	80	73	808
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	28	36	36	432
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	14	5	13	150
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	12	12	22	898
H : Disputes						1							2	1			1	3	1	1		1			11
I : Housing		2	6	2				2		2		1	3	4	3	1		1	13	12	9	3	5	1	70
Grand Total	**76**	**111**	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**145**	**194**	**141**	**171**	**199**	**3554**

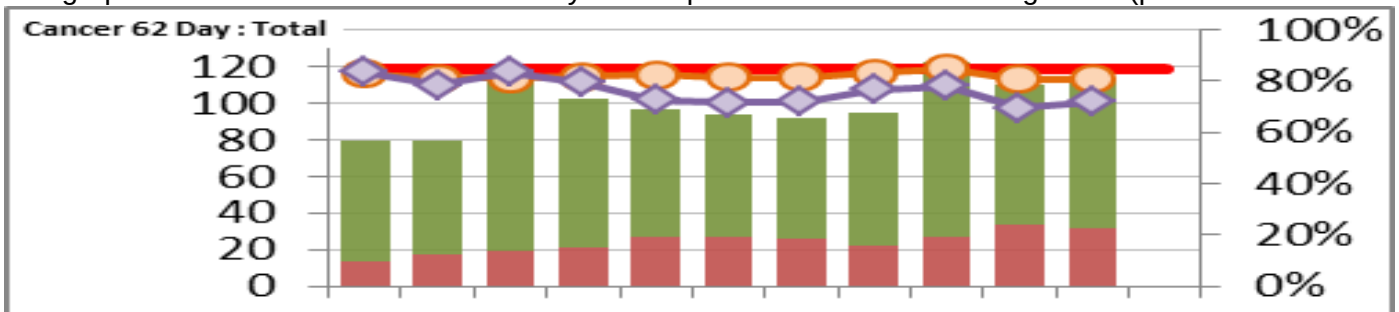
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Trust delayed transfers of care	3.2%	4.5%	3.4%	4.8%	4.1%	4.4%	4.8%	4.2%	3.6%	4.1%	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%

The Referral to Treatment (RTT) performance has been underperformed in March and the number of patients waiting over 18 weeks has increased both as a result of the drop in the levels of elective activity during escalation and also as a result of lost activity during the industrial action days [mainly outpatient activity]. It is unlikely that the RTT performance will recovery until quarter 2.

The performance on Cancer targets in February (reported a month in arrears) shows a continued underperformance on the 62 day target at 72% with a continued emphasis on increasing the number of treatments to reduce the overall number of patients waiting over 62 days. The 2 week-wait performance has improved this month and has achieved the target of 93%. There were 8 breaches [12 patients] of the 104 day target. Of the 12 patients 4 originated from MTW only and 8 were referred from other Trusts. The 62 day position for patients managed entirely by MTW improved further this month to 76.3%. The majority of cancer two week wait breaches are due to patients choosing dates outside of breach. 50% of patients are offered an appointment before day 10 despite the volumes of cancer referrals increasing. The performance trajectory agreed with NHS Improvement is outlined below alongside current performance.



The graph below shows MTW overall 62 day cancer performance to date during 15/16 (please note data is always one month in arrears)



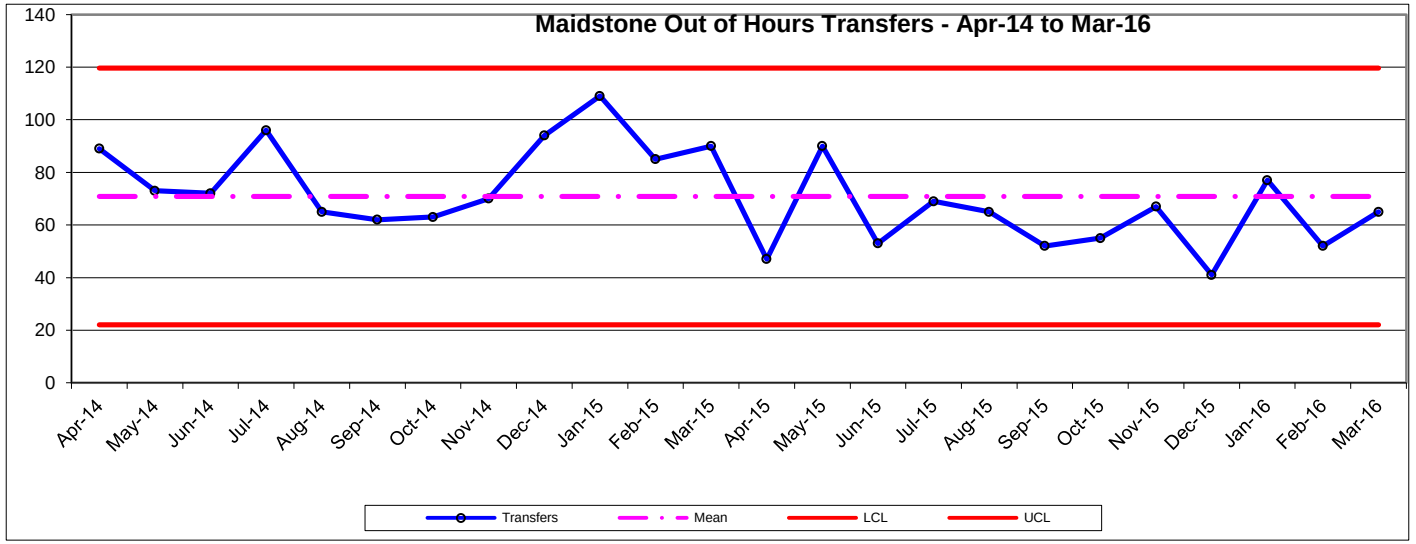
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
pass	66.0	62.0	96.0	81.0	70.0	67.0	66.0	72.5	95.5	76.5	81.0	
Breach	13.0	17.0	19.0	21.0	26.5	26.5	25.5	22.0	27.0	33.5	31.5	
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Ntnl Score	83.0%	81.1%	81.2%	81.7%	82.5%	81.4%	81.6%	83.3%	85.0%	80.9%	80.8%	
Our Score	83.5%	78.5%	83.5%	79.4%	72.5%	71.7%	72.1%	76.7%	78.0%	69.5%	72.0%	

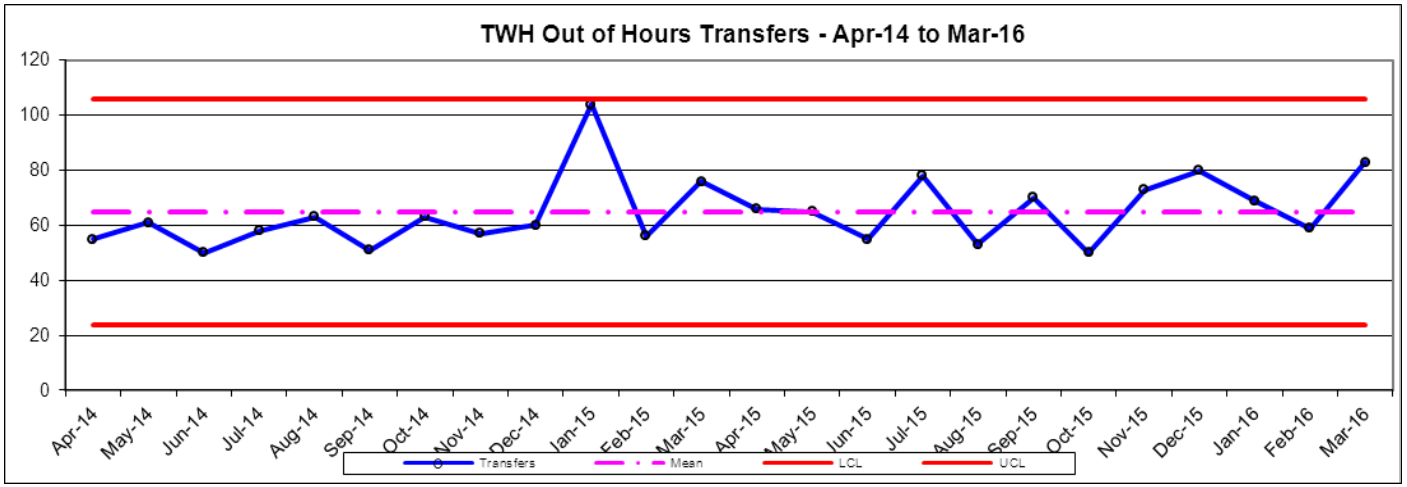
- MTW only performance has dipped since an improvement in December, partly due to patient choice to delay treatment until after the Christmas period and a focus in February to clear backlog of patients. Action plans are in place to ensure MTW patient performance is improved as a priority so that the Trust achieves overall 85% compliance by September.
- Late referrals from other Trusts continues to hamper overall performance. Work is underway with other organisations to improve this situation working on specific pathways and the oncology referral process
- Referrals from MTW to other providers for treatment are small in number and so performance can fluctuate significantly. Action plans are in place to ensure timely referral to other centres for treatment.

There are very detailed actions in place with each tumour site to deliver the improvements needed and this is monitored via directorate review meetings and the MTW Cancer Board.

Out of hours ward transfers [excluding maternity and assessment areas]

This data shows the number of "out of hour" ward transfers that took place each month over the last two years.
The data excludes Assessment Units, Maternity and Paediatrics
On average there are 136 "out of hour" ward transfers per month across the site (71 at Maidstone and 65 at Tunbridge Wells)
The number peaked to its highest level in January 2015 at 213 but for January 2016 had reduced significantly to 146
March 2016 is above the average across the Trust at 148 with Maidstone below average at 65 and TWells above average at 83


Maidstone Out of Hours Transfers - Apr-14 to Mar-16
140
120
100
80
60
40
20
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Transfers
Mean
LCL
UCL


TWH Out of Hours Transfers - Apr-14 to Mar-16
120
100
80
60
40
20
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Transfers
Mean
LCL
UCL

Quality exception report

The main area for focus remains falls prevention with a year-end rate of 6.7 compared to the previous year's rate of 6.2. There are comprehensive actions in place with additional support for the falls lead nurse to support staff in clinical practice.

Complaints response rates have improved this month significantly and the year position is 74.3 % compared to 68% the previous year. The focus now is on sustaining response rates and continually striving to achieve the highest quality of responses.

Workforce

During the month the Trust continued its recruitment performance and now employs 5,160 whole time equivalent substantive staff representing a net increase of 160 WTE against the same month last year. However, despite the recruitment success the dependence upon temporary staff remained higher than planned and further work is ongoing to ensure, in line with NHS Improvement requirements, we reduce our dependence upon expensive agency and interim workers. The use of bank staff reduced in March (280.8 WWTE) compared to the previous month (331.4 WTE). The use of overtime was lower in March 2016 compared to the same period last year as a result of a reduction in use by the Estates and Facilities Directorate.

Sickness absence in the month was 3.7%, representing a 0.4% improvement on last month and 0.5% improvement of the same period last year (4.2%). The year-end position is 3.9%. Statutory and mandatory training compliance continues to be above 90% of staff compliant with the core subjects. Actions are in place to improve compliance further. The new appraisal cycle for non-medical staff has just commenced.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 March 2016**

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

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

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

******A&E 4hr Wait is Quarter to date, Forecast is for Quarter 4 only

	Safe	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
1-01	*Rate C-Diff (Hospital only)	0.00	4.4	12.0	7.4	-4.6	-3.7	11.5	7.4	
1-02	Number of cases C.Difficile (Hospital)	0	1	28	18	-10	-9	27	18	
1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
1-04	Elective MRSA Screening	99.0%	99.0%	99.0%	99.0%		1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	97.0%	98.0%	97.0%	98.0%		3.0%	95.0%	98.0%	
1-06	**Rate of Hospital Pressure Ulcers	3.6	2.0	2.4	2.7	0.3	-0.3	*3.0*	2.7	3.0
1-07	***Rate of Total Patient Falls	5.7	6.5	6.2	6.7	0.5	0.5	*6.2*	6.7	
1-08	***Rate of Total Patient Falls Maidstone	5.8	5.5	5.2	6.1	0.9			6.1	
1-09	***Rate of Total Patient Falls TWells	6.9	7.2	6.9	7.2	0.3			7.2	
1-10	Falls - SIs in month		2		43	43				
1-11	Number of Never Events	1	0	2	2	0	2	*0*	2	
1-12	Total No of SIs Open with MTW	32	17			-15				
1-13	Number of New SIs in month	16	6	118	101	-17	-19			
1-14	**Serious Incidents rate	0.76	0.26	0.51	0.42	-0.09	0.36	*0.0584 - 0.6978*	0.42	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	1.07	0.63	1.12	1.09	-0.04	-0.14	*0 - 1.23*	1.09	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.2%	95.2%	95.6%	95.3%	-0.3%	0.3%	95.0%	95.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	97.8%	96.0%	96.6%	96.6%	0.1%	1.6%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	2.39%	3.39%	2.49%	2.56%	0.07%	-0.4%	*3.00%*	2.56%	
1-20	C-Section Rate (non-elective)	13.8%	15.9%	15.0%	12.9%	-2.17%	-2.1%	*15.0%*	12.9%	

	Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
4-01	******Emergency A&E 4hr Wait	89.3%	84.5%	92.0%	82.6%	-9.4%	-12.4%	95.0%	82.6%	90.1%
4-02	Emergency A&E >12hr to Admission	0	0	2	1	-1	1	*0*	1	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	90.2%	89.0%	91.5%	90.4%	-1.2%	0.4%	90%	90.4%	
4-06	18 week RTT - non admitted patients	97.9%	96.1%	96.9%	97.4%	0.4%	2.4%	95%	97.4%	
4-07	18 week RTT - Incomplete Pathways	96.6%	90.8%	96.6%	90.8%	-5.7%	-1.2%	92%	90.8%	
4-08	18 week RTT - 52wk Waiters	1	2	0	7	7	7	*0*	7	
4-09	18 week RTT - Incomplete Backlog 18wk	538	2,174	538	2,174				2,174	
4-10	% Diagnostics Tests WTimes <6wks	99.9%	99.6%	100.0%	99.6%	-0.4%	0.6%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	8	4	8	1	-7	-8	9	1	
4-12	*Cancer two week wait	95.5%	93.0%	95.5%	91.8%	-3.6%	-1.2%	93.0%	91.8%	
4-13	*Cancer two week wait-Breast Symptoms	94.4%	81.3%	94.4%	84.0%	-10.4%	-9.0%	93.0%	84.0%	
4-14	*Cancer 31 day wait - First Treatment	97.8%	96.1%	97.8%	95.3%	-2.5%	-0.7%	96.0%	95.3%	
4-15	*Cancer 62 day wait - First Definitive	75.9%	72.0%	75.9%	70.8%	-5.1%	-14.2%	85.0%	70.8%	
4-16	*Cancer 62 day wait - First Definitive - MTW	79.8%	76.3%	79.8%	76.1%	-3.7%		85.0%		
4-17	*Cancer 104 Day wait Accountable	New	8.0	New	75.5	New	75.5	-	75.5	
4-18	Delayed Transfers of Care	4.3%	5.6%	4.0%	6.2%	2.1%	2.7%	3.5%	6.2%	
4-19	% TIA with high risk treated <24hrs	41.7%	76.0%	72.2%	71.0%	-1.1%	11.0%	60%	71.0%	
4-20	% spending 90% time on Stroke Ward	84.6%	89.3%	81.8%	82.4%	0.6%	2.4%	80%	82.4%	
4-21	Stroke:% to Stroke Unit <4hrs	38.6%	58.3%	38.8%	49.1%	10.3%	-5.9%	55.0%	49.1%	
4-22	Stroke: % scanned <1hr of arrival	48.9%	77.1%	43.5%	56.2%	12.7%	13.2%	43.0%	56.2%	
4-23	Stroke:% assessed by Cons <24hrs	62.2%	72.9%	72.4%	70.3%	-2.1%	-14.7%	85.0%	70.3%	
4-24	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-25	Patients not treated <28 days of cancellation	0	9	0	16	16	16	*0*	16	

	Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.4	103.0	-0.4	3.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	103.0	-3.9	3.0			100.0
2-03	Crude Mortality	1.1%	0.8%	1.1%	1.2%	0.1%				
2-04	****Readmissions <30 days: Emergency	12.1%	11.4%	11.7%	11.2%	-0.5%	-2.4%	*13.6%*	11.2%	14.1%
2-05	****Readmissions <30 days: All	11.3%	10.7%	10.9%	10.4%	-0.5%	-4.2%	*14.7%*	10.4%	14.7%
2-06	Average LOS Elective	3.1	3.2	3.2	3.2	0.0	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.3	8.2	6.8	7.4	0.6	1.0	*6.5*	7.4	
2-08	New:FU Ratio	1.60	1.26	1.55	1.27	-0.28	-0.25	*1.52*	1.27	
2-09	Day Case Rates	86.6%	84.2%	83.7%	84.4%	0.7%	4.4%	80.0%	84.4%	82.2%
2-10	Primary Referrals	9,476	9,116	102,330	105,518	3.1%	2.4%	94,755	105,518	
2-11	Cons to Cons Referrals	3,178	3,086	40,600	41,308	1.7%	4.4%	39,585	41,308	
2-12	First OP Activity	11,982	10,831	143,014	138,706	-3.0%	0.8%	137,569	138,706	
2-13	Subsequent OP Activity	21,597	31,813	258,679	271,034	4.8%	3.8%	260,989	271,034	
2-14	Elective IP Activity	735	539	7,734	7,487	-3.2%	-6.3%	7,988	7,487	
2-15	Elective DC Activity	3,675	3,077	37,802	38,613	2.1%	0.1%	38,556	38,613	
2-16	Non-Elective Activity	4,192	4,160	47,308	45,617	-3.6%	-5.5%	48,289	45,617	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	11,066	14,801	130,315	141,226	8.4%	3.9%	135,922	141,226	
2-18	Oncology Fractions	5,809	6,135	69,902	69,304	-0.9%	-3.4%	71,761	69,304	
2-19	No of Births (Mothers Delivered)	507	460	5,708	5,742	0.6%	0.6%	5,708	5,742	
2-20	% Mothers initiating breastfeeding	79.3%	73.0%	81.5%	77.2%	-4.3%	-0.8%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.6%	0.86%	0.29%	0.45%	*0.2%*	*0.0%*	*0.47%*	0.45%	0.47%

	Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
5-01	Income	39,496	36,441	403,247	400,930	-0.6%	0.1%	400,718	400,930	
5-02	EBITDA	5,870	1,765	35,319	8,061	-77.2%	-66.2%	23,821	8,061	
5-03	Surplus (Deficit) against B/E Duty	2,727	1,363	163	(23,401)			(12,132)	(23,401)	
5-04	CIP Savings	2,232	1,799	23,796	20,764	-12.7%	-3.4%	21,500	20,764	
5-05	Cash Balance	3,796	1,200	3,796	1,200	-68.4%	-44%	2,127	1,200	
5-06	Capital Expenditure	8,475	4,165	14,008	15,359	9.6%	-23.3%	*20,013*	15,359	
5-07	Establishment (Budget WTE)	5,492.4	5,702.9	5,492.4	5,702.9	3.8%	0.0%			
5-08	Contracted WTE	5,002.2	5,160.1	5,002.2	5,160.1	3.2%	-4.7%			
5-09	***Contracted not worked WTE	(96.0)	(102.3)	(96.0)	(102.3)					
5-10	Locum Staff (WTE)	22.4	80.9	22.4	80.9	261.1%				
5-11	Bank Staff (WTE)	411.0	304.6	411.0	304.6	-25.9%				
5-12	Agency Staff (WTE)	323.4	280.8	323.4	280.8	-13.2%				
5-13	Overtime (WTE)	75.9	47.5	75.9	47.5	-37.3%				
5-14	Worked Staff WTE	5,721.6	5,767.9	5,721.6	5,767.9	0.8%	1.1%			
5-15	Vacancies WTE	490.2	542.8	490.2	542.8	10.7%				
5-16	Vacancy %	8.9%	9.5%	8.9%	9.5%	6.7%				
5-17	Nurse Agency Spend	(744)	(1,030)	(5,779)	(10,409)	80.1%				
5-18	Medical Locum & Agency Spend	(979)	(1,064)	(10,153)	(12,362)	21.8%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.4%	9.9%		10.0%	0.6%	-0.6%	*10.5%*	10.0%	8.4%
5-21	Sickness Absence	4.2%	3.7%		3.9%			*3.3%*	3.9%	3.7%
5-22	Statutory and Mandatory Training	85.6%	90.2%		90.2%	4.6%	5.2%	85.0%	90.2%	
5-23	Appraisal Completeness	81.8%	80.0%		80.0%	-1.9%	-10.0%	90.0%	80.0%	
5-24	Overall Safe staffing fill rate	100.2%	101.6%	100.9%	101.6%	1.3%		93.5%	101.6%	
5-25	****Staff FFT % recommended work	New	66.9%	New	58.4%		8.9%	58.0%	58.4%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	305	New	305					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	28.1%	New	25.3%		-4.7%	30.0%	25.3%	25.1%
5-28	A&E Resp Rate Recmd to Friends & Family	New	13.9%	New	13.1%		-6.9%	20.0%	13.1%	13.1%
5-29	Mat Resp Rate Recmd to Friends & Family	20.9%	14.8%	18.9%	19.8%	0.9%	4.8%	15.0%	19.8%	23.4%

	Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Single Sex Accommodation Breaches	0	0	68	6	-62	6	0	6	
3-02	*****Rate of New Complaints	1.99	1.66	4.08	2.11	-1.97575	0.79	*1.318-3.92*	2.11	
3-03	% complaints responded to within target	69.0%	82.2%	68.0%	74.3%	6.3%	-0.7%	75.0%	74.3%	
3-04	****Staff Friends & Family (FFT) % rec care	New	83.3%	New	82.9%	New	7.9%	75.0%	82.9%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	96.2%	New	96.4%	New	1.4%	95.0%	96.4%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	New	86.1%	New	88.4%	New	1.4%	87.0%	88.4%	86.9%
3-07	Maternity Combined FFT % Positive	90.0%	91.2%	90.6%	94.7%	4.1%	-0.3%	95.0%	94.7%	95.5%
3-08	OP Friends & Family (FFT) % Positive	New	80.7%	New	80.1%	New			80.1%	

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

**CWT run one mth behind, YTD is Quarter to date*

*** Serious Incidents Rate is per 1,000 Occupied Beddays*

**** Contracted not worked includes Maternity /Long Term Sick*

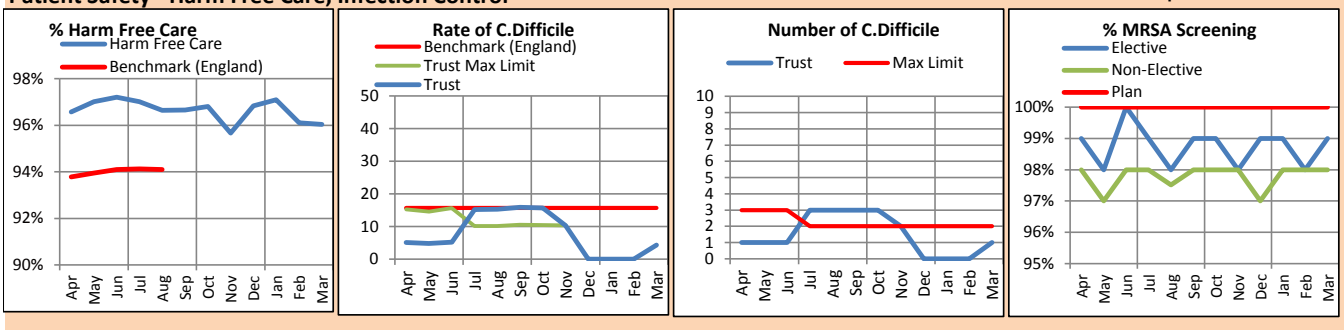
***** Staff FFT is Quarterly therefore data is latest Quarter*

****** IP Friends and Family includes Inpatients and Day Cases*

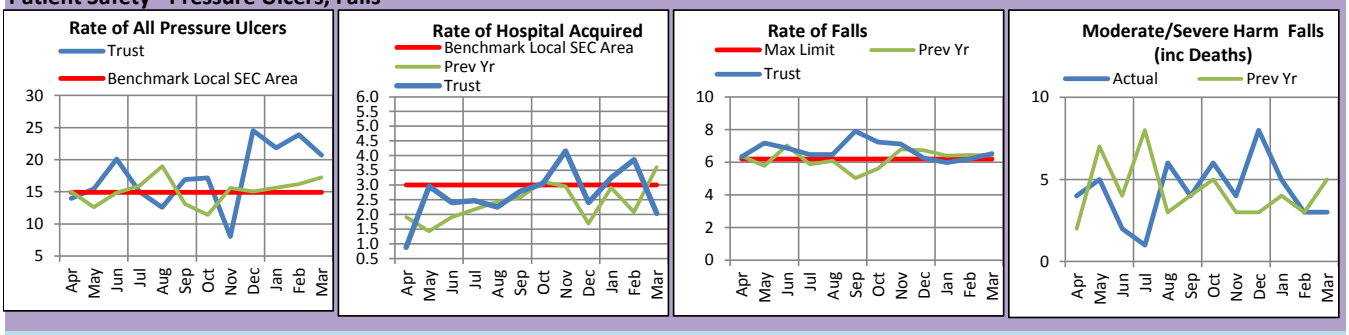
*******SHMI is within confidence limit*

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

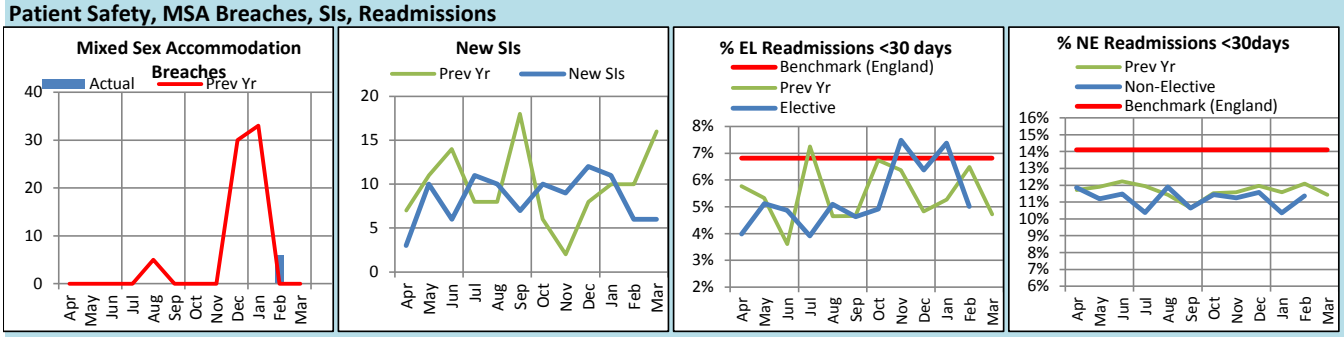
Patient Safety - Harm Free Care, Infection Control



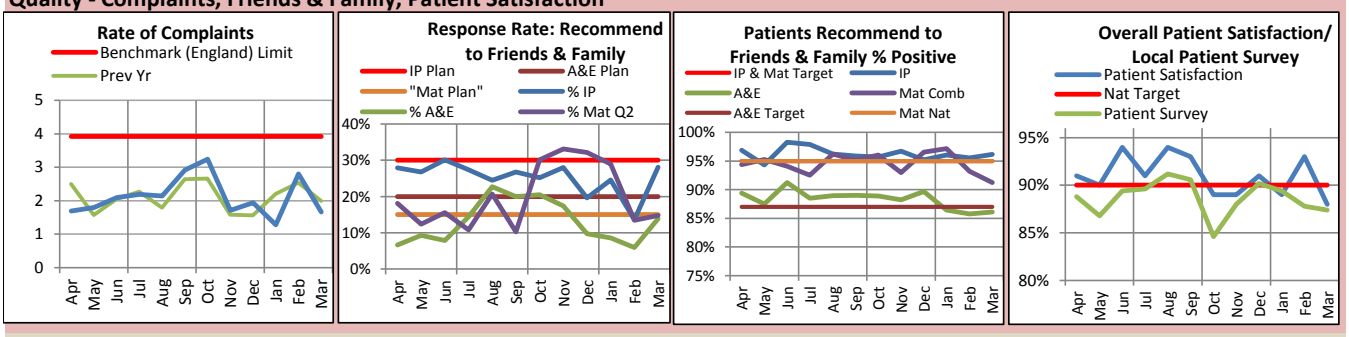
Patient Safety - Pressure Ulcers, Falls



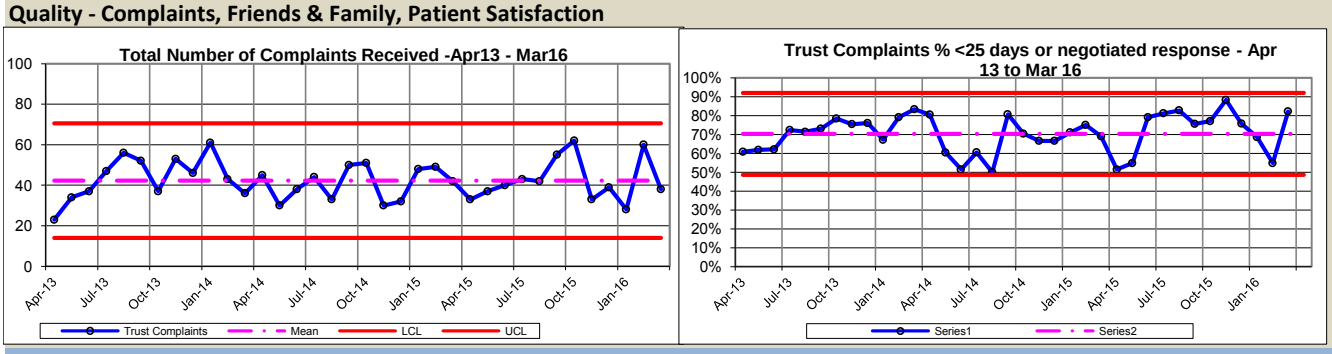
Patient Safety, MSA Breaches, SIs, Readmissions



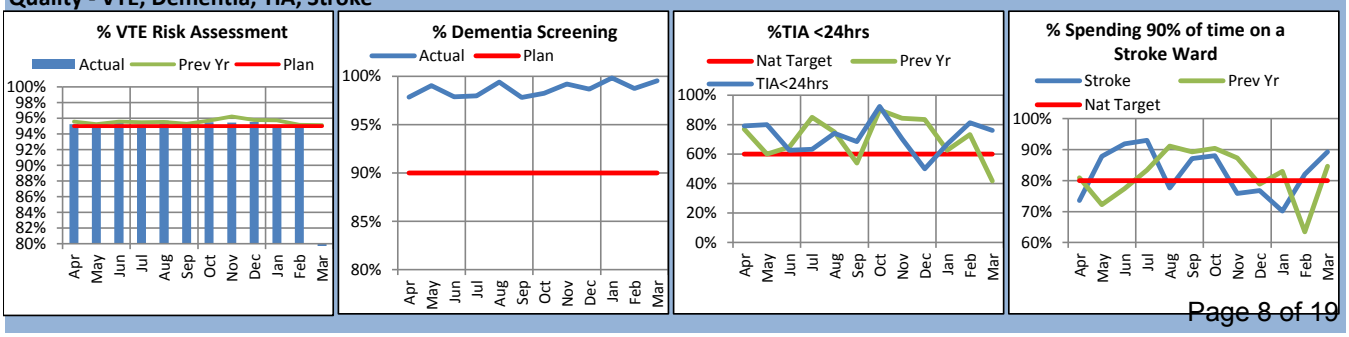
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

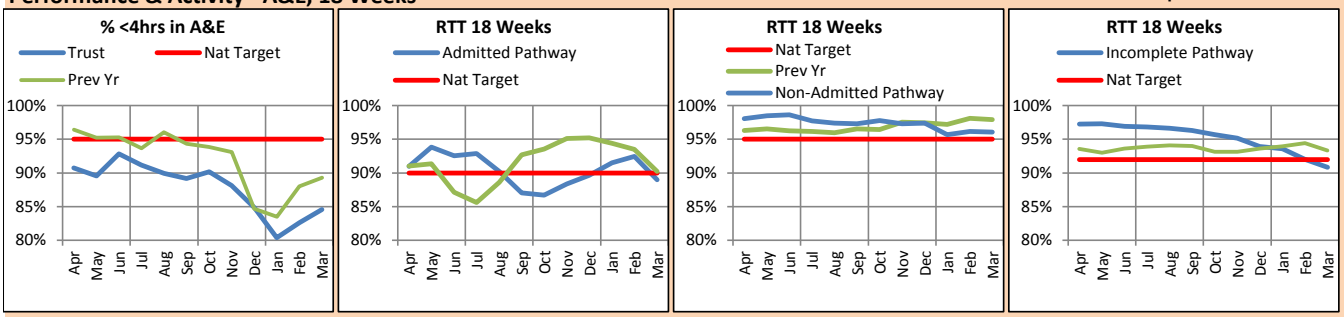


Quality - VTE, Dementia, TIA, Stroke

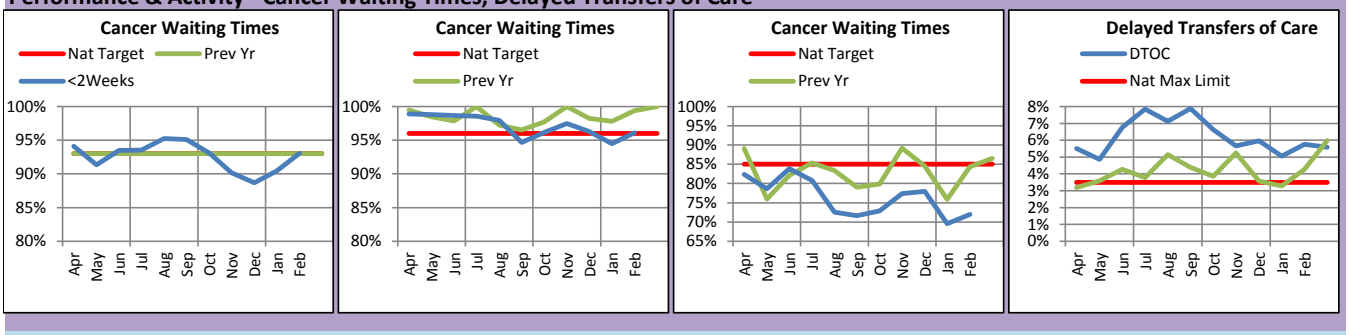


INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

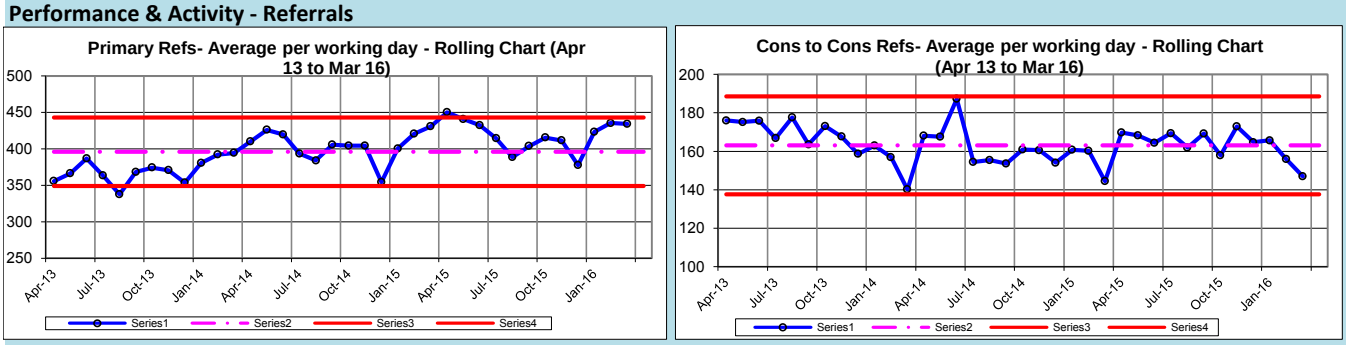
Performance & Activity - A&E, 18 Weeks



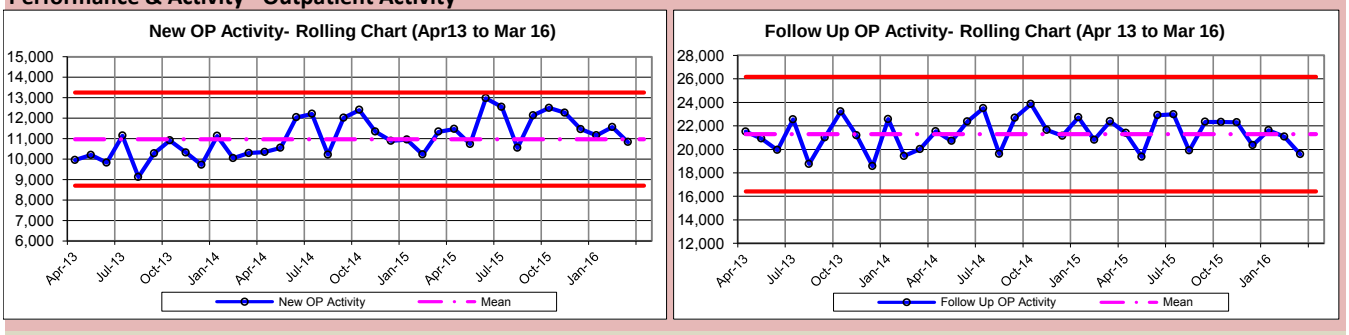
Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



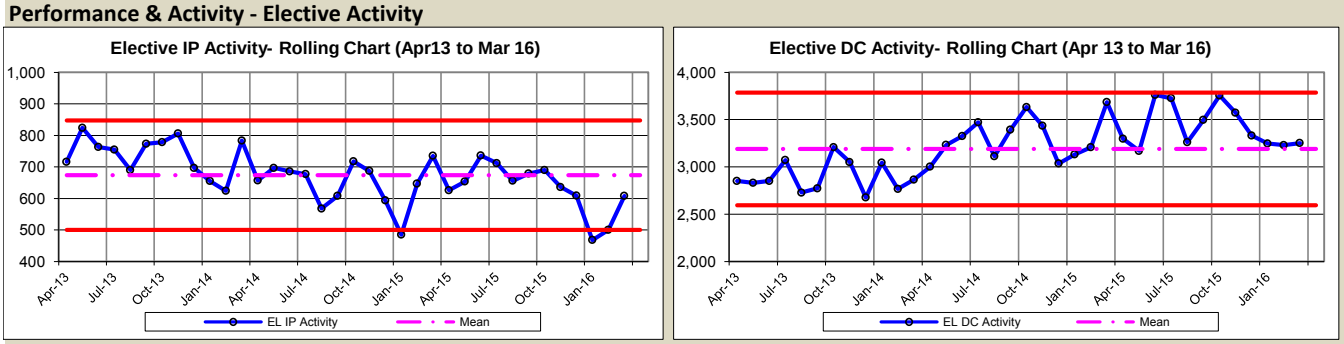
Performance & Activity - Referrals



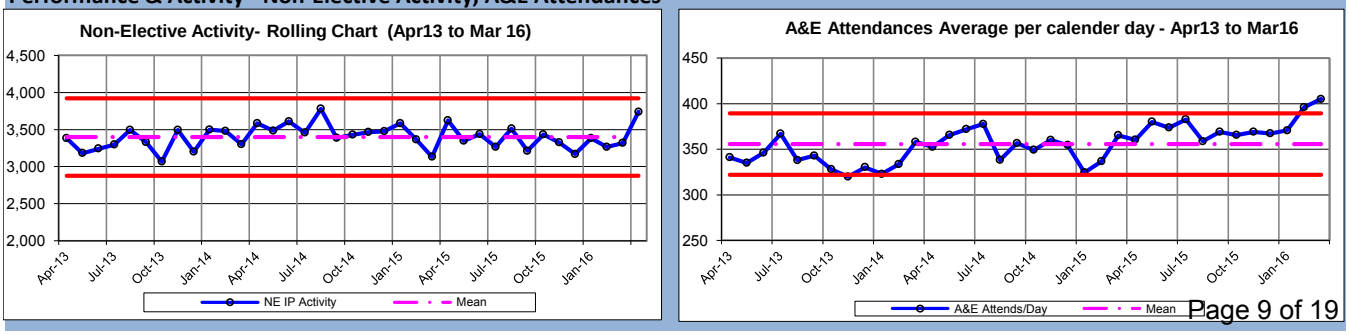
Performance & Activity - Outpatient Activity



Performance & Activity - Elective Activity

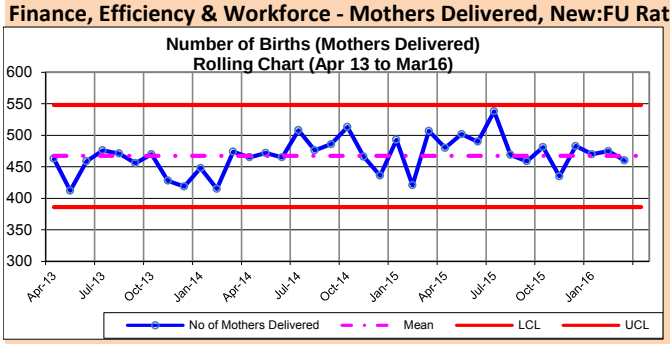


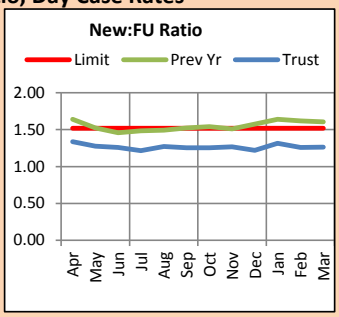
Performance & Activity - Non-Elective Activity, A&E Attendances

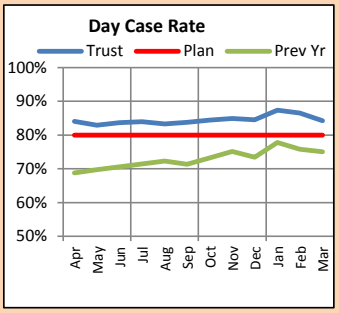


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

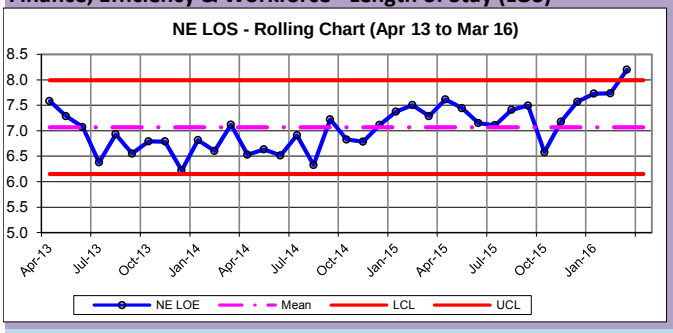
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

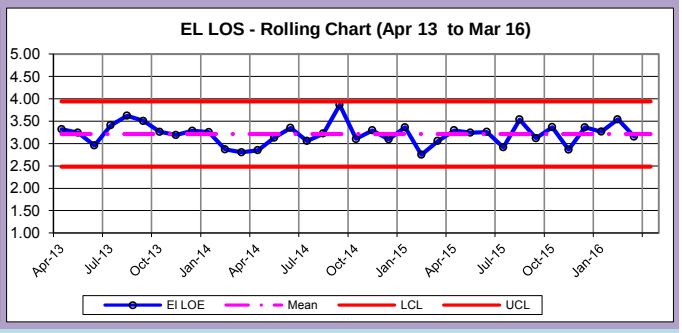




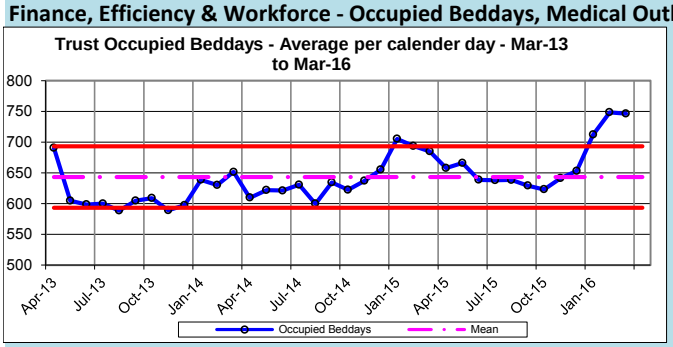


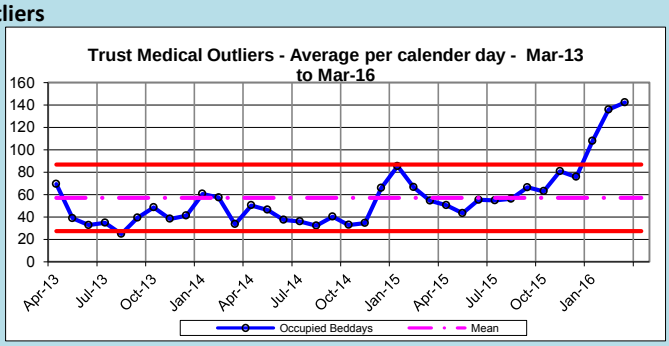
Finance, Efficiency & Workforce - Length of Stay (LOS)



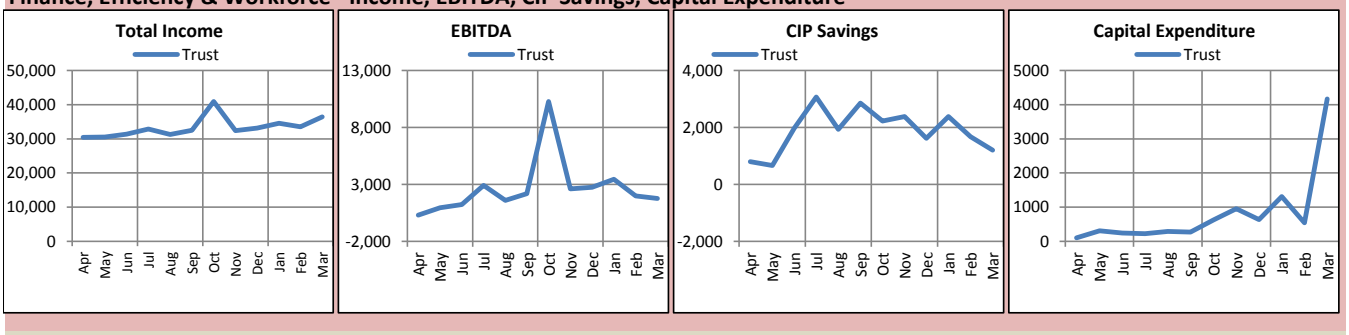


Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

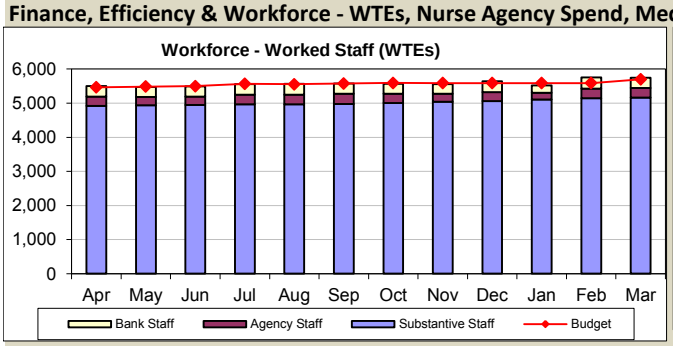


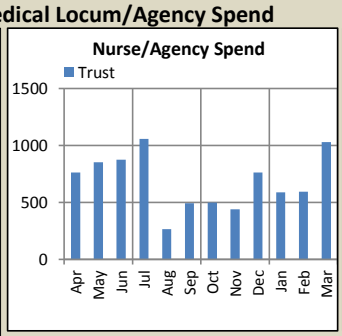


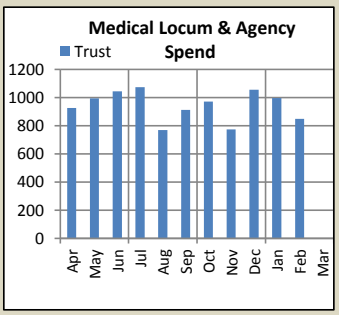
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



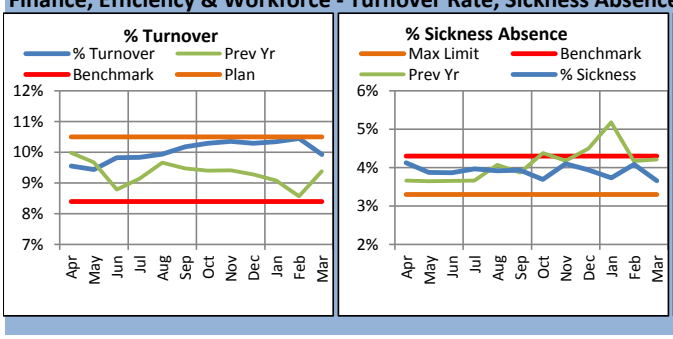
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

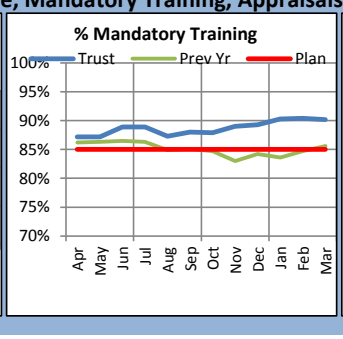


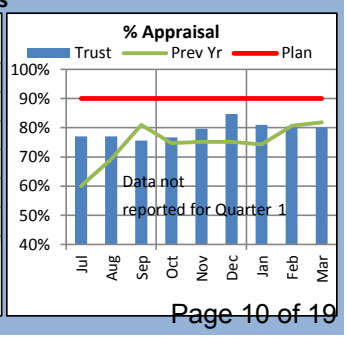




Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals







Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

Review of latest Financial Performance	**Director of Finance**

Summary / Key points

- The Trust had an adverse variance against plan at the end of March 2016 of £11.27m, an improvement of £0.7m in the month.
- The Trust's net deficit to date (including technical adjustments) is £23.40m against the planned deficit of £12.13m. In the month the Trust operated at a surplus of £1.36m against a plan of £0.65m surplus for March.
- In March the Trust operated with an EBITDA surplus of £1.76m which was £2.09m adverse to plan.

The Trust held £1.2m of cash at the end of March, a reduction of £7.3m from the end of February.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee

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

To note the year-end financial position

[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

Briefing paper – Trust Board

M12 Financial Performance overview

1. Overview of the Financial Position at M12 2015/16

1.1. This written summary provides an overview of the financial position at M12 of 2015/16. It should be read alongside the detailed finance pack, which has also been circulated to committee members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 12. The Finance pack shows for month 12 the Trust moved favourably by £0.7m against its in-month surplus plan of £0.65m resulting in a year to date deficit of £23.4m against a planned deficit of £12.13m. This is an adverse year to date variance of £11.26m. These figures include the full utilisation of reserves available for the first twelve months of 2015/16.

Income

1.3. Total income for the year is £400.71m against a budget of £400.93m. Income for the month is £36.44m compared to the £39.60m plan for the month.

1.4. The income headlines are outlined below:

- Total income is £0.20m favourable to plan at year end.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges. A total of £8.34m provisions/deductions and £6.42m threshold adjustments are included in the full year position
- A&E attendance activity remains higher than in the corresponding period of last year.
- The A&E Conversion rate has increased from 25.94% in month 11 to 26.90% in month 12.
- Re-chargeable on High cost drugs and devices are favourable in the month by £1.33m, and year to date £7.65m but these are pass through costs charged back to CCGs so there is a corresponding over-spend in the non-pay budgets.

1.5. There was an increase in Elective inpatient and day case activity compared to last month's level (£4.05m in month 12 compared to £3.80m in month 11) with under performance of £5.29m for the full year, including dependency on outsourced activity.

1.6. The increase from last month's level is due to the reduced level of cancelations (782 in March vs 1077 in February) which enabled more elective activity to be undertaken. Elective cancellations remain high as a result of the high number of non-elective patients occupying beds.

1.7. In month 12 A&E attendances were at their highest in the current financial year and the conversion rate increased from 25.94% to 26.90%. To date A&E attendances are above planned income levels (£0.5m) but this is higher than last year's level of income by 44.9%.

1.8. The Trust continues to experience an increase in the acuity of patients presenting in A&E and ultimately LOS when such patients are admitted. Overall, the level of occupied bed/day remains high and has increased further in month 12 resulting in increased usage of escalation capacity to manage flows in A&E.

1.9. The high levels of A&E attendances, as well as the increase in A & E conversion rates and the discharge of several long stay patients in month 12 have resulted in the Trusts' highest level of NEL activity in the current year.

1.10. NEL activity has reduced YTD compared to the corresponding period of last financial year. The income from NEL activity admissions have increased by 3.6% in March (compared to

the corresponding period of last financial year), the richer and more acute case-mix experienced throughout the current financial year has resulted in longer lengths of stay and an increase in the occupied bed days (OBD). During the same comparator period between years delayed transfers of care (DTOCs) have increased to their highest ever levels with some previous months exceeding 7%). The increase in OBDs has generated a 11.5% increase (compared to the same period of last financial year) in income from excess bed days which are only paid beyond the relevant HRG "trim point".

1.11. From April 2015 to March 2016, the Trust reported a total of 205,151 non elective occupied bed days compared to the 194,836 bed days used in the corresponding period of last year, representing a 5.29% increase. Our high bed utilisation rate coupled with our inability to discharge patients quicker is increasing the level of OBDs.

1.12. The increase in acuity (evidenced by an increased level of income per spell) and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers (which is currently at its highest ever level – 60.13% up on last year's level). This high bed occupancy and LOS levels is forcing the Trust to increasingly rely on escalation capacity.

1.13. Outpatient activity (excluding diagnostics) is £5.34m in month 12 compared to £4.59m in the previous month. Year on year, the income from outpatient activity is 4.5% higher the corresponding period of the previous financial year but is still lower than planned levels (£0.1m full year).

1.14. Readmissions, A&E waits, RTT and other contractual penalties increased from a YTD level of £6.3m in February to £8.4m at year end. The Readmissions, RTT and A&E penalties are calculated from Month 12 data whilst the other contractual penalties (e.g. First to Follow up OP ratios, Data quality queries) are estimates.

1.15. An 85% achievement rate for CQUINs continues to be assumed in the income position.

1.16. Non recurrent transitional support of £3.63m full year effect for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Outsourcing

1.17. The value of income related to outsourced elective activity remains at last month's level of £0.45m in March with a full year value of £3.45m. For outsourced activity the Trust pays costs that remove any contribution that it would earn from undertaking the activity in-house. Over 80% of the income for outsourced activity for the year to date relates to orthopaedic cases where there may be potential to undertake this work internally by increasing actual or productive in house capacity.

Expenditure

1.18. Operating costs are £15.46m adverse for the year against a planned budget of £392.87m, including available reserves. Pay was favourable to plan by £1.65m in March generating an adverse variance of £9.96m at year end.

1.19. Non pay (including reserves of £1.8m year to date) overspent by £0.52m in March and is £5.5m overspent full year.

1.20. The full year major overspends on agency usage are in Nursing (£6.9m), Medical agency (£2.56m), Scientific/Therapeutic agency (£1.27m) and Admin & Clerical (£1.15m). Nurse agency spend has risen from last month's level of spend (£990k) by £40k. This reflects the opening of the new ward at TWH. Month 12's nurse agency spend was the highest this financial year. Total agency costs are up on last month's levels by £207k overall (£1,950k compared to £1,742k). Total bank costs (including medical locums) are over planned levels by £0.28m in the month which gives a year to date overspend of £1.47m. The bulk of the

adverse movement in the month was on nurse bank (£217k) but medical locum have overspent at the yearend by £1.36m

1.21. The trajectory submitted to the TDA set out a reduction in agency costs from September (for trained nursing) of £0.5m through to the end of March with an overall reduction, including additional permanent staffing, of £0.3m. In March the qualified agency nursing increased to £998k from £953k in February. This was £656k greater than the March trajectory target which was set at £297k. The trajectory submitted to the TDA assumed that the total qualified agency nursing spend would be 5.2% by March but the Trust performance was actually 10.2% worse at 15.4%. Escalation pressures have contributed to the Trust not meeting the planned trajectory reduction.

1.22. Significant non pay overspends for yearend are:

- Drugs and medical gases £8m adverse (offset in the position by the over performance in HCD income to date of £7m)
- Clinical Supplies is £1.59m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs. The spend levels have dropped and are £66k lower than last month's levels. This reduction will in part be due to the reduced elective activity levels.
- Purchase of Healthcare from non NHS is adverse to plan by £4.48m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income (£3.45m), though this provides no net contribution to the Trust financial position.

1.23. Significant non pay underspends for the yearend are:

- Other non-pay costs are underspent by £5.1m. Included in other non-pay also includes costs relating to the corporate manslaughter legal case which are estimated at £0.55m.
- Premises costs are £3.2m underspend full year effect which is due to an expected rates rebate of £2m for the Tunbridge Wells Hospital, some of which relates to prior years.

1.24. EBITDA is a £8m surplus and is now adverse to plan by £15.8m.

1.25. The financing costs including those related to the PFI and deprecation total £45.3m which is adverse against the plan by £8m, £12.8m relates to impairments.

Balance Sheet & Capital

1.26. Cash balances of £1.2m were held at the end of March (£8.5m at the end of February). In March the Trust received the remaining £6.4m from the Interim Revenue Support Facility and £3.7m in respect to capital PDC.

1.27. The Trust's outturn performance reflects the reductions in capital resource limit from the forecast underspend in depreciation in part resulting from the substitution of the new ward project for the previously planned equipment & ICT projects, and in part from finance improvement measures that reduced outturn depreciation costs, but also the funding resource. The Trust spent £15.4m capital expenditure in 2015/16 (including donated assets) against the original plan of £20m for the year. The revised capital resource limit (excluding donated assets) is £14.795m, including the final adjustment for the PFI lifecycle capital spend. Despite the impact on the programme of the uncertainties and timing of the external financing application (funded as capital PDC of £3.5m), the Trust succeeded in utilising almost all of its capital resource limit, reporting a small underspend of £45k in its draft annual accounts.

2. CIP Delivery

2.1. The month 12 position shows a total CIP delivery (including full year effects) of £20.8m against the target that was included in the TDA plan of £21.5m, so under-performing by £0.7m.

2.2. Under performance on Length of Stay (£1.27m), Theatre Productivity (£0.49m), Back office (£0.8m), PPU (£0.23m), Drugs (£0.20m) and Medical Efficiency (£0.1m) are in part offset by overachievement in Nursing and STT Efficiency £0.85m, Procurement efficiencies £1m and Contract Management £0.83m.

3. Conclusion

3.1. As we move into the new financial year staffing costs remain a key area of continued focus as part of the Integrated Recovery Plan and normal day to day control. Overall agency costs are up on last month's levels mainly due to the new ward opening at TWH.

3.2. The Finance Committee are requested note this report.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M12 - March 2016

March 2016

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 12

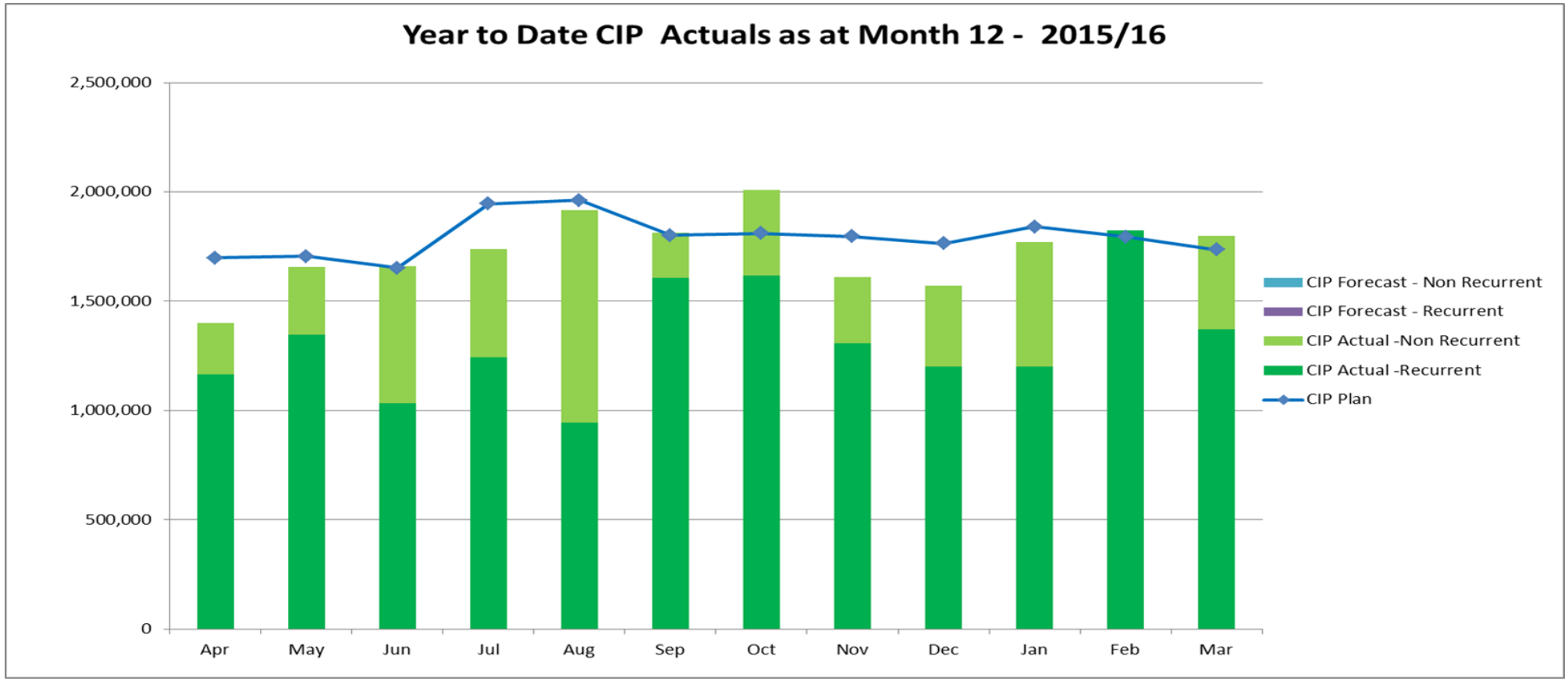
(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,132)	(23,401)	(11,269)	RED
1b) Year to Date, Actual compared to Plan	(12,132)	(23,401)	(11,269)	RED
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				RED
- Total Efficiencies for Year to Date compared to Plan	18,146	17,542	(604)	
- Recurrent Efficiencies for Year to Date compared to Plan	18,146	12,373	(5,773)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	17,542	(604)	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	12,373	(5,773)	
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	14,795	14,750	45	GREEN
5) Permanent PDC accessed for liquidity purposes		16,908		RED
Trust Overall RAG Rating				RED
(B) Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)				
Year to Date Rating	2.00	1.00	(1.00)	RED
Forecast Outturn Rating	2.00	1.00	(1.00)	RED

RAG STATUS		
Red	Amber	Green
A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
PDC accessed	Not applicable	PDC not accessed
If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
If score is 2.5 or lower	Not applicable	Score of over 2.5
If score is 2.5 or lower	Not applicable	Score of over 2.5

Maidstone and Tunbridge Wells NHS Trust



Rec YTD	15,856,821
NR YTD	4,907,352
	20,764,173

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-10 CCQ Quality Improvement Plan (QIP) – exception report Chief Nurse

As was agreed at the Trust Board on 23/03/16, the enclosed exception report details only those Compliance Actions that still have an element that is outstanding, or need to be drawn to the Board's attention.

These are 3 Compliance Actions that meet this criteria.

For Compliance Action 6 (out of hours transfer from ICU), following a discussion at the Quality Committee 'deep dive' meeting on 13/04/16, the rating of the Compliance Action was discussed at the Trust Management Executive on 20/04/16, and it was agreed that although such transfers are still occurring, the Trust's status should be rated as 'Blue', as the number of transfers at the Trust was below the national average. Previously, the status had been rated 'Red' as the internal target had been set to trigger 'red' if there were greater than 5 transfers out of hours. Despite the amended rating, the monitoring of such transfers will however still continue.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 20/04/16

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

CQC Quality Improvement Plan

Exception Report April 2016

Progress on the delivery of improvements has been reported to TME, external stakeholders and the Trust Board for assurance for a year. Considering that there are now only 3 compliance actions that remain outstanding, from here on an exception report is being produced.

Compliance Action 6: out of hours ITU transfers

There are still occasions when ITU patients need to be transferred out of hours for clinical reasons, but it has been agreed that the Trust's position should be rated as 'Blue', as the number of transfers at the Trust was below the national average. When such transfers do occur there are sufficient safeguards in place to ensure that the transfer is safe and carried out in a planned way. The ITU bed availability is assessed 3 times a day every day. 24 hour critical care outreach service ensures smooth and safe transition of patients.

Compliance Action 9: due regard to patient cultural and linguistic background or disability

The new translation service contract has been awarded and is currently being implemented. This will provide an enhanced quality service with financial benefits. There is now a substantive Engagement, Equality and Diversity lead in post and will lead on the outstanding actions for this compliance action.

Compliance action 14: children's services engagement and involvement with the surgical directorate

The Clinical Director has given assurance that the outstanding audit relating to Paediatric in-patient being under shared care between Paediatrics and Speciality Teams is on track and will be completed in May 2016.

Outstanding actions

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. There is an element of judgment on the RAGB rating, based on the update and evidence provided and discussions.

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

Blue	Fully Assured
Amber	Not running to time and / or more assurance required
Green	Running to time, in progress / not running to time but sufficient assurance of progress
Red	Not assured / actions not delivering required outcome

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on communications board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During March 9 patients, 8 at TWH and 1 at Maidstone were transferred out of hours for clinical need. This compares with 10 in February (8 TWH, 2 Maidstone), 10 in January, 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. Incident reports were raised each time. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues. Trust operational plan in place with additional ward at TWH opened in March 2016.		1/3/15 (for robust patient identification and tracking New ward opened 19th March 2016	
Action Plan running to time: Yes (revised date)				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Continuing issues with patient flow across the trust impacting on ICU patient discharges.				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*	**Operational Lead:** *Richard Hayden, Deputy Director Human Resources & John Kennedy, Deputy Chief Nurse*			
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Substantive post holder in post April 2016 Chief Nurse is E&D Board Lead	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15 (for interim) New date substantive 1/04/16	
2. Develop an E&D awareness programme for all staff	E&D training 89% compliant against 85% target (April 2015). Benchmarking & intelligence from partner Trust to inform awareness programme and roll out plan that is both department specific and generic. This will be developed by the substantive E&D Lead.		1/10/15 New date 31/07/16	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations	WF strategy approved June 2015. E&D priorities included & supported by project plan approved Workforce Committee September 2015 BME Forum second meeting 21/9/15. SEC BME Chair in attendance. Trust WRES data reviewed. Trust has partnered with Stonewall to support LGBT staff. Data submitted for Stonewall Equality Index		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated July 2015. Translation service currently being re-procured		1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion	Meeting and agreed contact for best practice with Leicester Partnership Trust. Work will not progress until lead is in post		1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities	Under assessment with intention to commission external support Priority Plan to be finalised linked to EDS2 grading plan. WRES data presented to Board 30/9/15. Comprehensive review will be undertaken by substantive postholder		1/4/16 New date 31/07/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Development of new Diversity Management Group. First meeting 30 October 2015.		1/9/15	
Action Plan running to time:	YES			
Assurance statement :				
In progress				
Areas of concern for escalation:				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned and awaiting results. Assurance given this is still on track.		1/8/15 Clinical Director: Audit allocated but results not expected until May 2016	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	New Governance framework developed and agreed with implementation commenced December 2015		1/9/15 New date: 1/12/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): SOP				
Assurance statement :				
Audit is ongoing				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-11 Planned and Actual Ward Staffing for March 2016 — Chief Nurse

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

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

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues. Notable in this respect are John Day, Chaucer and Ward 20.

Escalation areas account for the remainder of the over-fill. These areas remain the same; namely UMAU, SAU and to a lesser extent MSSU. MSSU have had increased demand as much of the elective work load has been undertaken here to free beds in the main surgical wards.

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

A number of wards have had a shift in RN:CSW ratios, in these areas this was a considered action based on professional judgement, available skill mix and patient acuity and dependency. Notably this applies to ward 10, Peel and Cornwallis. Ward 12 have a number of EU nationals awaiting NMC PIN and continue to have some level of vacancy.

Maidstone Stroke Unit has recently experienced a number of changes in staff. The Ward Manager and the Stroke CNS have a plan in place to maintain recruitment momentum and to develop existing staff to enable them to provide thrombolysis bleep cover.

Accident & Emergency (A&E) Departments overal fill rates are good against planned staffing levels. As expected Tunbridge Wells A&E had an increased RN fill rate, particularly at night.

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

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

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

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

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

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set bout below:

The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

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

Which Committees have reviewed the information prior to Board submission?

▪

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

Assurance

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

March '16		Day		Night		Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	96.1%	113.7%	98.4%	116.1%	22.0%	100.0%	11	0		8 specials required in month (named patients). CSW numbers also include EU nurses awaiting PIN during the month (17 shifts).	107,868	108,298	(430)
MAIDSTONE	Romney	100.0%	92.5%	98.4%	95.2%			3	0			66,973	69,552	(2,579)
MAIDSTONE	Cornwallis	91.9%	127.4%	90.3%	96.8%	86.1%	100.0%	0	0		RN:CSW ratio shift during the day an accepted risk based on acuity.	93,344	80,943	12,401
MAIDSTONE	Coronary Care Unit (CCU)	76.3%	N/A	101.6%	N/A	133.3%	95.8%	0	0		CCU co-located on Culpepper Ward. Staff cross cover during week/shift according to current acuity & dependency.	104,039	103,262	777
MAIDSTONE	Culpepper	100.0%	98.4%	101.6%	100.0%	58.3%	95.2%	2	0					
MAIDSTONE	John Day	94.9%	124.7%	98.4%	61.3%	50.0%	87.9%	11	1		RNs awaiting PIN (10 shifts) included in CSW numbers. Reduced fill rate at night had some impact on care delivery (no clinical omissions) Rota to be reviewed to ensure appropriate spread through the 24hr period	105,856	144,930	(39,074)
MAIDSTONE	Intensive Treatment Unit (ITU)	96.4%	N/A	98.8%	N/A			0	0			162,340	171,591	(9,251)
MAIDSTONE	Pye Oliver	92.9%	109.7%	98.4%	90.3%	11.7%	88.9%	4	1			95,666	148,331	(52,665)
MAIDSTONE	Chaucer	96.1%	117.7%	96.8%	137.6%	92.5%	91.9%	5	0		14 specials (named patients) plus management of noro-virus bay.	79,298	140,699	(61,401)
MAIDSTONE	Lord North	89.5%	100.0%	92.5%	87.1%	102.9%	100.0%	4	1		Acuity & dependency made the RN day fill rate acceptable as support available from senior nursing staff. Night CSW acceptable due to overall dependency levels.	97,051	102,766	(5,715)
MAIDSTONE	Mercer	98.4%	103.2%	96.8%	137.1%	2.7%	50.0%	2	0		Specials on 20 nights, plus period of increased requirement to manage noro-virus outbreak (2 nights). CSW usage was to cover a number of patients in month, with significant cognitive disturbances and falls risks (1 patient had previously been sectioned under MH act prior to transfer to	91,166	105,000	(13,834)
MAIDSTONE	Edith Cavell (MOU)	97.1%	96.8%	100.0%	100.0%	0.0%	0.0%	2	0			134,418	59,360	75,058
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	91.8%	91.4%	133.3%	206.5%	2.7%	90.9%	3	0		Trolley bays escalated overnight throughout the month.	119,337	164,330	(44,993)
TWH	Stroke	103.9%	95.8%	99.1%	90.9%	125.0%	80.0%	4	0			133,978	153,671	(19,695)
TWH	Coronary Care Unit (CCU)	97.8%	67.7%	97.8%	N/A	96.9%	96.8%	3	0		Unable to fill CSW shift on 10 occasions during the month.	57,300	75,601	(18,301)
TWH	Gynaecology	89.6%	106.5%	100.0%	100.0%	35.8%	97.1%	1	0		Accepted risk, to manage dependency with increased CSW during the day.	66,260	66,995	(735)
TWH	Intensive Treatment Unit (ITU)	107.7%	100.0%	109.3%	N/A			0	0			185,376	206,954	(21,578)
TWH	Medical Assessment Unit	96.1%	110.5%	121.5%	101.1%	9.6%	83.3%	5	0		Ward relocation during month. Post relocation treatment bays were escalated over night.	151,252	228,164	(76,912)
TWH	SAU	117.2%	212.9%	143.5%	345.2%			1	0		Escalation. Cover provided to SSSU at night and support provided to recovery.	65,750	154,534	(88,784)
TWH	Ward 32	85.5%	106.5%	100.0%	100.0%	2.4%	100.0%	0	0		Day shifts cross-covered by Wells Suite staff.	119,910	143,416	(23,506)
TWH	Ward 10	80.6%	124.2%	96.8%	164.5%	24.1%	95.0%	0	0		20 nights of specials/cohorted care required. Cluster of three patients (named). Later in month 1 psychiatric patient needing support for 3 shifts.	124,165	128,692	(4,527)
TWH	Ward 11	101.8%	107.5%	94.4%	159.7%	53.9%	97.6%	3	0		1 patient needing a constant nursing presence throughout the month. Plus cohort of 3 patients at high risk of falls + 3 patients with tracheostomy requiring increased levels of observation overnight.	125,584	133,629	(8,045)
TWH	Ward 12	90.0%	97.8%	89.5%	109.7%	14.8%	91.7%	0	0		Reduced RN fill rate at night due 4 shifts not being filled by agency at short notice.	108,139	128,927	(20,788)
TWH	Ward 20	94.9%	121.0%	102.4%	150.0%	50.0%	92.9%	8	0		Cohort for falls risk required overnight. 2 patients requiring constant supervision (mental health issues, and high risk of absconding).	122,805	149,985	(27,180)
TWH	Ward 21	109.6%	72.0%	114.5%	79.6%	19.4%	91.7%	5	1		CSW rill rate a considered risk against use of agency. Some impact on staff breaks, clinical care maintained.	119,912	136,434	(16,522)
TWH	Ward 22/2	89.6%	114.4%	97.1%	97.8%	75.0%	100.0%	5	1		RN:CSW ratio switch due to move of Ward 22 to Ward 2 mid month. Ward staffing levels remained safe throughout.	93,043	112,394	(19,351)
TWH	Ward 30	80.9%	120.7%	89.5%	101.1%	3.0%	100.0%	0	0		Accepted risk for RN fill rate. Uplifted CSW (own staff via Bank) to maintain fundamental aspects of clinical care.	121,746	132,158	(10,412)
TWH	Ward 31	95.7%	101.3%	102.4%	98.9%	65.1%	92.9%	0	3			136,057	163,960	(27,903)
TWH	Ante-Natal	98.4%	80.6%	100.0%	90.3%			0	0		CSW fill rate accepted risk for ante-natal. Priority given to post-natal and labour wards.			
TWH	Delivery Suite	97.1%	91.9%	97.1%	100.0%	14.8%	91.2%	0	0			590,515	663,555	(73,040)
TWH	Post-Natal	98.6%	93.5%	101.6%	92.5%			0	0					
TWH	Gynae Triage	95.2%	100.0%	96.8%	106.5%			0	0			11,354	10,560	794
TWH	Hedgehog	103.8%	65.4%	115.6%	174.2%	3.8%	100.0%	2	0		Escalated overnight. Reduced CSW during the day a considered approach to ensure night time covered.	186,189	226,329	(40,140)
TWH	Birth Centre	100.0%	100.0%	103.2%	93.5%			0	0			65,393	66,272	(879)
TWH	Neonatal Unit	98.6%	90.3%	98.9%	87.1%			0	0			160,643	162,180	(1,537)
MAIDSTONE	MSSU	137.5%	89.6%	95.2%	N/A			0	0		Additional activity taken from TWH. Increased RN cover to enable.	55,535	36,090	19,445
TWH	Peel	89.1%	138.7%	97.8%	N/A			0	0		Consider approach to the use of CSW cover for RN gaps during the day to ensure adequate cover at night.	80,271	81,584	(1,313)
TWH	SSSU	107.2%	121.7%	N/A	N/A			0	0		Escalation; support provided to Theatre Recovery.	36,096	32,204	3,892
MAIDSTONE	A&E	101.0%	85.5%	99.2%	103.2%	11.9%	86.4%	0	0		CSW fill rate down due to inability to fill with bank. Risk accepted not to use agency CSW.	161,634	246,431	(84,797)
TWH	A&E	97.8%	97.0%	105.8%	93.0%	15.9%	85.9%	3	0			252,724	399,489	(113,765)
											Total Established Wards	**4,588,987**	**5,406,269**	**(817,282)**
											Additional Capacity beds	39,045	112,150	-73,105
											Other associated nursing costs	2,420,637	2,448,682	-28,045
											Total	7,048,669	7,967,100	-918,431

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-12 Trust Board Members' hospital visits (23/01/16 – 22/04/16) Trust Secretary

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

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

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

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

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

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

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

Hospital visits undertaken by Board members, 23rd January to 22nd April 2016

Trust Board Member	Areas registered with the Trust Secretary / Assistant Trust Secretary as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman of Trust Board (AJ)	▪ A&E (MH)	-
Chief Executive (GD)	▪ Health Records (Paddock Wood) ▪ Endoscopy Unit (MH) ▪ Endoscopy Unit (TWH) ▪ A&E (TWH) (assistance with a learning disability group)	-
Chief Nurse (AB)	▪ Cardiac Path Lab (MH) ▪ Ward 20, Orthogeriatrics (TWH) ▪ Ward 30, Elective Orthopaedics (TWH) ▪ Ward 31, Orthopaedic Trauma (TWH)	-
Chief Operating Officer (AG)	-	-
Deputy Chief Executive (JL)	▪ Stroke Unit (MH)	-
Director of Finance (SO)	▪ Mercer Ward (MH) ▪ Ward 22, Acute Elderly (TWH)	-
Director of Infection Prevention and Control (SM)	-	-
Director of Workforce (RH)	-	-
Medical Director (PS)	-	-
Non-Executive Director (KT)	▪ A&E (Tunbridge Wells Hospital) ▪ Involvement with various consultant interviews	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	▪ Cornwallis Ward (MH) ▪ Pye Oliver Ward (MH) ▪ Whatman Ward (MH) ▪ A&E (MH)	-
Non-Executive Director (ST)	-	-

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-13	Confirmation of the Trust's Final Planning Submissions	Director of Finance

Summary / Key points

The following report provides an update on the:

- Approach taken to develop the Trust's annual Business Plan for the Financial Year 2016/17 (FY17)
- The development of the Financial Plan submitted to NHS Improvement on the 18th April 2016, and
- A copy of the One year Operational Plan for 2016/17

Appendix 1 Efficiency Savings Programme

Which Committees have reviewed the information prior to Board submission?

- Finance Committee 25.04.16

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

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

1 Internal business planning update

1.1 Context

The purpose of this update to The Finance Committee is twofold:

- Firstly to provide a summary of the approach taken to develop the Trust's annual Business Plan for the Financial Year 2016/17 (FY17), and
- Secondly, following submission of the Business Plan to the NHS Improvement (NHSI) on 18th April 2016, to provide an update on the final version of the plan submitted.

1.2 Directorate planning process

Throughout the process Business Planning Steering Group (BPSG) members have worked with the Directorates to support them in the development of their business plans. The BPSG have tasked the operational leads for ensuring that Directorate plans are aligned to the clinical strategy, LTFM, local health and care system commissioning strategies before scrutiny by the Trust management executive, the Workforce Committee and Finance Committee.

This integrated and collaborative approach has been taken to ensure that corporate plans suitably reflect bottom-up Directorate planning whilst, at the same time, ensuring Directorate plans are consistent with the strategic direction assumed by the Trust and to gain assurance that all relevant matters have been accurately taken into account.

This, as an ongoing process, has involved:

- The dissemination of centrally held information to Directorates to inform the business planning process at a detailed level
- Ongoing one-to-one informal meetings with Directorates to review and agree baseline positions for activity demand and capacity, workforce requirements, capital planning, efficiency and savings plans (ESPs)
- The development by Directorates of individual Business Plans and presentations supported by BPSG 'deep dive' meetings with individual clinical directorates
- Attendance by Directorate clinically-led management teams at a minimum of two formal Executive-led challenge meetings
- Collation of Directorate information to ensure that all planning is cohesive and triangulated throughout the Trust thereby informing the overall Trust business and financial planning through to setting the budget for FY17, and
- Culminating in clinical presentations to a joint meeting of the Trust Management Executive (TME) and Board

1.3 Activity demand and capacity planning

Activity assumptions have been based on demographic growth plus in year waiting list growth. A baseline has been derived by extrapolating a 2015/16 outturn which has been uplifted for demographic growth derived and steady state waiting list. Additional activity has been identified to reduce waiting list backlogs in order for the Trust to deliver its RTT performance standard compliance both at a Trust aggregate and individual speciality level during the financial year. Assumptions have been shared with and signed off by directorates using their local knowledge of demand. The directorates have confirmed this can be met through one of the following:

- Use of current capacity
- Previously planned and agreed new capacity
- Efficiency improvements
- Use of independent sector

The Trust has carried out an assessment of current capacity against the demand requirements. Work has been ongoing with the Directorates who have continued to review and update their detailed capacity plans linked to both workforce and financial impact. Consistency and reasonableness test have been carried out to ensure that demand and capacity outputs are credible, congruent with and meet planning expectations. Improvement trajectories have also been set for other access standards. These include A&E, diagnostic waits and 62-day cancer targets with further work being undertaken to look at any probable impacts on capacity.

Assumptions that have been applied to activity and capacity numbers for 2016/17 are:

- Elective capacity return to steady state from April and is maintained throughout the winter period
- Outsourcing to increase and ensure additional activity required to reduce backlogs is achieve by end of Q3 before returning to similar levels used in 2015/16
- Assumes the same level of non-elective activity as 2015/16 at current average length of stay (LoS) and current delayed transfers of care (DToC).

1.4 Planning and impact on quality

Quality, as core day to day business, is embedded within all aspects of care, performance and development in order to meet the Trust's guiding principles of patient care, safety and quality of care. The Trust's Business Plan sets out an expected deficit of £22.9m though the Trust is focusing on improving this position through the provision of quality-driven services and continued challenge to ensure value for money.

1.5 Workforce

The Trust has adopted a rigorous workforce planning process, ensuring that clinical directors, supported by multi-disciplinary senior clinicians, are at the heart of the decision making process within their respective Directorates:

- Workforce assumptions are largely based on the levels of delivery of care in 2015/16, plus normalisations to ensure that key vacancies have been included
- Directorate business plans have been developed using benchmarked workforce metrics and triangulating with finance and activity
- Nursing and medical establishments continue to be reviewed to ensure delivery of key quality indicators
- The Trust has a strong pipeline of nurse recruitment and, as substantive staffing increases, is forecasting a reducing utilisation of temporary staff in 2016/17
- Directorates will continue to work on initiative plans to attract staff to work for the organisation and target opportunities overseas to reduce vacancies, where appropriate.
- All Directorate workforce plans have been formally approved by the relevant Clinical Director ensuring a multi-disciplinary approach in the formation of the local plan

The Trust has a number of workstreams to ensure compliance against the TDA/Monitor rules and to reduce the reliance upon temporary staffing, these include 'Temporary Staffing' work stream, with the Chief Operating Officer as the Executive Sponsor, 'Procurement' work stream, with the Director of Finance as the Executive Sponsor and 'Nursing Efficiencies', with the Chief Nurse as the Executive Sponsor. These workstreams ensure compliance in accordance with the TDA/Monitor rules, adherence to the Price Caps and reduction in demand against temporary staffing, in terms of recruitment and retention.

1.6 Finance

The final Financial Plan has been collated with the starting point as FY16 outturn, adjusted for full year effects, expected activity changes in relation to holding waiting lists steady state, clearing the specialities with backlogs, demographic growth, service changes, normalisation in FY16 and non-recurrent items. The draft financial plan includes the impact of the FY17 national tariff and demographic growth which equates to £7.8m. Our efficiency programme (Appendix 1) incorporates the expected improvements from agency

negotiations for capped rates and recruitment initiatives for key nursing vacancies. The Trust is also considering a range of approaches to managing its resource requirements, eg the use of managed service arrangements.

Work is complete on bottom-up budgets these will be loaded to the general ledger for month 1 reporting. The aim is for budget sign off with all directorates by the end of May. The executive-led business planning sessions with Directorates have been continuing since November 2015 and ensure the Trust's financial plans are suitable, feasible and acceptable against the Trust's strategy.
The final plan submission bridges from FY16 M10 outturn forecast with material bridging items identified and explained.

The Trust's five year capital programme is focussed on delivering the clinical strategy, driving access and operational performance improvements and reducing backlog and clinical risk to ensure appropriate patient safety and experience, within an efficient environment. The Trust has re-prioritised and scaled down its capital programme in the light of the constraints on external capital and also to reflect the stretching of its existing asset base; it will also access charitable funding to support its capital investment, particularly in cardiology and oncology.

1.7 Sustainability and Transformation Planning

The Trust's operational plans are, in part, driven by the requirements of the emerging regional Sustainability and Transformation Plan (STP), which itself is driven by the Forward View and the connected local priorities. Whilst the Trust is committed to this approach, such a major transformation of primary care, community based health and social care, and locally delivered secondary care services into fully integrated and significantly enhanced services will, necessarily, impact the Trust on several fronts:

- Out of hospital care
- Hospital based care
- Centralisation of specialist services.

With a transition of service provision moving from the acute to the community setting, the Trust will need to identify new models of hospital care, target the potential capacity to expand the specialist service provision it offers, reshape its cost base and service delivery models to be able to deliver high quality and affordable care provided by an appropriately trained and engaged workforce. Consequently, the Trust is currently working through its strategy to support its forward planning.

1.8 Conclusion / Next Steps

The annual plan was submitted to NHS Improvement (NHSI) on the 18th April.

NHS England (NHSE) has recently issued further guidance regarding the sign off of acute contracts with commissioners. Whilst the final date for contract agreement to avoid arbitration is 25 April, the national deadline for signing of contracts remains the 31 March. Where agreement has not been reached by 23 March, and a material gap exists Trust and commissioners will be expected to put themselves forwards for formal mediation. At this stage it is looking highly likely that the Trust will need to enter formal arbitration with West Kent CCG.

As part of the planning submission to NHSI, the Trust has to confirm agreement or decline the ability to sign up to the proposed control total a surplus of £7.8m after receiving £12.5m sustainability funding. In collation of the attached plan and acknowledgement of the risks to deliver this plan, the Trust is not in a position at this stage to accept the control total.

The Trust has agreed to participate in the STP advisory group that has been set up by Monitor / TDA. The group will help review and steer the development of a template for STP footprint finances. This group will be in place for the next two to three months. Meetings have commenced and the main focus of the discussion is the returns that commissioners and providers will be expected to complete as part of the process.

The Trust has expressed an interest in the Finance Improvement Programme, which is being co-ordinated by NHSI. The Trust has received confirmation that is has been shortlisted. There have been a number of companies that have expressed an interest as part of the bidding stage to work with MTW. The Trust is expecting to be advised this week of the shortlisted companies.

Maidstone and Tunbridge Wells NHS
NHS Trust

Annual Business Planning Update 2016/17

Finance Committee
25th April 2016

Key Submission Dates

Maidstone and Tunbridge Wells NHS Trust

External Deadlines	Submission	Date	Achieved
~~January/February Trust Board~~	~~First Draft~~	~~Feb 2016~~	Yes
~~TDA Draft High Level Plan~~	~~Draft Submission~~	~~8th Feb 2016~~	Yes
~~March Trust Board~~	~~Final Draft~~	~~23rd Mar 2016~~	Yes
~~TDA Annual Plan submission~~	~~Final Submission~~	~~18th Apr 2016~~	Yes
STP submission	Draft Submission	By End of June 2016	
STP review	Review	By End of July 2016	

Planning Assumptions

Clinical Income

- Tariff inflator applied at 1.6% (Local prices 1.1%, block items 1.1%, PbR high cost drugs 4.5%, PbR devices 1.7%)
- Demographic growth and waiting list steady state included
- CQUIN applied at 90% (2.5% CCG / 2% NHSE)
- Marginal rate applied at 70:30 as per guidance
- New To Follow Up Ratios assumed as per 15/16 actuals

Other Income

- Absorbs the ending of tapering local PFI support (£4m)
- Absorbs the last year of non recurrent transitional funding from NHSE (specialist) for cancer tariffs (£4.6m)
- Excludes winter funding
- Excludes non recurrent funding from CCGs
- Assumes 1% inflation for Education, 2% Private Patients and 2.1% for Commercial Income

Pay

- Based on 15/16 forecast outturn at month 10, vacancies re-established at mid-point
- Assumes 3.3% cost increase on substantive and 1% on bank, which includes incremental drift and Opted Out impact
- Nursing establishments costed as per current proposals whilst review underway

Non Pay

- Based on 15/16 forecast outturn at month 10, adjusted for Non Recurring and Full Year Effect (FYE)
- Assumes 1.7% inflation

Planning Assumptions

Other

- Assumes a £22m efficiency programme (5.5% of turnover), currently minimal head count reduction
- Assumes 0.75% contingency reserve for risk management (£3m)
- Assumes local pressures / business cases of £3.3m
- Depreciation and PFI charges are based on the 8th February planning assumptions, actuals will be available late March
- Financial plan does not include provisions for fines relating to operational performance targets, therefore assuming all mandatory targets are met
- Unidentified CIP phased from July
- The plan currently excludes any opportunities from the Carter recommendations

Activity/Capacity

- Assumes elective capacity returns to steady state from April and is maintained throughout the winter period
- Outsourcing to continue at similar levels as 2015-16
- Elective activity assumes 1.3% demographic growth
- Assumes the same level of non elective activity as per 15/16, at current average LOS and current DTOC and demographic growth of 1.2% for non elective,
- Productivity levels assumed as per previous financial years (any benefits identified in year will aim to reduce the current unidentified CIPs)
- Plan includes a significant reduction in the backlog

General

- Whatman ward and Foster Clark are funded within the cost base FYE
- Romney ward is funded within the cost base FYE
- Escalation areas funded as follows: Whatman Ward, Foster Clark and Short Stay Ward TWH based on 15 overnight beds.
- Escalation area that are not funded: Cath Lab out of hours (TWH and Maidstone), AMU Maidstone overnight, escalation into Recovery 1 and 2.
- No financial adjustments made relating to further strike action

Progress to date

- Executive Challenge meetings have been taking place with Directorates since December with particular focus on demand and capacity constraints and driving efficiencies

- Consolidation of budgets and setting clear establishments (bottom up approach complete)

- CIP opportunities identified - further work required within the medicine directorate

- Contract negotiations ongoing
  - West Kent CCG (Host CCG) offer received. Trust proposal shared (baseline difference £0.5m)
  - West Kent have shared high level QIPP plans (£7.5m). Contract negotiation meeting has taken place where QIPP schemes and Provider Intentions were discussed in detail
  - Highly likely that the Trust will go into formal arbitration with West Kent CCG
  - Offer received from NHSE. Trust have met with NHSE following this meeting changes will be made to reflect an accurate FOT for 15/16

Summary I&E

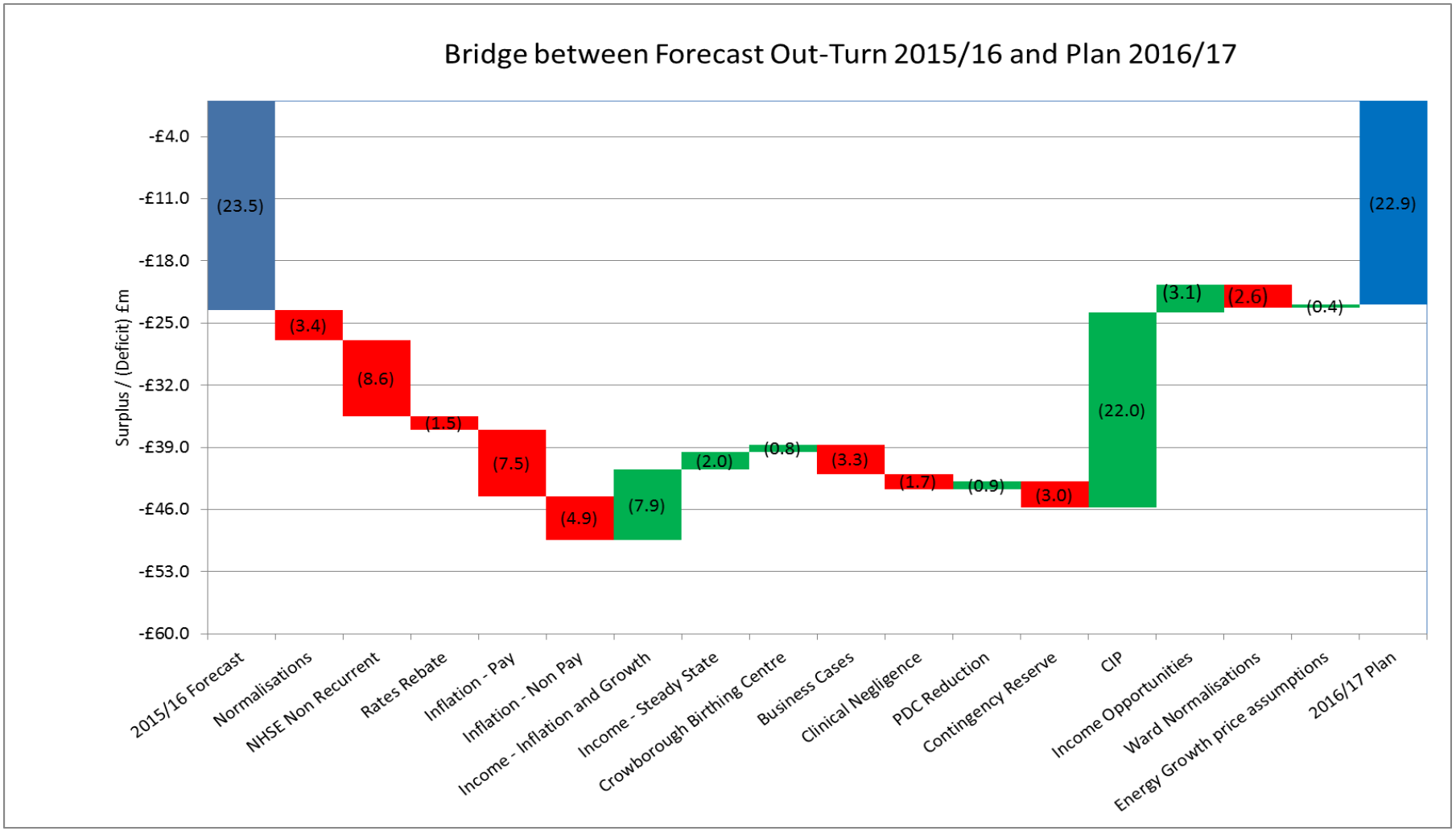
Maidstone and Tunbridge Wells NHS
NHS Trust

Statement of Comprehensive Income (SoCI)	2015/16 Plan (£m)	2015/16 Forecast (£m)	2016/17 Plan (£m)
Income			
Clinical Income	350.6	351.7	372.8
Non Clinical Income	30.1	26.3	20.1
Education Income	11.0	11.5	11.1
Other	9.4	11.6	12.3
	401.0	**401.2**	**416.3**
Expenditure			
Pay	(237.4)	(245.9)	(253.0)
Drugs and Medical Gases	(36.8)	(43.8)	(47.5)
Other Non Pay	(103.0)	(101.0)	(104.8)
	(377.2)	**(390.7)**	**(405.3)**
EBITDA: Surplus / (Deficit)	**23.8**	**10.4**	**11.0**
EBITDA %	*6%*	*3%*	*3%*
Depreciation & other	(17.7)	(16.0)	(16.5)
Net Interest	(14.4)	(14.2)	(14.8)
PDC Dividend	(4.8)	(4.4)	(3.4)
Impairments	(0.5)	(4.5)	(13.5)
	(37.4)	**(39.1)**	**(48.2)**
Surplus / (Deficit) before Technical Adj.	**(13.5)**	**(28.7)**	**(37.1)**
Technical Adjustments	*1.4*	*5.2*	*14.2*
Net Surplus / (Deficit) - Post Technical	**(12.1)**	**(23.5)**	**(22.9)**

Comments: Year on Year movements

- Clinical income has increased by £21.1m year on year mainly due to:
  - Tariff inflation and demographic growth £7.8m
  - Crowborough Birthing Centre new activity £1.8m
  - Waiting List Steady State £2m
  - Income opportunities £3.1m
  - Minor Injury Unit £1.4m
  - RTT backlog £2.8m
- Non Clinical income has decreased due to the dissolution of KMHIS. The reduction of income equates to £5.7m, this is offset by a reduction in costs of £5.7m.
- Pay has increased by £7.1m the main drivers for this are:
  - Increase - £7.5m Pay Inflation
  - Increase - New Ward at TWH £2.2m
  - Increase - Crowborough Birthing Centre £1.0m
  - Full Year Effect of Foster Clarke and Whatman £1.6m
  - Decrease - KMHIS Dissolution (£5.6m)
- PDC dividend has reduced by £1m this is mainly due to changes in the non current liabilities arising from loans.
- The overall Trust plan assumes that Whatman ward will be open for 8 months of the financial year for winter escalation. Additional income has not been included for winter pressures. The plan assumes full year funding for Foster Clark.

Bridge from 2015/16 forecast outturn to 2016/17 Plan



Phased I&E

Maidstone and Tunbridge Wells NHS Trust

	April (£m)	May (£m)	June (£m)	July (£m)	August (£m)	Septem ber (£m)	October (£m)	Novemb er (£m)	Decemb er (£m)	January (£m)	February (£m)	March (£m)	Proposed 2016/17 Plan (£m)
Clinical Income	27.1	28.4	27.6	29.5	27.2	27.8	29.7	28.2	27.3	28.3	26.5	28.4	335.9
High Cost Drugs and Devices	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	36.8
Non Clinical Income	1.6	1.6	1.8	1.6	1.6	1.7	1.6	1.6	1.8	1.6	1.6	1.9	20.1
Education Income	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	11.1
Private Patient Income	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	7.0
Other Operating Income	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	5.3
Total Operating Income	**33.7**	**35.0**	**34.4**	**36.2**	**33.8**	**34.5**	**36.3**	**34.8**	**34.1**	**35.0**	**33.2**	**35.3**	**416.3**
Substantive Staffing Costs	(18.7)	(18.8)	(18.9)	(18.3)	(18.2)	(18.2)	(18.2)	(18.3)	(18.3)	(18.3)	(18.3)	(18.3)	(220.9)
Temporary Bank Staffing Expenses	(1.6)	(1.6)	(1.6)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(18.5)
Temporary Agency Staffing Expenses	(1.4)	(1.3)	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.0)	(1.0)	(13.6)
Total Pay Expenses	**(21.6)**	**(21.6)**	**(21.6)**	**(21.0)**	**(20.9)**	**(20.9)**	**(20.8)**	**(21.0)**	**(20.9)**	**(20.9)**	**(20.9)**	**(20.9)**	**(253.0)**
Drugs & Medical Gases	(4.0)	(4.0)	(4.0)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(47.5)
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)	(2.2)
Supplies & Services - Clinical	(2.7)	(2.7)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(31.6)
Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(5.5)
Services from Other NHS Bodies	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(8.1)
Purch healthcare from non NHS	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(7.7)
Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(3.5)
Premises	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(19.9)
Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(18.2)
Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(1.6)
Other Non Pay Costs	(0.7)	(0.7)	(0.7)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(6.5)
Total Non-Pay Expenses	**(13.0)**	**(13.0)**	**(12.9)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(12.6)**	**(152.3)**
Total Operating Expenses	**(34.6)**	**(34.6)**	**(34.6)**	**(33.6)**	**(33.5)**	**(33.5)**	**(33.4)**	**(33.6)**	**(33.5)**	**(33.5)**	**(33.5)**	**(33.5)**	**(405.3)**
EBITDA	**(0.8)**	**0.4**	**(0.2)**	**2.5**	**0.3**	**1.0**	**2.9**	**1.3**	**0.6**	**1.5**	**(0.3)**	**1.8**	**11.0**
EBITDA Margin %													
Depreciation	(1.4)	(1.4)	(1.3)	(1.3)	(1.3)	(1.3)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(16.5)
Interest Receivable /(Payable)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.3)	(1.3)	(1.3)	(14.8)
Dividend	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(3.4)
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(13.5)	(13.5)
Non-Operating Income / Expenses	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(3.0)**	**(2.9)**	**(16.5)**	**(48.2)**
Surplus / (Deficit) before Technical Adj.	**(3.7)**	**(2.4)**	**(3.0)**	**(0.3)**	**(2.6)**	**(1.9)**	**(0.1)**	**(1.7)**	**(2.4)**	**(1.5)**	**(3.2)**	**(14.6)**	**(37.1)**
Technical Adjustments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	13.6	14.2
Net Surplus / (Deficit) - Post Technical	**(3.6)**	**(2.3)**	**(2.9)**	**(0.2)**	**(2.5)**	**(1.8)**	**0.0**	**(1.6)**	**(2.3)**	**(1.4)**	**(3.2)**	**(1.1)**	**(22.9)**

Workforce Plan

Maidstone and Tunbridge Wells NHS Trust

		2015/16 Plan (March 2016) WTE	2015/16 (January 2016) WTE	2016/17 (April 2016) WTE	2016/17 (March 2017) WTE
Substantive	Medical	683.1	617.5	646.6	668.6
	Nursing	2,173.1	1,976.0	2,101.7	2,183.3
	Other Clinical	1,534.8	1,443.6	1,534.4	1,543.4
	Non Clinical	1,115.8	1,032.5	978.5	1,031.8
Substantive Total		**5,506.9**	**5,069.6**	**5,261.2**	**5,427.1**
Agency	Medical	6.0	14.0	25.9	13.4
	Nursing	17.1	143.4	163.8	92.4
	Other Clinical	25.3	87.7	63.5	48.2
	Non Clinical	0.9	18.4	22.2	1.4
Agency Total		**49.4**	**263.5**	**275.4**	**155.4**
Bank	Medical (Incl. Locum)	5.1	45.5	42.7	33.6
	Nursing	107.7	213.4	207.4	191.9
	Other Clinical	5.2	20.4	7.8	7.6
	Non Clinical	20.5	44.2	30.4	21.7
Bank Total		**138.5**	**323.4**	**288.3**	**254.8**
Total Staff		**5,694.8**	**5,656.5**	**5,824.9**	**5,837.3**

Comments:

- The workforce plan applies a number of assumptions with regards to recruitment timeframes and the interplay with the substantive and agency workforce.
- The main drivers to the increase in WTE are as follows:
  - 97 WTE relating to the new ward at TWH and Crowborough
  - 30WTE Foster Clarke / Whatman Ward
  - Vacancy normalisations 105 WTE
  - A net reduction of 83 WTE relating to the cessation of the KMHIS
  - Other Agreed Business Cases 19.74WTE
    - ENT 5th Consultant = 6.71WTE
    - Neurology Consultant = 1.00wte
    - Part Time Breast Consultant = 2.56wte
    - Bowel Screening 5.40wte
    - Consultant Intensivists = 4.00wte

Income Plan by Commissioner

Maidstone and Tunbridge Wells NHS Trust

Commissioner Split of Income (Excl Non PbR HCD, Devices)	2015/16 Plan £m	2015/16 Forecast Outturn £m	2016/17 Plan £m
West Kent CCG	203.5	210.7	228.4
Dartford, Gravesham & Swanley CCG	3.1	3.5	3.5
Ashford CCG	0.8	1.0	1.2
Canterbury & Coastal CCG	0.4	0.5	0.5
South Kent Coast CCG	0.3	0.4	0.5
Thanet CCG	0.2	0.2	0.3
Swale CCG	4.8	5.0	5.4
Medway CCG	11.1	10.4	10.5
Eastbourne, Hailsham and Seaford CCG	0.3	0.5	0.6
High Weald Lewes Havens CCG	19.3	19.0	22.3
Sussex MSK Partnership 2 Ltd	1.2	1.3	1.3
Horsham & Mid Sussex CCG	0.9	0.9	1.2
Hastings & Rother CCG	1.0	1.3	1.5
Crawley CCG	0.1	0.1	0.1
Brighton & Hove CCG	0.1	0.1	0.1
East Surrey CCG	0.6	0.6	0.6
Bexley CCG	0.2	0.3	0.3
Bromley CCG	0.5	0.5	0.6
Non Contracted Activities	2.7	2.7	2.8
Kings	0.1	0.2	0.2
CCG Income	**251.3**	**258.9**	**281.8**
NHS England - Specialist Commissioning	67.6	55.1	52.2
NHS England - Prisoner Health	0.3	0.2	0.2
Trust Development Authority	0.0	0.0	0.5
Total Commissioner Income (Excl Non PbR HCD, Devices)	**319.1**	**314.2**	**334.8**

Comments: Year on Year movements

- The income plan has been driven by the 15/16 outturn position with known adjustments. These adjustments include a steady state assumption but exclude a reduction in the current backlog.
- Tariff inflation and demographic growth of £7.8m has been applied to the plan
- The income plan assumes delivery of 90% CQUIN
- West Kent CCG income increases by £7.7m. This is driven by:
  - Tariff inflation (£2.6m) and demographic growth (£2.5m)
  - £3.7m service changes (CIPs)
  - £2.6m Income opportunities
  - £2m adjustment for steady state elective activity
  - **£4.2m relating to Minor Injury Unit and RTT backlog**
- High Weald CCG income increases by £3.3m. This increase is mainly driven by the Trust acquiring the Crowborough activity from the 1st April (£1.8m). The remaining increase is tariff inflation and demographic growth (£0.9m) and service changes (CIPs) £0.4m
- NHSE Specialist commissioning income decreases by £2.9m. This decrease relates to the ending of the non recurrent transitional funding for cancer tariffs (£4.6m), tapering of NHD support funding (£4m) offset by the removal of the marginal rate on specialist services (£2.8m), tariff inflation and growth (£0.6m) and service changes (£2.2m)

Phased Income Plan

Maidstone and Tunbridge Wells NHS Trust

Trust Income	April (£m)	May (£m)	June (£m)	July (£m)	August (£m)	September (£m)	October (£m)	November (£m)	December (£m)	January (£m)	February (£m)	March (£m)	Proposed 2016/17 Plan (£m)
PbR													
Day Cases	2.9	3.1	3.1	3.3	3.1	3.1	3.5	3.3	2.9	3.2	3.0	3.2	37.7
Elective	2.0	2.3	2.1	2.3	1.9	2.1	2.3	2.3	2.0	1.9	2.0	2.3	25.6
A&E	1.5	1.6	1.6	1.7	1.5	1.5	1.5	1.5	1.5	1.5	1.4	1.6	18.3
Non Elective	7.2	7.5	7.4	7.8	7.4	7.2	7.6	7.3	7.6	7.4	6.9	7.8	88.9
Non Elective (cap)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(2.8)
Outpatients New	2.0	2.1	2.0	2.3	1.9	2.1	2.3	2.2	2.0	2.2	2.0	2.0	24.9
Outpatients Follow up	2.3	2.4	2.2	2.5	2.2	2.3	2.6	2.4	2.1	2.5	2.2	2.3	27.8
Outpatients unbundled Imaging	0.8	0.9	0.8	0.9	0.8	0.8	0.9	0.9	0.8	0.9	0.8	0.8	10.2
Specialist commissioning threshold	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
Challenges	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(3.6)
Total PbR Income	**18.2**	**19.3**	**18.7**	**20.1**	**18.3**	**18.6**	**20.1**	**19.3**	**18.3**	**18.9**	**17.7**	**19.5**	**227.0**
Non PbR													
Direct Access, other direct	7.1	7.3	7.1	7.5	7.1	7.3	7.7	7.1	7.2	7.5	7.1	7.3	87.3
Maternity Pathway	1.0	1.0	1.0	1.1	1.0	1.1	1.1	1.0	0.9	1.1	0.9	0.8	12.0
Total Non PbR Income	**8.1**	**8.3**	**8.1**	**8.6**	**8.1**	**8.3**	**8.8**	**8.1**	**8.1**	**8.6**	**8.0**	**8.1**	**99.2**
Other Clinical Income													
NHD Support	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	8.5
Income from activities HCD	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	27.3
Income from activities Other	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	9.6
Total Other Clinical Income	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**	**45.3**
Non NHS Clinical Income													
Private Patients	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	7.0
Injury Cost Recovery	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.2
Other Non NHS for Patient Care	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	5.3
Total Non NHS Clinical Income	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**13.5**
Non Clinical Income													
Education Training & Research	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	11.1
Non Patient Services	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	12.9
Commercial - Car Parking	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.3
Commerical - Catering	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.1
Commerical - Accomodation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
Dontaed Asset Income	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.0	0.2	0.0	0.0	0.3	0.8
Government Grant Income	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
All other income	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.6
Total Non Clinical Income	**2.5**	**2.5**	**2.7**	**2.5**	**2.5**	**2.6**	**2.5**	**2.5**	**2.7**	**2.5**	**2.5**	**2.8**	**31.2**
Total Income	**33.7**	**35.0**	**34.4**	**36.2**	**33.8**	**34.5**	**36.3**	**34.8**	**34.1**	**35.0**	**33.1**	**35.3**	**416.3**

Phased Activity Plan

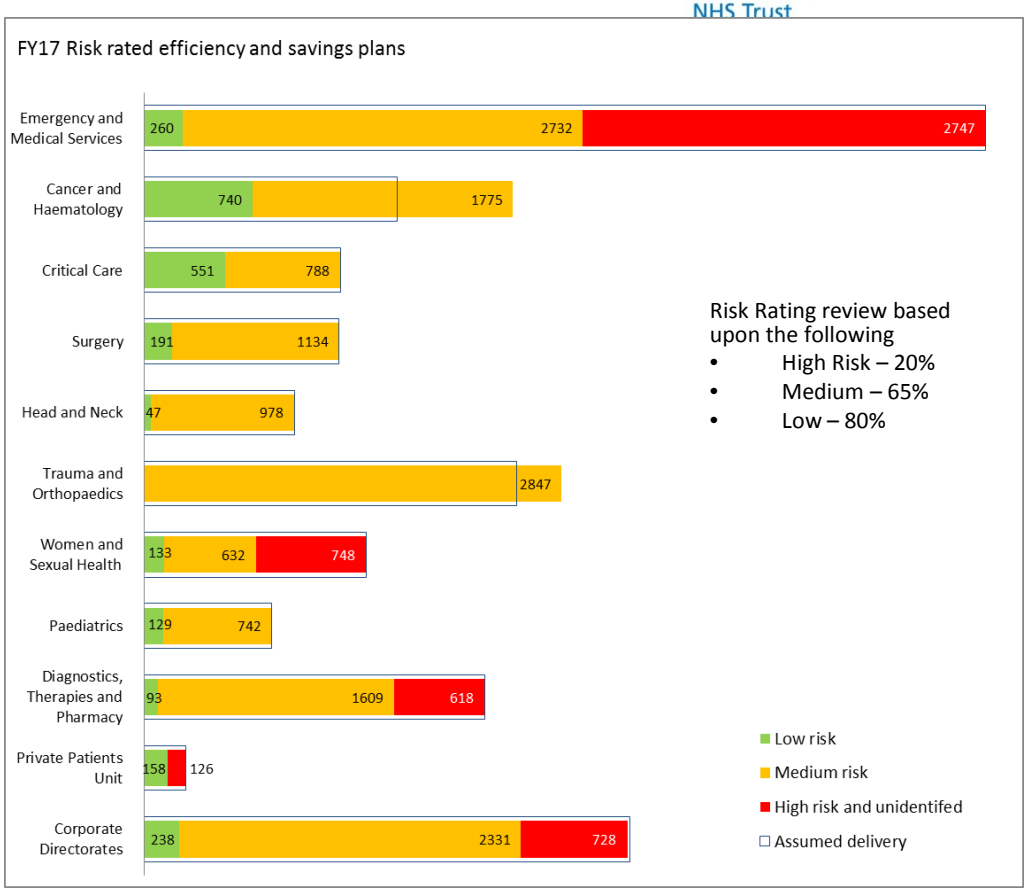
Maidstone and Tunbridge Wells NHS Trust

Trust ACTIVITY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Proposed 2016/17 Plan
PbR													
Day Cases	3,290	3,547	3,487	3,783	3,472	3,495	3,917	3,773	3,290	3,629	3,461	3,672	42,817
Elective	665	784	703	756	653	713	778	787	676	639	669	767	8,591
A&E	11,455	12,044	11,981	12,671	11,783	11,664	11,642	11,210	11,610	11,102	10,336	12,408	139,907
Non Elective	3,738	3,856	3,806	4,021	3,811	3,701	3,901	3,750	3,921	3,806	3,539	4,041	45,891
Non Elective (cap)	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatients New	11,182	12,093	11,683	12,999	11,057	12,091	13,132	12,310	11,161	12,338	11,169	11,505	142,721
Outpatients Follow up	21,934	22,668	21,179	23,460	20,538	21,904	24,288	22,545	20,088	23,425	20,861	21,481	264,370
Outpatients unbundled Imaging	6,529	6,747	6,304	6,983	6,114	6,520	7,230	6,711	5,980	6,973	6,210	6,394	78,695
Specialist commissioning threshold	0	0	0	0	0	0	0	0	0	0	0	0	0
Challenges	0	0	0	0	0	0	0	0	0	0	0	0	0
Total PbR Activity	**58,792**	**61,740**	**59,144**	**64,674**	**57,427**	**60,089**	**64,889**	**61,085**	**56,725**	**61,913**	**56,245**	**60,268**	**722,991**
Non PbR													
Direct Access, other direct	105,151	112,378	104,379	115,739	105,701	108,317	122,195	111,908	96,562	117,593	111,884	117,208	1,329,013
Maternity Pathway	951	975	949	1,042	975	1,000	1,042	948	894	1,012	834	737	11,359
Total Non PbR Activity	**106,102**	**113,352**	**105,328**	**116,781**	**106,676**	**109,317**	**123,237**	**112,856**	**97,456**	**118,604**	**112,718**	**117,945**	**1,340,372**

Efficiency Savings Programme - Directorate

Maidstone and Tunbridge Wells NHS Trust

Directorate	Assumed delivery £000	Efficiency and savings	Variance £000
Emergency and Medical Services	5739	4,001	-1,738
Cancer and Haematology	1727	2,515	788
Critical Care	1340	1,340	0
Surgery	1325	1,325	0
Head and Neck	1025	1,025	0
Trauma and Orthopaedics	2543	2,847	304
Women and Sexual Health	1513	785	-728
Paediatrics	870	871	1
Diagnostics, Therapies, Pharmacy	2320	1,702	-618
Private Patients Unit	284	158	-126
Corporate Directorates	3314	2,569	-745
Total identified plans	**22,000**	**19,138**	**-2,862**
Unidentifed plans			
Emergency and Medical Services		1,738	
Women and Sexual Health		728	
Diagnostics, Therapies, Pharmacy		618	
Private Patients Unit		126	
Corporate Directorates		728	
Total unidentified plnas		**3,938**	
Total plans	**22,000**	**23,076**	**-2,862**



- Unidentified gap is £3.9m, however this is offset by overachievement in some directorates (£1m)
- Directorate PIDs and Plans in progress to support the identified schemes
- QIA Clinic scheduled with Chief Nurse & Medical Director to review/sign off all identified schemes
- Unidentified projects phased from July 2016
- Unidentified projects classified as High Risk
- Identification of schemes continue to reduce the value classified as unidentified
- Risked value calculated based upon risk ratio below.
- On-going validation of schemes identified as high risk to convert to Med/Low risk and assure delivery

Capital Programme

Maidstone and Tunbridge Wells NHS
NHS Trust

Capital Summary - Apr 16 Final Draft	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	5 Year Plan £'000
Estates						
Estates Projects - Backlog maintenance	2,000	800	800	800	800	5,200
Ward refurbishment/Decant ward	0	3,000	1,500	1,500	1,500	7,500
Estates Projects - other renewals	598	200	360	400	400	1,958
Energy infrastructure/EPC	2,730	360	250			3,340
Subtotal - internally generated funds	**5,328**	**4,360**	**2,910**	**2,700**	**2,700**	**17,998**
TWH - Lifecycle (IFRIC 12 PFI capital)	552	499	466	592	978	3,087
Staff Accommodation Maidstone		2,276				2,276
New MRI Maidstone - build element		1,650				1,650
TWH Satellite Radiotherapy Bunkers	4,056	3,244				7,300
Maidstone Hospital Theatres' Renewal		3,000	12,000			15,000
	9,936	**15,029**	**15,376**	**3,292**	**3,678**	**47,311**
ICT						
ICT - Infrastructure	735	1,035	663	778	702	3,913
ICT - Clinical System	310	218				528
ICT - Non-clinical systems	928	158	47	26	26	1,185
Core IT System Upgrade PAS (SaCP)	698					698
	2,671	**1,411**	**710**	**804**	**728**	**6,324**
Equipment						
Linac replacement programme		2,400	2,700	2,400	2,400	9,900
Trustwide equipment	2,200	2,187	2,422	2,103	2,503	11,415
Inventory management system	296					296
Fluroscopy/CT machines						0
Donated Equipment	800	300	300	300	300	2,000
MRI Maidstone - equipment		850				850
Crowborough Birth centre - equipment/IT	85					85
	3,381	**5,737**	**5,422**	**4,803**	**5,203**	**24,546**
Total	**15,988**	**22,177**	**21,508**	**8,899**	**9,609**	**78,181**

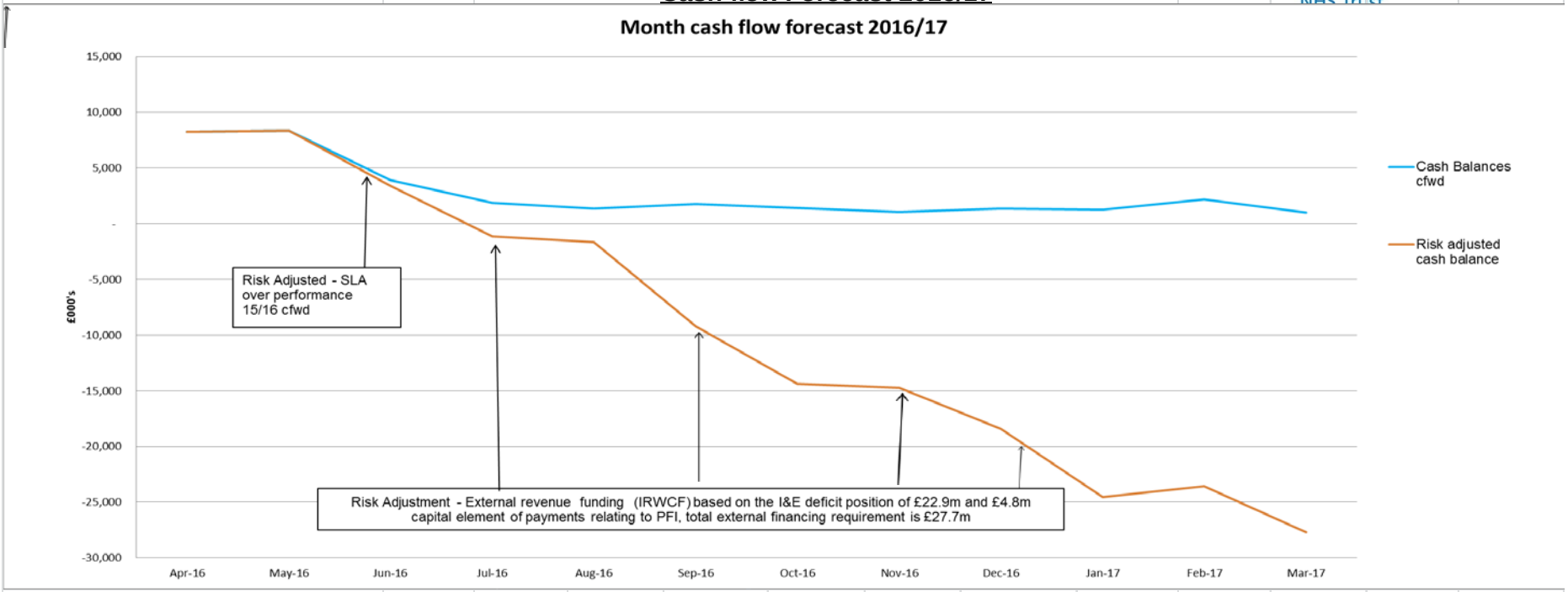
Comments:

- The Trust is planning a rolling five year capital programme of £78m. This is inclusive of:
  - £18m essential improvements in backlog estates
  - Renewal of a main theatre block at Maidstone site (£15m)
  - Replacement equipment programme of £25m, including linear accelerators
  - £6m IM&T modernisation programme
- The Trust is planning for capital investment loans to support the scale of the required estate renewal. The loans will support delivery of:
  - Increase diagnostic capacity (£2.5m)
  - Development of a satellite radiotherapy facility (£7.3m)
  - Theatre modernisation at Maidstone site (£15m)

Cash Support

Maidstone and Tunbridge Wells NHS
NHS Trust

Cash flow Forecast 2016/17



£000's	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cash Balances cfwd	**8,280**	**8,379**	**3,904**	**1,851**	**1,370**	**1,775**	**1,388**	**1,032**	**1,368**	**1,243**	**2,189**	**1,000**
risk adjusted - SLA overperformance 15/16 cfwd	-	-	500	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
risk adjusted - External revenue funding - IRWCF	-	-	-	2,000	2,000	10,000	14,774	14,774	18,774	24,774	24,774	27,701
Risk adjusted cash balance	**8,280**	**8,379**	**3,404**	**(1,149)**	**(1,630)**	**(9,225)**	**(14,386)**	**(14,742)**	**(18,406)**	**(24,531)**	**(23,585)**	**(27,701)**

Assumptions	£m's	Reducing the risk element
Double block from WK CCG in April	34.0	
External revenue funding liked to I&E deficit	22.9	
External revenue funding for capital element of PI	4.8	
External capital funding for pre-technical value	4.1	If the funding for the capital schemes is not given, the relevant capital spend linked to the projects will not get incurred
opening and closing cash balance remain uncha	1.0	
SLA overperformance 15/16 cfwd	1.0	
I&E pre-technical remains unchanged	0.0	
No SLA over performance 16/17	0.0	

Risks

- CIP Gap
  - There is currently an unidentified gap of £3.9m, however this is partially offset by £1m of planned over delivery. A number of schemes are rated as medium or high risk. Work is on-going with the directorates in particular medicine. There are a number of key opportunities to be further developed LOS, Lord Carter etc

- Recruitment
  - Delivery of a number of pay savings will be reliant on a continuous recruitment strategy
  - Agency usage is at £13.6m which is within the cap level set by the TDA. This will require a significant reduction in agency demand
  - Impact of the potential review of bank rates and corresponding impact on agency spend

- Ability to manage within non-elective bed base
  - Escalation beds and winter pressures, therefore impacting elective activity
  - Impact on performance and therefore fines levied by commissioners
  - No provision for fines is included within the plan

- Contract negotiations
  - Negotiations are currently on-going. Plan includes a benefit for the following areas (£3.2m):
    - Romney Ward fully funded as a step up step down unit £1.8m
    - Marginal rate (non elective threshold) adjusted £0.5m
    - FYE for SPC01 and improved coding in Oncology £0.5m
    - Well babies PYE £0.2m
    - Increase for a number of small block items PYE £0.1m
  - Review of QIPP plans (£7.5m) underway by directorates –challenge process for deliverability has commenced
  - Offer received from NHSE
  - CQUIN delivery assumed at 90%

Next Steps

- Submit final plan to NHS Improvement on 18th April

- Continue work with Directorates to:
  - Finalise staffing establishments (where appropriate rotas)
  - Identify additional efficiencies to close the current gap
  - Executive round 3 challenge sessions (where applicable)
  - Review unapproved business cases

- Issue budgets to Directorates for formal sign off

- Finalise contract negotiations, (final date for contract agreement is 25th April to avoid arbitration)
  - Potential arbitration with West Kent CCG

- Submission of STP plans by the end of June (linked to contract negotiations and agreement of performance trajectories)

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Maidstone and Tunbridge Wells Hospitals

Summary of One Year Operational Plan 2016/17
Maidstone and Tunbridge Wells NHS Trust
18th April 2016

Contents

Table of figures

Abbreviations used

A&E	Accident and Emergency	Maidstone	Maidstone Hospital
ATC	Adjusted Treatment Cost	MDT	Multi-disciplinary team
CCG	Clinical Commissioning Group	MRI	Magnetic resonance imaging
CNST	Clinical Negligence Scheme for Trusts	NHSE	NHS England
CQC	Care Quality Commission	NHSI	NHS Improvement (formerly Monitor and the TDA)
DToC	Delayed Transfers of Care	NICE	National Institute for Health and Care Excellence
ED	Emergency Department	NIV	Non-invasive ventilation
ENT	Ear, Nose and Throat	OP&P	Operational Productivity and Performance
ERG	Executive Recovery Group	OPD	Outpatient Department
ESPs | CIPs	Efficiency and Savings Plans | Cost Improvement Plans	PDSA	Plan, Do, Study, Act
fye	Full year effect	PFI	Private finance initiative
GP	General practitioner	PMO	Programme Management Office
GS1	Global standards bar coding	PO	Purchase Order
HIT	High impact team	Q	Quarter
HR	Human Resources	QIPP	Quality, Innovation, Productivity and Prevention
I&E	Income and Expenditure Account	RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
ITU	Intensive Therapies Unit (Intensive Care Unit)	RTT	Referral to Treatment
KCC	Kent County Council	SLA	Service Level Agreement
KMHIS	Kent and Medway Health Informatics Service	T&O	Trauma and Orthopaedics
KPI	Key performance indicators	TDA	Trust Development Agency
LoS	Length of Stay	the Trust	Maidstone and Tunbridge Wells NHS Trust
LTFM	Long term financial model	TWH	Tunbridge Wells Hospital
linac	Linear particle accelerator	wte	Whole time equivalent

1 Activity planning

Maidstone and Tunbridge Wells NHS Trust (the Trust) has received contract offers from West Kent Clinical Commissioning Group (CCG) and NHSE. Contract negotiations are ongoing between the Trust and its commissioners. Both parties are currently reviewing details of the commissioner's Quality, Innovation, Productivity and Prevention (QIPP) schemes as well as the provider intentions of the trusts. The Trust is working towards the national deadline for contract sign-off by the 25th April 2016.

The Trust has carried out detailed capacity and demand analysis to ensure that, where necessary, all gaps are identified and resolved in conjunction with the CCG and other providers. Further information is included in Section 2.5: Triangulation of indicators.

The Trust has reflected on its performance during the current financial year with particular regard to access targets; activity plans are being set on the basis that the Trust will achieve the agreed trajectories for Accident and Emergency (A&E), Referral to Treatment (RTT) and Cancer.

1.1 Basis of activity planning

The Trust's activity plans for 2016/17 are based on outputs from:

- Detailed assessment of current capacity which has been undertaken and compared to current demand assumptions
- The demand models have been shared with our host commissioner and jointly discussed as part of contract negotiations. These have been based on demographic growth and the need to maintain or improve patient access targets
- Levels of demographic growth set out by both Kent and East Sussex County Councils to provide a more local reflection of changes to demography. These have been used as they are based on Office for National Statistics estimates but have been adjusted in light of local knowledge (eg future house building)
- Growth/ reduction in waiting list levels seen during 2015/16 have been incorporated into the Trust's estimates of demand for 2016/17 in order to ensure adequate capacity. The 2016/17 plan includes the Type 3 A&E (Minor Injuries Unit) attendances at Edenbridge and Sevenoaks which became the Trust activity from 1st April 2016. This activity is not included in the 2015/16 actual or forecast as this was not the Trust activity at this time
- Additional activity has been identified to reduce waiting list backlogs in order that Trust achieves the RTT performance standard compliance both at a Trust aggregate and individual speciality level in 2016/17.

To summarise the effect of this approach on activity and capacity numbers for 2016/17:

- Assumption made that elective capacity returns to steady state from April and is maintained throughout the winter period
- Outsourcing to increase to ensure additional activity required to reduce backlogs is achieved by end of Q3 before returning to similar levels used in 2015/16
- Elective activity assumes 1.3% demographic growth
- Assumes the same level of non-elective activity as 2015/16 at current average length of stay (LoS) and current delayed transfers of care (DToC) and demographic growth of 1.2% is assumed for non-elective activity

- Productivity levels assumed as in previous financial years with any in-year benefits identified utilised to support the reduction in current unidentified Efficiency and Savings Plans (ESPs)
- The plan includes a significant reduction in backlog activity as per the submitted performance trajectories.

1.2 Planning assumptions

The Trust's activity returns are underpinned by agreed planning assumptions. In depth analysis of performance against plan for 2015/16, particularly for non-elective admissions, has been undertaken. This has highlighted that 2014/15 activity levels were exceptionally high, particularly during the summer of 2014. During the period from January to March 2016 the Trust has seen unprecedented levels of emergency demand. The impact of this, as at 1st March 2016 has been incorporated into plans for 2016.

The plan incorporates key service developments starting at differing times of the year. These have been reflected into monthly phasing. It has also been reflected in the split by CCG where developments at just one site would have a greater impact on an individual CCG. Where detailed QIPP schemes have been received they have been included in the plans. Overall, the Trust proposed activity is as shown in the following table:

Trust activity	2015/16 Plan (activity)	2015/16 Forecast Outturn (activity)	2016/17 Plan (activity)
PbR			
Day Cases	38,556	38,613	42,817
Elective	7,988	7,487	8,591
A&E	135,922	141,226	163,967
Non Elective	48,289	45,617	45,891
Non Elective (cap)	0	0	0
Outpatients New	137,570	138,706	142,673
Outpatients Follow up	260,990	271,034	264,304
Outpatients unbundled Imaging	70,156	79,626	78,695
Specialist commissioning threshold	0	0	0
Challenges	0	0	0
Total PbR Activity	**699,471**	**722,308**	**746,937**
Non PbR			
Direct Access, other direct	1,258,462	1,307,951	1,304,953
Maternity Pathway	10,497	11,155	11,359
Total Non PbR Activity	**1,268,959**	**1,319,106**	**1,316,313**

Figure 1: Planned activity 2016/17

At this stage, commissioner QIPP schemes have been excluded from the Trust plans.

1.3 Capacity

The Trust has undertaken detailed analysis of its current capacity and compared it to forecast demand. This has been shared and discussed with commissioners. The Trust's assumption is that any capacity gaps will lead to the

Trust outsourcing activity by 50 to 60 cases per month to ensure performance targets are met. This will predominately be elective cases but there will be outpatients as well for Orthopaedics and Neurology.

2015/16 will see the full year impact of the Trust's admissions avoidance schemes and these are now fully incorporated into baseline capacity. A number of ESPs (CIPs) have already been developed to deal with gaps between demand and capacity and these have been reflected in the plans.

1.4 Operational standards

Our activity plans are set to reduce the backlog to a sustainable waiting time level. The Trust has assumed that the reduced elective capacity in Q4 will be outsourced at this stage. Additional activity required to reduce the over 62 day cancer backlog has been identified and stretch targets set to ensure achievement. Once reduced, activity levels will be sufficient to maintain performance on cancer standards.

Due to the loss of activity in Q4 the Trust has set out its trajectory to deliver aggregated level performance from the end of Q1 and for all specialities by end of Q3 in 2016/17 and the activity for this has been incorporated into our plans. To deliver its 18 week RTT performance standards, the Trust has set maximum waiting list and backlog sizes for each speciality in line with the NHS Intensive Support Team recommendations. The Trust has identified key high-risk specialties and developed recovery plans for each involving additional Trust capacity and use of independent sector.

The Trust will continue to work towards delivering all cancer standard standards at an aggregate level performance during 2016/17 and continue to implement the cancer action plan agreed by the Trust Development Agency (TDA), now part of NHS Improvement (NHSI), in August 2015. This will be delivered through a combination of increased capacity and improvements to the patient pathway.

The Trust has been struggling to maintain the four hour A&E performance standards since November 2014 and has introduced a range of steps to recover performance. The Trust will continue to work with its partners to improve patient flows and reduce delays in the system. An activity trajectory has been agreed with our local commissioners for delivery of the 4 hour A&E standards. An additional 38 bedded ward is now opened to support non-elective pathways at TWH.

2 Quality planning

2.1 Context

Quality is a core day to day business at the Trust. It is embedded within all aspects of care, performance and developments in order to meet the Trust vision 'to provide the highest, consistent, quality care to our patients, whether in or outside hospital setting' ('Moving Forward - 2015/16 to 2019/20', 2014).

There is a clear link between the Trust vision and current and planned quality improving work. These plans are also informed and directed by the recommendations from our Care Quality Commission (CQC) inspection and through working collaboratively with our local CCGs and patient groups such as HealthWatch Kent.

2.2 Approach to quality improvement

2.2.1 Organisation-wide improvement methodology and governance

The Trust-wide approach to improvement is led at Executive/ Board level. Quality improvement is overseen by the Trust Clinical Governance Committee and the Trust Management Executive Committee. Quality improvement assurance is overseen by the Quality Committee which is a sub-Board committee.

Priorities for improvement are identified via the Board level committee risk register and key performance indicators. This includes feedback from the local health economy including CCG and HealthWatch Kent. All organisational service improvements are reviewed at a senior level and signed off by Executives. Improvement plans are supported by the PMO, as well as relevant clinical and operational managers. All improvement plans are subjected to a quality impact assessment which is signed off by the Chief Nurse and the Medical Director.

The Trust broadly uses a six stage framework for quality improvement (NHS Institute for Innovation and Improving, 2008; Gage W, 2013). We will also be employing a 'Plan, Do, Study, Act' (PDSA) improvement cycle in our falls work over the coming year (NHS Institute for Innovation and Improving, 2008).

2.2.2 Named Executive Lead

The Executive Lead for Quality is the Chief Nurse.

2.2.3 Progress against CQC Quality Improvement Plan

Following CQC inspection in October 2014 and their report received in January 2015 a Quality Improvement Plan has been developed and actions undertaken. To date, the enforcement notice has been lifted; 13 compliance actions have been completed, five compliance actions are near completion and one remains outstanding. The Quality Improvement Plan is reviewed at Board level monthly. The only current risk is Compliance Action 6 which relates to ITU overnight unplanned discharges. There are continued challenges with a small number of out of hours' transfers from ITU at TWH; this is being addressed following the opening of the new ward which will assist capacity and flow.

2.2.4 Quality Accounts

An annual Quality Account provides direction for quality improvement for the coming year. Our Quality Account 2014/15 was agreed with partners within the local health economy with support from HealthWatch Kent, Kent County Council (KCC), West Kent CCG and High Weald Lewes Havens CCG.

The quality priorities were grouped to three themes: Patient Safety, Patient Experience and Clinical Effectiveness and Governance. Work has continued throughout the year on these priorities and will be reported in the next Quality Account published early summer 2016.

2.2.5 Three quality priorities for 2016/17

- To fully embed the changes made to the governance structures and build on the links established between the Board level committees and the directorate level committees to improve communication and foster a culture of proactive and effective clinical governance
- To continue a focus on patient falls prevention work. Whilst improvements have been made, further work is required to further develop a strong safety culture and proactive risk management at a ward/ department level
- To continue to develop the mortality surveillance process within the Trust to enable the identification of themes and trends, review specific diagnostic groups and triangulate data from other sources (for examples complaints, patient safety incidents). This will foster learning and allow a focus on quality improvement.

2.2.6 Top three risks to quality with plans for mitigation

- The establishment of the changed governance structure will take time. To mitigate this there has already been engagement work with staff which will continue over the coming months. Guidance and support will be offered by the central clinical governance team to help support new structures and processes in place and a refreshed training program relating to clinical governance will be rolled out in 2016
- Duty of Candour compliance has shown a substantial improvement over the last year; however, more work is required to reach full compliance. The mitigation in place is further training and support for clinical staff from the central patient safety team. Further mitigation is the expected recruitment of 1.8 whole time equivalent (wte) administrators in April 2016 who will further support the Duty of Candour process
- The mortality review process would benefit from moving to an IT-based data collection system. Currently mortality reviews are undertaken in paper form which makes data comparison and analysis inefficient. Mitigation is the continual use of paper-based forms and an improved administration process.

2.2.7 Focus on well-led elements

- We have a current Trust strategy; 'Moving Forward - 2015/16 to 2019/20'; we are in the final stages of development of a new Clinical Strategy which is being taken to the Trust Board for approval in April 2016
- We have recently reviewed and improved our governance structures providing clarity over responsibility, quality and performance
- We have several systems to identify, understand and address problems; examples are:
  - Sub-board Quality Committee and Quality Committee 'deep dive' where quality issues are reviewed in detail to challenge and ensure assurance
  - Incident Reporting system and summary of themes and trends reviewed at Trust Clinical Governance Committee
- We ensure patients and staff are involved and engaged with how service is provided; examples include:
  - Patient Experience Committee
  - Strong links and engagement with HealthWatch Kent
  - Open staff meetings
- We ensure continuous learning is achieved through various methods including a focus on sharing learning from incidents, complaints and claims through Trust-wide communications.

2.2.8 Sign up to Safety priorities for 2016/17

The following safety improvement domains have been identified which need focused improvement as a result of a review of data by legal services over claims against the Trust through the NHS Litigation Authority data in the last five years, a review of the trends and themes from Serious Incidents and feedback from the CQC. These claims are from the 'low value, high volume' (failure/ delay diagnosis, failure to obtain informed consent), 'high value, high volume' (handover communication, failure to monitoring or respond to abnormal fetal heart rate, obstetric).

Sign up to Safety priorities for 2016/17 are to:

- Improve communication during the handover of care process
- Improve the effectiveness of identifying and act upon deviations from normal during labour and birth (including fetal monitoring)
- Improve the quality of patient involvement in decision making and standards of obtaining informed consent
- Reduce the number of inpatient falls.

The Safety Improvement plan will follow the PDSA 90 day improvement cycle supported by the NHSE 'Sign up to Safety' campaign. The first of these 90 day cycles will be used to develop a three year plan for each of the domains in collaboration with the domain lead, Safety Improvement team and Trust Management Executive.

2.3 Seven day services

The Trust completed the NHSI 'seven day assessment tool' in September 2015. On receiving the results from trusts' submissions from across the country, our Trust undertook an analysis to understand its performance relative to other trusts. Overall, the Trust's performance was average across most areas relative to the results of others. Headlines:

- Generally, 70 to 80% of patients admitted as an emergency receive a thorough clinical assessment by a suitable consultant, seven days a week, within 14 hours of arrival (90 to 100% for Intensive Therapy Unit (ITU), Paediatrics and Cardiology)
- Nearly all diagnostic services were available to all hospital inpatients seven days a week. Consultant-directed diagnostic tests and completed reporting are available seven days a week for critical patients within one hour but less so for urgent patients and not for non-urgent patients
- Prioritised interventions are available to hospital inpatients seven days a week. Inpatients have 24 hour access to consultant-directed interventions apart from interventional radiology and interventional endoscopy (access does not necessarily mean Trust provision, more a pathway to these consultant-directed interventions)
- Not all patients in High Dependency Units (HDU) are seen and reviewed by a consultant twice daily
- Once transferred to a general ward not all patients are reviewed, as part of a consultant-delivered ward round, at least once every 24 hours seven days a week.

The Trust's actions to start to address the Seven Day Service Challenge and help to reduce excess deaths at the weekend are three-fold:

- Agree workable plans to improve upon the results achieved through completion of the assessment tool.
- Understand the worth of extending senior decision making capabilities on the wards seven days per week to enable earlier discharge
- Consider the need and benefits of extending the hours of senior clinical decision makers in obstetrics and A&E, in the first instance, followed by other specialties.

The Trust already provides a good level of diagnostic services throughout the weekend. However, the Trust's ability to provide extended services seven days per week will depend heavily on its ability to recruit to substantive senior clinical decision maker roles such as consultant posts. This is inherently difficult across most specialties nationwide at the moment with no sign of potential improvement in the short term. The priority in 2016/17 will be on recruitment to provide more senior clinical decision-making capacity at the weekend.

More widely, the Trust is now working in close partnership with its fellow providers in West Kent to develop models of improved and integrated urgent care provision to limit the pressure on A&E and the rest of the hospital. The CCG has developed a draft Urgent Care Strategy, largely aimed at providing better urgent care options for patients in West Kent. The Trust is fully supportive of the strategy's development. A&E based GP out of hours and GP normal hours' services are already in place at the Trust with partner IC24.

2.4 Quality impact assessment process

2.4.1 Clinically led quality assessment

With the scale of the challenge the Trust is facing, robust clinical risk assessment of all ESPs is an essential component of the Trust's assurance processes. The Trust currently assigns a Clinical Lead to every project, engaged at all stages of the assessment and signoff process; the Clinical Lead completes a quality assessment of every project which includes:

- Identification and agreement of key performance indicators (KPIs) to provide sensitive early warning systems, which in the first instance will lead to responsive and timely action as required. The Programme Management Office (PMO) team are responsible for tracking and reporting KPI performance and providing a regular progress update to the Programme Board
- A detailed risk assessment identifying any risks to patient safety, patient experience or clinical effectiveness. This allows risks to be mitigated at the earliest possible stage, and
- An equality impact assessment which ensures that no patient or staff group is adversely affected by the project.

2.4.2 Ensuring quality through clinically-led assessment

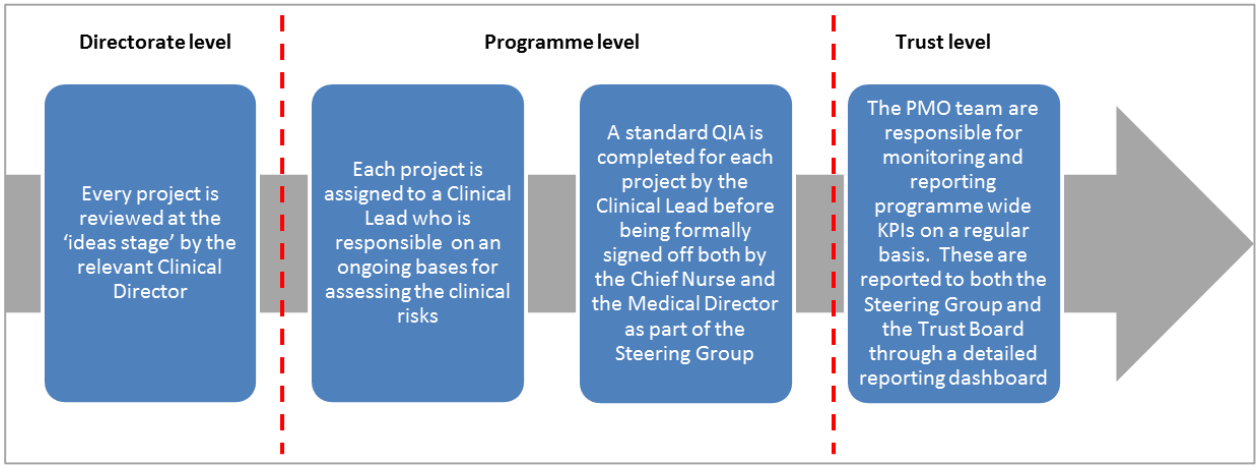


Figure 2: High level quality impact process

2.4.3 Strengthening our governance arrangements to ensure quality is maintained

Our programme management arrangements further strengthen both governance and leadership which, in turn, has a positive effect upon our ability to monitor and maintain quality.

2.5 Triangulation of indicators

As part of business planning the Trust has carried out a detailed demand and capacity analysis to assess the inputs required to deliver the organisation plan for 2016/17. This analysis included the following:

- Expected activity levels anticipated including impact of any service change/ development
- Identifying the capacity to achieve sustainable waiting times to meet current demand
- Identifying any gaps in current capacity compared with the analysis for outpatients, theatres and beds
- Implications of this analysis for workforce and estate.

This analysis has led to the Trust devising a number of plans in response and these will be outlined, in turn, within the following section.

2.5.1 Outpatients

Capacity analysis undertaken as part of business planning has shown that demand on outpatients remains generally steady across all specialities with some growth in specific specialities. Previously a number of short-term measures have been used to meet demand and respond to the changes in demand. The Trust is continuing to review its overall outpatient capacity, both on and off site, with planned increases to respond to growth for specific specialities.

The plans to increase Outpatient Department (OPD) capacity in 2016/17 include appointing a number of new consultants as well as focusing on improved scheduling of outpatients, further reductions in new to follow up ratios and implementing alternatives to consultant led services such as nurse led/ therapy led clinics etc.

2.5.2 Operating theatres

Capacity analysis undertaken as part of business planning has shown that demand on theatres has continued to grow due to a number of factors including sustaining waiting times, change in case mix towards day case procedures and growth in demand within a number of specialities. Throughout 2015/16 a number of short-term measures have been used to meet and respond to the changes in demand including working with local private providers to outsource some activity.

The plans to increase Theatre capacity in 2016/17 include appointing a number of new consultants as well as focusing on improved utilisation of sessions, moving day-case procedures to outpatients and improving elective patient flow at TWH following the opening of a new ward.

2.5.3 Operational performance standards

18 week RTT performance standards

The Trust waiting list size and backlog has grown due to significant emergency pressures during the last quarter of 2015/16, cancellations of elective activity and limited independent sector capacity. The Trust has plans to deliver aggregated level performance from July 2016 and throughout the rest of 2016/17 as the backlog is addressed. As part of this plan the Trust has set maximum waiting list and backlog sizes for each speciality in line with the NHS Intensive Support Team recommendations. These are used regularly each week to monitor progress and allow effective management of risks to delivery. However, it should be noted that 18 week performance also depends on improving the flow of patients through both hospital sites, availability of elective beds and a decrease in DToCs.

Ear, Nose and Throat (ENT), Gynaecology and Neurology have come under increasing pressure during 2015/16 to deliver incomplete speciality performance at the end of Q4 due to elective cancellations. Recovery plans are in place to increase capacity including appointing one substantive consultant within ENT and Neurology specialties as well as outsourcing activity. The Trust is working with these specialities to revise their pathways to transfer care from hospital to communities to free up capacity and transfer appropriate day case procedures to outpatient settings.

Trauma and Orthopaedics (T&O) also remains an area of significant challenge mainly due to the impact of increased referrals and elective cancellations resulting in steady rise over the last few months to patients on the waiting list and backlog. The speciality is significantly above the Trust target and the department is taking various actions to address these issues. This will include working with local private providers to agree outsourcing plans to increase capacity, improving elective flow within TWH, moving day case work to Maidstone and working with commissioners on alternative pathways including virtual outpatient clinics and robust referral criteria.

The Trust has agreements with local private providers to provide extra outsourcing capacity to ensure resilience throughout the year. Working in conjunction with NHS West Kent, the Trust plans to finalise its outsourcing plans for the winter period by July 2016.

Delivering the cancer standards

The Trust will continue to work towards delivering all cancer standards at an aggregate level performance during 2016/17. The Trust will also continue to implement the cancer action plan agreed by the TDA in August 2015 which includes:

- Working with other providers to improve pathways and reduce number of shared breaches
- Increasing Multi-disciplinary team (MDT) co-ordinator capacity
- Reviewing capacity for diagnostics (by modalities) in line with changing clinical needs of patients and putting in place necessary plans to meet demand
- Reviewing two week outpatient capacity to ensure it meets current demand
- Reviewing and implementing new revised pathways for all tumour groups to ensure 62day compliance.

The Trust will work with GP practices in West Kent to reduce the number of inappropriate GP referrals through the cancer pathway. This requires a change in behaviour and the benefits are anticipated to be slow.

The Trust has set a stretch target of 120 treatments each month and plans to reduce the over 62 day backlog (with and without a decision to treat) to less than 60 patients. This will allow more effective management of the patient tracking list (PTL) and therefore delivery of 62 day standard during 2016/17 for all specialities. Regular meetings will be held with tumour group leads and relevant teams to ensure delivery and monitor progress throughout the year.

Delivering the A&E four hour performance standard

Despite strong performance in 2013/14, a good start to 2014/15 and several individually successful resilience schemes, the Trust has struggled since November 2014 to sustain four hour performance. Given the continued performance since April 2015, the Trust will be unable to achieve the 95% standard for the year 2015/16. While responsibility for the A&E four hour standard rests with the Trust, the successful delivery of the constitutional standard is indicative of the functioning of the whole system.

The key factors driving under-performance are:

- Average LoS for Emergency Department (ED) admitted patients averaged around 6.8 days between Summer 2013 and Summer 2014 though has risen since then and remained stubbornly around 7.5 days throughout almost the whole of 2015
- Increased ED demand with a steady 2 to 3% growth year-on-year with the usual winter dip in attendances has not materialised this year
- Ambulance arrivals have been increasing and at a more rapid rate than total attendances. In 2011, we typically had 2,550 ambulance arrivals per month. In 2015, it was approximately 3,050
- DToCs ran at 3% or so through 2013, gradually crept up through 2014 to 4 to 5%, then spiked sharply over the summer of 2015, hitting just under 8% in July and September. It has since fallen back into the 4 to 5% range.

Other factors contributing to under-performance are:

- Patient flow and delays in moving patients through the system
- System-wide issues not enabling patients to be discharge in a timely way with high numbers of patients medically fit for discharge
- Delays in accessing mental health beds
- Care home availability, delays in assessments and readmissions
- Availability of domiciliary care.

In order to recover performance, the Trust has:

- Introduced steps to reduce LoS for both elective and non-elective admissions by implementing SAFER discharge bundle including daily board rounds and associated ward-level performance dashboard
- Implemented an Integrated Discharge Team to bring together the Trust Discharge Coordinators, KCC care managers and Kent Community Health NHS Foundation Trust community liaison team into one team
- Built an additional 38 bed ward at the TWH site to support non-elective patient pathways and capacity including Acute Admissions Unit and Acute Medical Unit
- Established an Ambulatory Care working group to develop new pathways for non-elective patients presenting with ambulatory sensitive conditions to avoid hospital admissions
- In partnership with IC24 and the CCG, improved access to Urgent Care Primary Care Service
- The high impact team HIT service aligned to A&E to avoid hospital admission for non-medical reasons
- Porter dedicated to A&E to improve patient flows
- Take home and settle service.

3 Approach to workforce planning

3.1 Workforce strategy

In September 2015 the Trust agreed a new workforce strategy for the next five years (Workforce Strategy: Shaping Our Future Together 2015-2020). The Workforce Strategy defined the ambition of the Trust to construct an organisation where people deliver excellence each day and feel engaged, enabled and empowered to work for the Trust.

The Strategy has six interrelated workforce priorities:

- Recruitment and retention
- Temporary staffing
- Culture
- Health and wellbeing
- Integrated education
- Equality and diversity.

The table following shows the expected wte changes from the 2015/16 forecast outturn to the 31st March 2017:

	WTE	2015/16 Plan (March 2016)	2016/17 (April 2016)	2016/17 (March 2017)
Substantive	Medical	677.63	646.65	668.63
	Nursing	1593.45	1540.23	1587.24
	Other	3229.28	3074.43	3171.26
Substantive Total		**5500.4**	**5261.3**	**5427.1**
Agency	Medical	5.99	25.87	13.37
	Nursing	17.11	157.73	89.06
	Other	26.26	91.72	52.91
Agency Total		**49.4**	**275.3**	**155.3**
Bank	Medical (Incl. Locum)	5.61	42.75	33.65
	Nursing	107.7	94.82	76.55
	Other	25.72	150.8	144.59
Bank and Locum Total		**139.0**	**288.4**	**254.8**
Total Staff		**5688.8**	**5825.0**	**5837.3**

Figure 3: Whole time equivalent movements 2015/16 to 2016/17

The workforce plan applies a number of assumptions with regards to recruitment timeframes and the interplay with the substantive and agency workforce. The main drivers to the increase in wte are as follows:

- 124 wte relating to the new wards at TWH and the Crowborough Birthing Centre
- 30 wte Foster Clarke and Whatman Wards
- Vacancy normalisations 40 wte
- A net reduction of 83 wte relating to the cessation of the Kent and Medway Health Informatics Service (KMHIS)
- Other Agreed Business Cases 15.67 wte:
  - ENT 5th Consultant: 6.71 wte

- Neurology Consultant: 1.00 wte
- Part Time Breast Consultant: 2.56 wte
- Bowel Screening: 5.40 wte.

The Trust is working to reduce reliance and expenditure on agency staff through recruitment and adherence to the price caps and use of approved frameworks. NHSI has set a ceiling for the use of agency staff with the ceiling for the Trust for 2016/17 set at £13.6m.

3.2 Assurance and planning

Workforce assurance is at the heart of ensuring that the organisation meets its guiding principle of patient care, safety and quality of care. In order to deliver this assurance, the Trust adopts a rigorous workforce planning process and ensures that the clinical director, supported by multi-disciplinary senior clinicians, are at the heart of the decision making process.

The workforce planning process is integrated within the Trust Annual Business Planning Process and integrated with and supports the Trust's long term financial model (LTFM). Triangulation of the workforce plan with financial and activity plans is undertaken as part of the process.

The development of detailed Directorate plans forms part of the integrated business planning process in the Trust which takes place from October to April each year and, importantly, integrates education commissioning, recruitment, plans to reduce dependency on temporary staff (in particular high dependence on expensive agency staff) and national benchmarking into workforce planning (relevant National Institute for Health and Care Excellence (NICE) guidance, SAFER nursing care tool, Birthrate Plus etc). Nursing and Midwifery workforce undergoes bi-annual review using evidenced-based tools (for example Birthrate Plus). The reviews are taken to the Board in line with the guidance set out in the National Quality Board expectations. The Trust has developed a workforce planning resource database for managers to easily access benchmark information and Directorate teams are supported by HR business partners and finance managers during the process.

All our Directorate workforce plans, once developed, are formally approved by the Clinical Director (service lead) responsible for that Directorate ensuring a multi-disciplinary approach in the formation of the local plan. The Business Planning Steering Group tasks the operational lead for ensuring the plans are aligned to the clinical strategy, LTFM, local health and care system commissioning strategies before scrutiny by the Trust Management Executive and the Workforce Committee and Finance Committee. Both the Workforce Committee and Finance Committee ensure alignment and make recommendation to the Board for approval or variation.

Through development to final sign off by the Board, the plans receive rigorous challenge from the Executive Team and in particular the Medical Director and Chief Nurse to assure that any local workforce transformation programmes and productivity schemes do not impact on the quality of care that we provide to our patients and that the Trust's guiding principle is achieved.

All ESPs that have workforce implications require Quality Impact Assessment which are reviewed and approved by the Medical Director and Chief Nurse. Furthermore, both the Chief Nurse and Medical Director lead the workforce transformation programmes and productivity schemes.

The final plan was taken to Board for approval in March 2016.

The Trust has dedicated workstreams for:

- Nursing recruitment and retention (monthly), chaired by the Chief Nurse
- Medical recruitment (fortnightly)
- Temporary staffing (weekly), chaired by the Chief Operating Officer
- Nurse productivity (fortnightly), chaired by the Chief Nurse
- Medical productivity (fortnightly), chaired by the Medical Director.

3.3 Recruitment and retention

The Trust has a strong pipeline of nurse recruitment and, as substantive staffing increases, is forecasting a reducing dependency on temporary staff in 2016/17. The Trust will continue to work on initiative plans to attract staff to work for the organisation and target appropriate overseas opportunities to reduce vacancies.

A medical recruitment group has been developed to reduce the number of vacancies and dependency on locum staff. The group has representation from the medical workforce.

Temporary staffing controls have been enhanced with weekly reporting on utilisation, increased authorisation at senior levels and clear parameters around roster and rota management. All clinical Directorates/ wards have been supplied with Agency usage target to support the Trust's TDA trajectory plan. Weekly usage update is circulated to Executive team, providing an overview of usage against target and recovery action plan.

E-rostering policy and clear management guidelines are in place. Requests for temporary staff are made through the rostering system for nursing and support workers. There are clear processes for other staff groups for temporary staffing requests and clear authorisation process which have been reviewed to take account of the NHSI Agency Cap changes. Staffing levels are reviewed three times per day at the Site Operations Meeting and approval for the use of 'specials' has been escalated to the senior nursing management team. Risks identified out of hours that will potentially impact on the following day are reported during the 6am site report. Matrons work across directorates to ensure safe staffing levels across all patient care areas. Weekly reports are distributed to the Executive Team on temporary workforce utilisation by area to monitor use and areas of high dependency. There is a clear escalation process in place stipulated in both the E-rostering policy and the operational escalation policy. A business case has been submitted to replace the existing e-rostering system in 2016/17.

The Trust has launched its Operational Productivity and Performance (OP&P) analysis review and leads have been identified and appointed to the 15 recommendations.

3.4 Workforce risk

The Trust has high level assessments of the key risks within the organisation and these include workforce-related risks. Action plans relating to workforce-related risks are monitored by the Executive Team and monthly via the Board Assurance Framework which is presented to Trust Board.

The workforce risks are submitted on the overall Trust risk register. A workforce plan risk register is maintained as part of the business planning cycle and reported to the Workforce Committee and the Trust Management Executive prior to Board sign-off. Once the workforce plan has been approved by the Trust Board, the Trust's risk register will be updated to reflect any further risks identified following the approval process.

3.5 Reporting and review

The Board receive monthly updates on the staffing profile using agreed workforce KPIs including the following:

- Establishment (budget WTE)
- Contracted (WTE)
- Overtime (wte)
- Vacancy rate (%)
- Number of vacant posts (wte)
- Turnover rate (%)
- Sickness absence (%)
- Appraisal (including medical staff) (%)
- Statutory and mandatory training compliance (%)
- Locum staff (wte)
- Bank staff (wte)
- Agency staff (wte)
- Worked staff (wte)
- Nurse agency spend (£)
- Medical locum and agency spend (£).

The Workforce Committee (sub-committee of the Board) receives the following KPIs on a quarterly basis:

- Establishment (budget wte)
- Contracted wte
  - Additional professional scientific and technical
  - Additional clinical services
  - Administrative and clerical
  - Allied health professionals
  - Estates and ancillary
  - Healthcare Scientists
  - Medical and Dental
  - Nursing and midwifery registered
  - Students
- Medical wte per £1m per total income
- Nurse wte per £1m per total income
- Scientific, therapeutic, and technical worked wte per £1m operating Income
- Non-clinical wte per £1m per total income
- Total pay cost (£000)
- Payroll overpayments (£000)
- Bank staff use wte
- Agency staff use wte
- Locum wte
- Overtime wte
- Vacancies wte
- Vacancy %
- Redundancy (£000)
- Labour turnover rate
- Stability
- Sickness absence
- Statutory and mandatory training
- Percentage staff appraised
- RIDDOR reported staff incidents
- Trend analysis:
  - Pay bill
  - Staff in post by staff group
  - Sickness by staff group
  - Turnover rate by staff group
  - Statutory and mandatory training compliance
  - Staff usage.

Both the Board and Workforce Committee receive regular reports from staff survey and pulse surveys. Staff levels are published at Ward level and are visible for patients, visitors and staff. Regular nursing staffing reports are provided to Board by the Chief Nurse. A revised and updated workforce risk register was included in the Final Workforce Plan taken to Board for approval in March 2016.

The Trust is currently undertaking a detailed workforce review against ward establishments led by the Chief Nurse and the Deputy Director of Finance supported by the PMO team. The outputs of this review will link into to the nursing efficiency workstream.

4 Financial planning

4.1 Financial forecasts and modelling

The financial plan has been modelled in a consistent and integrated way with the activity and workforce models, taking the 2015/16 outturn as the starting point plus normalisations and known changes and factoring in similar changes to income, costs and whole time equivalents for:

- Clinical activity volumes changes from the activity model (demographics, waiting list improvement, specific service proposals)
- Price changes using the application of the draft 2016/17 tariffs and tariff rules eg the headline 1.1% tariff uplift plus specific Clinical Negligence Scheme for Trusts (CNST) impact on particular Health Resource Groups (HRGs) (net impact circa 1.5%); the suspension of penalties and fines, and the specialist commissioner threshold calculation
- The efficiency programme impacts on income, costs and staffing including planned workforce changes, agency reduction programme, Carter efficiency implementation plan
- inflation assessment for the published Pay and Prices levels, notified CNST premium, forecast retail price index (RPI) on the Private Finance Initiative (PFI) contract, assessed local cost pressures
- Agreed strategic developments eg the integration of Crowborough Birthing Centre into Trust operations.

The Information, Finance and PMO teams have worked in a matrix approach, under the oversight of the Trust's Business Planning Steering Group, to ensure all information is correlated and consistently applied, and the same underpinning assumptions have been employed.

The Trust is projecting a 2016/17 I&E breakeven deficit of £22.9m which is a reduction on the forecast 2015/16 outturn of £23.4m. The income and expenditure is shown in Figure 4 on the following page. Within this overall position the Trust is planning to:

- Absorb the impact of the ending of the tapering local PFI support (£4m) and the last year of non-recurrent transitional funding from Specialist Commissioners related mostly to cancer tariffs (£3.9m), together with non-recurrent cost and ESP benefits (£4.2m)
- Agree realistic and deliverable levels of clinical activity and reimbursement with local and specialist commissioners that meet national and local objectives on quality, access targets and NHS constitution
- Manage the impact of national pay and prices (3.1%), together with specific local cost pressures, and service changes (eg the dissolution of the local HIS consortium hosted by the Trust)
- Deliver a £22m efficiency programme, including the full year effects of 2015/16 projects (circa 5.5% of turnover) that includes maintaining downward pressure on temporary staffing usage and prices in line with national guidance. The Trust has a track record of delivering efficiencies at this level, and is planning to continue at a higher than nationally-required level in order to reduce the underlying deficit position whilst mitigating against the loss of circa £8m of non-recurrent transitional income.

The main changes between 2015/16 outturn and 2016/17 plan are set out in the bridge chart in Figure 5 following. Key elements of the planned changes are:

- A net cost impact of £1.6m for activity growth over and above planned ESP schemes. The activity modelling using the national model indicates demographic growth evaluated at circa £3.3m. In addition, waiting list improvements generate activity of circa £2.2m income value
- The Trust is working with commissioning partners to agree contracts for 2016/17. At this stage no specific QIPP schemes have been agreed or included in the activity or financial modelling.

	2015/16 Plan (£m)	2015/16 Forecast (£m)	2016/17 Plan (£m)
Clinical Income	320.3	315.3	330.8
High Cost Drugs and Devices	30.3	36.5	36.8
Non Clinical Income	30.1	26.3	20.1
Education Income	11.0	11.5	11.1
Private Patient Income	7.2	6.6	7.0
Other Operating Income	2.2	5.0	5.3
Total Operating Income	**401.0**	**401.2**	**411.2**
Substantive Staffing Costs	-211.5	-207.2	-229.0
Temporary Bank Staffing Expenses	-17.2	-18.9	-12.1
Temporary Agency Staffing Expenses	-8.6	-19.8	-11.2
Total Pay Expenses	**-237.4**	**-245.9**	**-252.3**
Drugs & Medical Gases	-36.8	-43.8	-47.5
Blood	-2.1	-2.2	-2.2
Supplies & Services - Clinical	-30.6	-33.0	-31.6
Supplies & Services - General	-5.3	-5.6	-5.5
Services from Other NHS Bodies	-6.3	-7.0	-6.8
Purch healthcare from non NHS	-2.9	-6.4	-4.9
Establishment	-4.0	-3.9	-3.5
Premises	-22.4	-19.4	-19.9
Clinical Negligence	-16.5	-16.6	-18.2
Transport	-1.3	-1.6	-1.6
Other Non Pay Costs	-11.5	-5.4	-6.3
Total Non-Pay Expenses	**-139.8**	**-144.8**	**-147.9**
Total Operating Expenses	**-377.2**	**-390.7**	**-400.3**
EBITDA	**23.8**	**10.4**	**10.9**
EBITDA Margin %	5.9%	2.6%	2.6%
Depreciation	-17.7	-16.0	-16.2
Interest Receivable /(Payable)	-14.4	-14.2	-14.5
Dividend	-4.8	-4.4	-3.4
Impairments	-0.5	-4.5	-4.5
Non-Operating Income / Expenses	-37.4	-39.1	-38.7
Surplus / (Deficit) before Technical Adjustments	**-13.5**	**-28.7**	**-27.8**
Technical Adjustments	1.4	5.2	4.9
Net Surplus / (Deficit) - Post Technical	**-12.1**	**-23.5**	**-22.9**

Figure 4: Income and expenditure plan

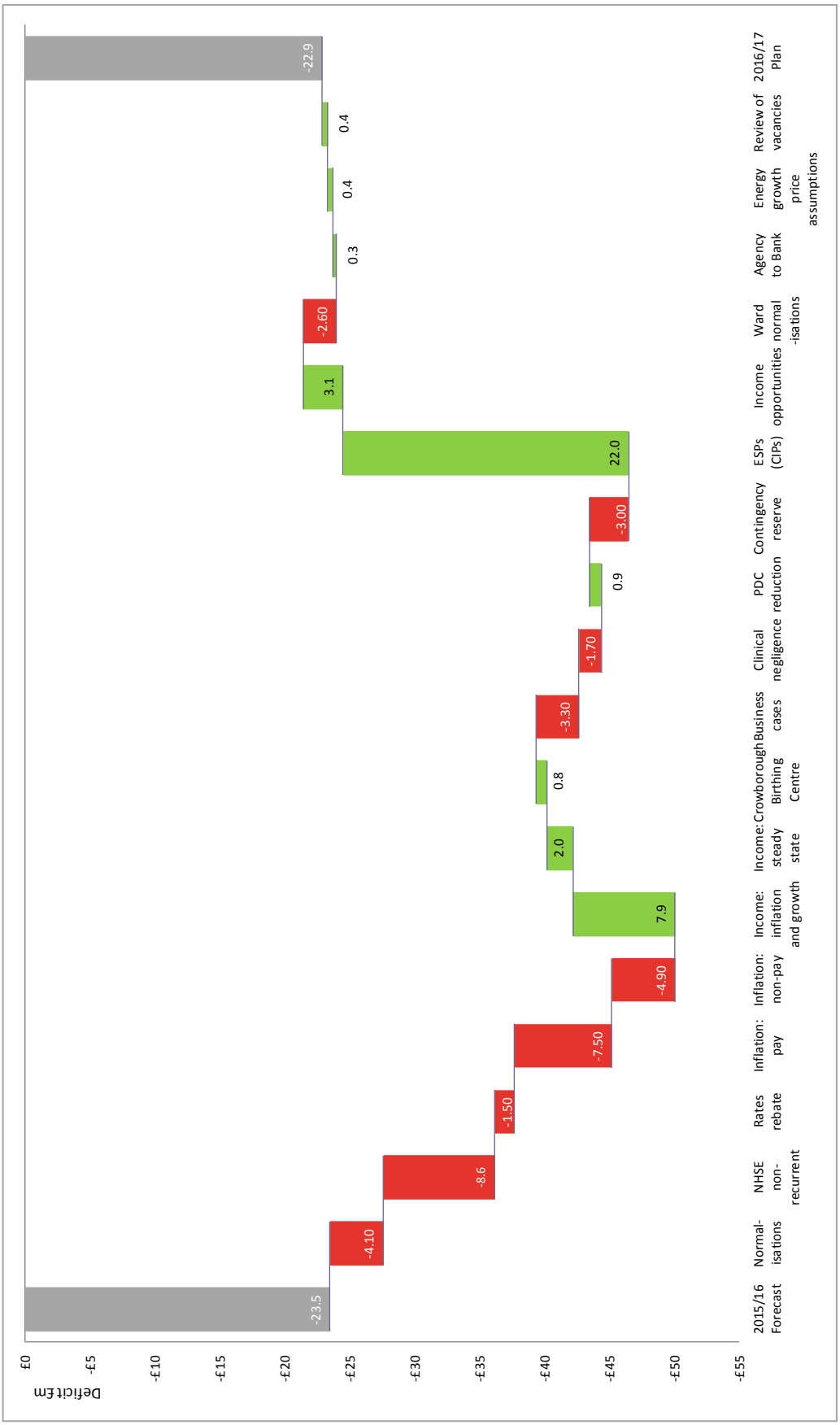


Figure 5: Bridge between 2016/16 forecast outturn and 2016/17 plan

The income plan includes penalties for readmissions and the removal of specialist service marginal threshold. The Trust has not included any provisions for performance penalties within the overall financial plan.

4.1.1 Risk Management

The Trust has included a planned contingency of £2.8m (0.73%) to provide for risk management. The net contributions of schemes included within the ESP programme are also subject to risk adjustments and will require mitigation plans as part of the full work up of project documentation.

Risk relating to:	
CIP Gap	▪ There is currently an unidentified gap of £3.9m; however this is partially offset by £1m of planned over delivery ▪ A number of schemes are rated as medium or high risk. Work is on-going with the directorates in particular medicine ▪ There are a number of key opportunities to be further developed, eg LoS, OPaP and SLR etc.
Recruitment	▪ Delivery of a number of pay savings will be reliant on a continuous recruitment strategy ▪ Agency usage is at £13.6m which is within the cap level set by the TDA. This will require a significant reduction in agency demand ▪ Impact of the potential review of bank rates and corresponding impact on agency spend.
Ability to manage within non-elective bed base	▪ Escalation beds and winter pressures, therefore impacting elective activity ▪ Impact on performance and therefore fines levied by commissioners ▪ No provision for fines is included within the plan.

Contract negotiations	▪ Negotiations are currently on-going. Plan includes a benefit for the following areas (£3.2m):
	  ▪ Romney Ward fully funded as a step up step down unit £1.8m
	  ▪ Marginal rate (non-elective threshold) adjusted £0.5m
	  ▪ Full year effect (fye) for SPC01 and improved coding in Oncology £0.5m
	  ▪ Well babies PYE £0.2m
	  ▪ Increase for a number of small block items PYE £0.1m
	▪ Review of QIPP plans (£7.5m) underway by directorates –challenge process for deliverability has commenced
	▪ Offer received from NHSE
	▪ CQUIN delivery assumed at 90%.

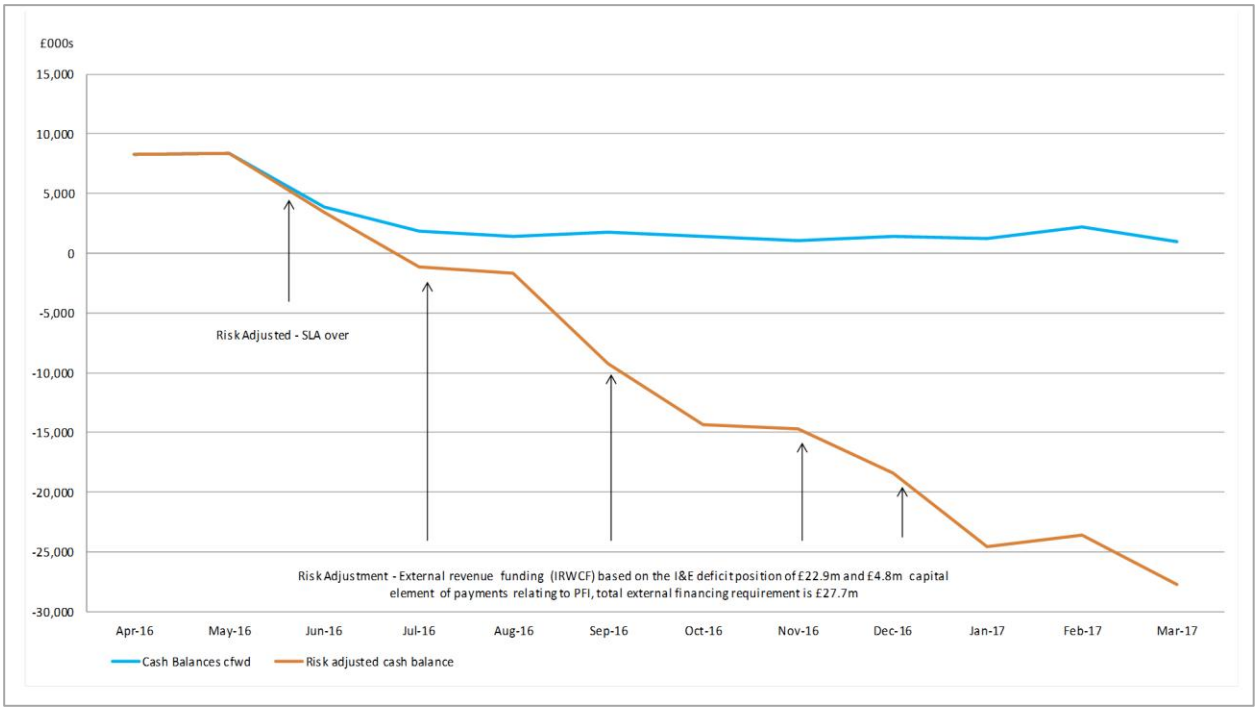
Depreciation/ PFI charges	▪ Based on 8th February submission – any increase when known will need to be funded from reserves.

Figure 6: Risk evaluation

4.1.2 Cash

The deficit I&E 2016/17 plan has been matched by a working capital assumption of £27.7m based on the 'equivalent value' approach including the capital repayment element of the PFI unitary payment. Interest on the IRWCF facility has been assumed at 3.5% within the plans, as well as the inclusion of the revenue loan agreed in 2015/16 (interest at 1.5%). The Trust continues to focus actively on reducing down outstanding levels of debt while managing its creditor cycle as efficiently as possible.

Figure 7 provides a summary of the monthly cash flow forecast for 2016/17, together with the assumptions used to drive cash.



£000s	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cash Balances cfwd	8,280	8,379	3,904	1,851	1,370	1,775	1,388	1,032	1,368	1,243	2,189	1,000
Risk adjusted - SLA overperformance 15/16 cfw	0	0	500	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Risk adjusted - External revenue funding - IRW(	0	0	0	2,000	2,000	10,000	14,774	14,774	18,774	24,774	24,774	27,701
Risk adjusted cash balance	**8,280**	**8,379**	**3,404**	**-1,149**	**-1,630**	**-9,225**	**-14,386**	**-14,742**	**-18,406**	**-24,531**	**-23,585**	**-27,701**

Assumptions	£m	Reducing the risk element
Double block from WK CCG in April	34.0	
External revenue funding liked to I&E deficit	22.9	
External revenue funding for capital element of PFI	4.8	
External capital funding for pre-technical value	4.1	If the funding for the capital schemes is not given, the relevant capital spend linked to the projects will not get incurred
Opening and closing cash balance remain unchanged	1.0	
SLA overperformance 15/16 cfwd	1.0	
I&E pre-technical remains unchanged	0.0	
No SLA over performance 16/17	0.0	

Figure 7: Monthly cash flow forecast 2016/17

4.2 Efficiency savings for 2016/17

To ensure ownership and delivery the Trust has recognised that the development of its ESPs programme needs to be through the Directorates. Through the Trust's business planning process, each Directorate has identified schemes that deliver efficiency, productivity and/ or service redesign. Figure 8 provides a summary of Directorate savings plans.

Directorate	Assumed delivery £000	Efficiency and savings plans £000	Variance £000	Risked value £000
Emergency and Medical Services	5739	4,001	-1,738	2,533
Cancer and Haematology	1727	2,515	788	1,746
Critical Care	1340	1,340	0	954
Surgery	1325	1,325	0	890
Head and Neck	1025	1,025	0	673
Trauma and Orthopaedics	2543	2,847	304	1,850
Women and Sexual Health	1513	785	-728	667
Paediatrics	870	871	1	585
Diagnostics, Therapies, Pharmacy	2320	1,702	-618	1,244
Private Patients Unit	284	158	-126	152
Corporate Directorates	3314	2,569	-728	1,851
Total identified plans	**£22,000**	**£19,138**	**-£2,845**	**£13,145**
Analysis of variance				
Emergency and Medical Services		1,738		
Women and Sexual Health		728		
Diagnostics, Therapies, Pharmacy		618		
Private Patients Unit		126		
Corporate Directorates		728		
Total unidentified plnas		**£3,938**		
Total plans	**£22,000**	**£23,076**	**-£2,845**	**£13,145**
Reconicliation of plans				
Identified plans			19,138	
Unidentified plans			£3,938	
Overprovision plans			-1,076	
Assumed delivery			**£22,000**	

Figure 8: Summary of Directorate planned efficiencies and savings

Work is ongoing to assure delivery of the Trust's ESP programme:

- Development of Directorate project initiation documentation and plans are in progress to support the identified schemes
- Directorate QIAs have been reviewed and signed off by the Chief Nurse and Medical Director
- The unidentified gap is £3.9m, however this is offset by overachievement in some directorates (£1m)
- Unidentified projects are phased from July 2016 and are all classified as high risk
- Identification of schemes continue to reduce the value classified as unidentified
- Schemes identified as high risk continue to be subject to ongoing validation to convert to medium and low risk and assure delivery.

A risked value for each project has been calculated based upon the following risk ratios:

- High risk: assumed to be 20% probability of achievement
- Medium risk: assumed to be 65% d probability of achievement
- Low risk: assumed to be 80% probability of achievement.

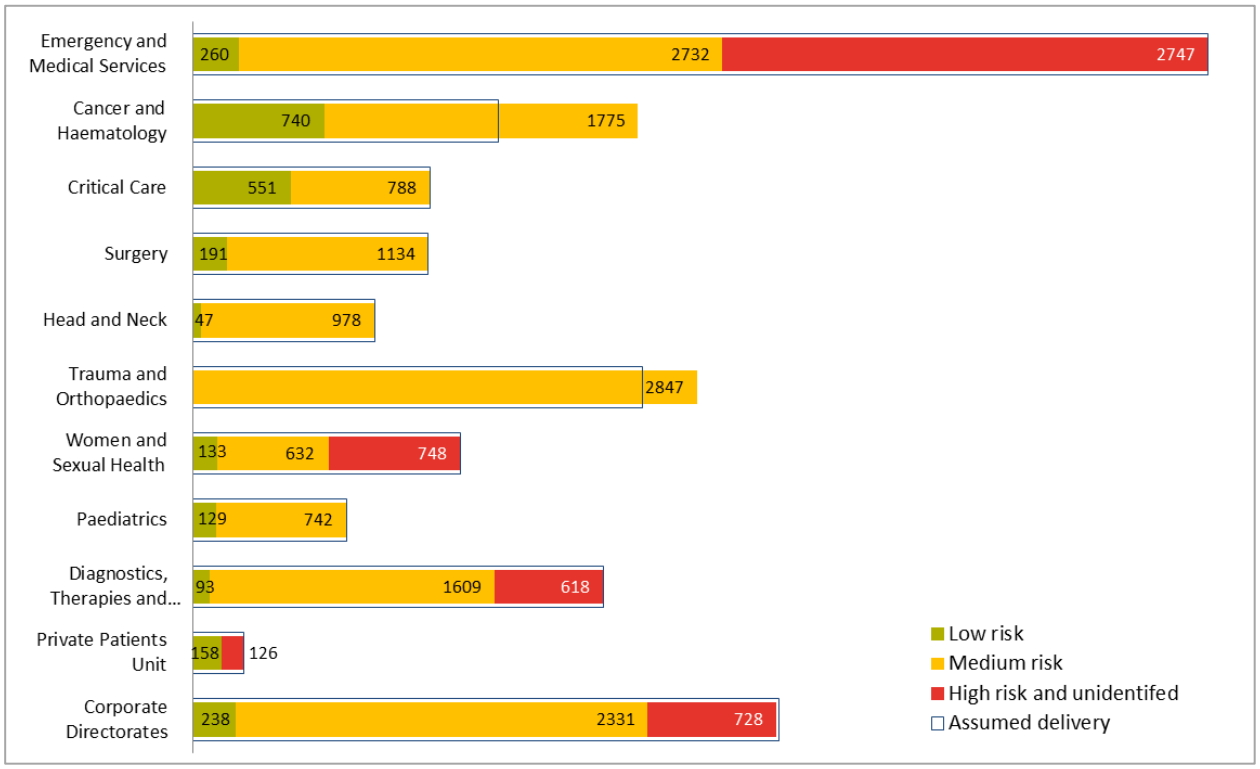


Figure 9: Risk rated efficiency and savings plans

To support this approach and the Directorates the programme management structure, processes and governance are in place, with appointed Executive Sponsors and Clinical Leads for each workstream. Additionally, there are 13 Trust-wide workstreams which incorporate Directorate schemes and provide a framework for Trust-wide delivery. These workstreams are:

- Operational Efficiency
  - LoS
  - Outpatient Utilisation
  - Theatre Utilisation
  - Patient Flow (Service-line reporting (SLR))
  - OP&P
- Resource Management
  - Temporary Staff
  - Nursing Productivity
  - Medical Productivity
  - Clinical Administration
- Corporate Support
  - Contract Management
  - Procurement
  - Drugs
  - Back Office functions.

During the end to end planning process, detailed plans have been produced with the exception of Patient Flow and OP&P as at this stage, these plans incorporate the analysis phase only. A peer review will be undertaken to identify interdependencies, providing assurance that Trust-wide plans are achievable and sustainable. Workstream Project initiation documents and plans have been produced and signed off by the Executive sponsors. Workstream QIA review and sign-off has been scheduled for the 29th April 2016.

4.2.1 Lord Carter's provider productivity work programme

The Trust attended a Productivity and Efficiency Workshop held at the Department of Health, on the 4th December 2015 for initial discussions linked to the findings reported within the Lord Carter Report and the

Adjusted Treatment Cost (ATC) metric, which was a rebadging of the Adjusted Treatment Index; as requested on the 11th December 2015, the detailed questionnaire was returned to the Productivity and Efficiency team.

During the workshop and in subsequent discussions with the Productivity and Efficiency team, the Trust has requested feedback 'Lessons Learned' from the 32 cohort Trusts and asked if the team could engage with us on a monthly basis so we may report progress based upon our current plan. Due to their current commitment, the Productivity and Efficiency team do not have the capacity to support this request; however, we do have good communication channels with the Productivity and Efficiency Team.

The PMO presented the initial analysis linked to SLR to the Trust Executive Team and Clinical Directors at the Trust Management Executive meeting held on 18th November 2015, with a follow up presentation on the 9th December 2015. This analysis identified that out of the top ten areas highlighted within the Lord Carter Report, the Trust was already reviewing eight out of the ten as part of the Trust's Efficiency Programme working in partnership with the SLR team and the Clinical Directorates.

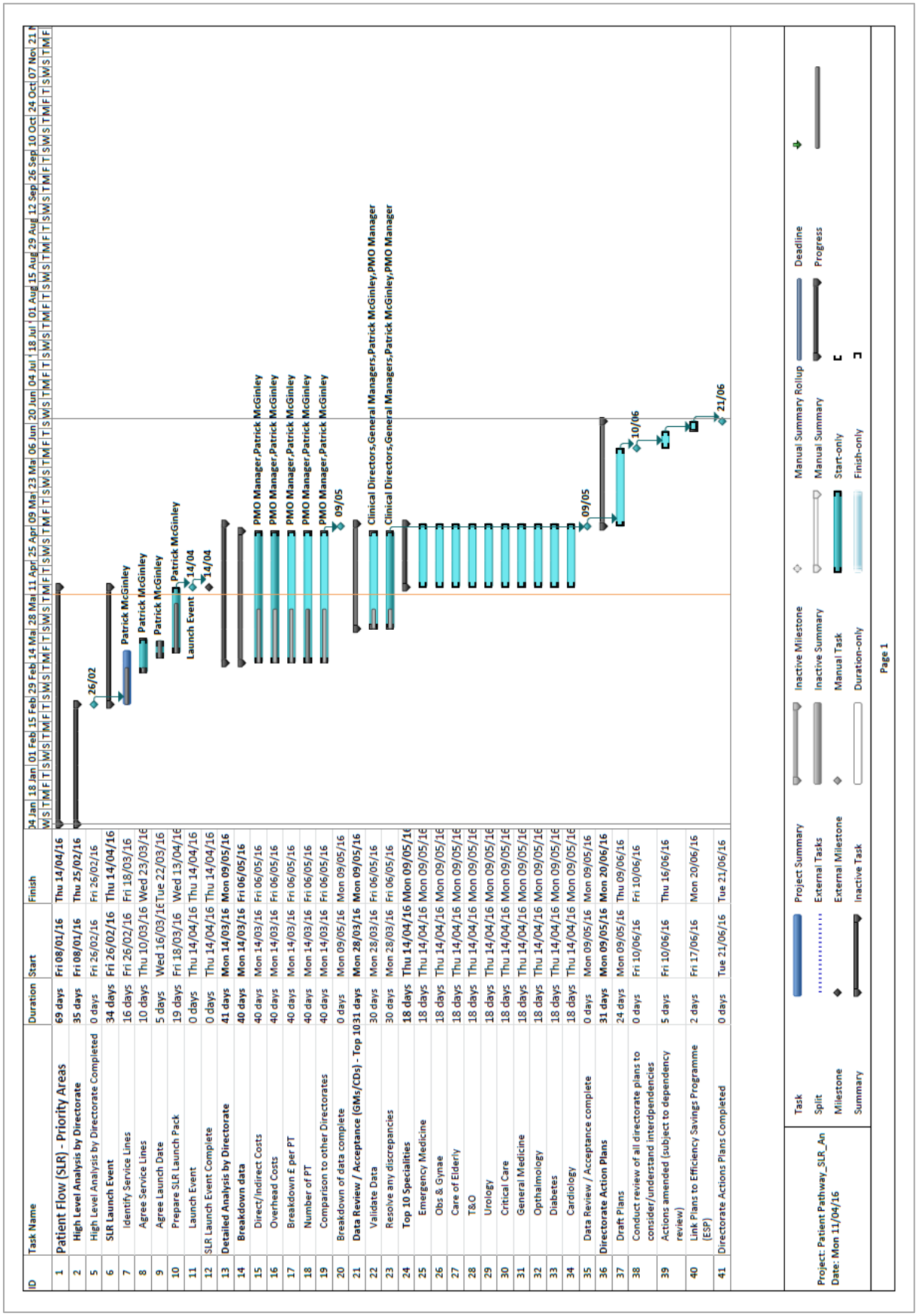
The Trust has formed a Trust-wide workstream 'Patient Flow', led by our Chief Operating Officer; this workstream will encompass the key analysis and governance to support the objectives as identified within analysis presented to the Trust on 20th November 2015 linked to ATC and the top ten specialities with the greatest financial improvements opportunity. The plan in Figure 10 on the following page shows the key activities to complete this analysis phase.

During the analysis phase, the Patient Flow workstream will run in parallel with the with the OPP workstream jointly chaired by our Deputy Chief Executive and Director of Finance. The objection of this workstream will be to conduct the analysis identified in the 'Operational Productivity and Performance in English NHS acute hospitals Report/ Independent report for the Department of Health by Lord Carter of Coles', which was distributed on the 5th February 2016. This workstream will focus on the analysis linked to the 15 recommendations identified in the report.

A project team, as shown in Figure 11 on page 27, has been appointed with senior staff members identified across the organisation to conduct the analysis, allowing the Trust to understand our current position and specifically what needs to be done to achieve these recommendations, this team will be supported by the Programme Management Office.

On 14th April 2016, the Trust held an 'OP&P - Lord Carter' launch session for the project team and senior staff to brief them on themes in terms of the expectation set within the November and February Lord Carter Reports.

The plan in Figure 12 on page 28 represents the key tasks during this analysis phase; the findings will be presented to the OP&P steering committee and subject to these findings, the current Trusts Efficiency Programme will combine with the OP&P, which will allow the Trust to have one Trust Wide priority delivery plan.



ID	Task Name	Duration	Start	Finish
1	**Patient Flow (SLR) - Priority Areas**	**69 days**	**Fri 08/01/16**	**Thu 14/04/16**
2	**High Level Analysis by Directorate**	**35 days**	**Fri 08/01/16**	**Thu 25/02/16**
5	High Level Analysis by Directorate Completed	0 days	Fri 26/02/16	Fri 26/02/16
6	**SLR launch Event**	**34 days**	**Fri 26/02/16**	**Thu 14/04/16**
7	Identify Service Lines	16 days	Fri 26/02/16	Fri 18/03/16
8	Agree Service Lines	10 days	Thu 10/03/16	Wed 23/03/16
9	Agree Launch Date	5 days	Wed 16/03/16	Tue 22/03/16
10	Prepare SLR Launch Pack	19 days	Fri 18/03/16	Wed 13/04/16
11	Launch Event	0 days	Thu 14/04/16	Thu 14/04/16
12	SLR Launch Event Complete	0 days	Thu 14/04/16	Thu 14/04/16
13	**Detailed Analysis by Directorate**	**41 days**	**Mon 14/03/16**	**Mon 09/05/16**
14	**Breakdown data**	**40 days**	**Mon 14/03/16**	**Fri 06/05/16**
15	Direct/Indirect Costs	40 days	Mon 14/03/16	Fri 06/05/16
16	Overhead Costs	40 days	Mon 14/03/16	Fri 06/05/16
17	Breakdown £ per PT	40 days	Mon 14/03/16	Fri 06/05/16
18	Number of PT	40 days	Mon 14/03/16	Fri 06/05/16
19	Comparison to other Directorates	40 days	Mon 14/03/16	Fri 06/05/16
20	Breakdown of data complete	0 days	Mon 09/05/16	Mon 09/05/16
21	**Data Review / Acceptance (GMs/CDs) - Top 10**	**31 days**	**Mon 28/03/16**	**Mon 09/05/16**
22	Validate Data	30 days	Mon 28/03/16	Fri 06/05/16
23	Resolve any discrepancies	30 days	Mon 28/03/16	Fri 06/05/16
24	**Top 10 Specialities**	**18 days**	**Thu 14/04/16**	**Mon 09/05/16**
25	Emergency Medicine	18 days	Thu 14/04/16	Mon 09/05/16
26	Obs & Gynae	18 days	Thu 14/04/16	Mon 09/05/16
27	Care of Elderly	18 days	Thu 14/04/16	Mon 09/05/16
28	T&O	18 days	Thu 14/04/16	Mon 09/05/16
29	Urology	18 days	Thu 14/04/16	Mon 09/05/16
30	Critical Care	18 days	Thu 14/04/16	Mon 09/05/16
31	General Medicine	18 days	Thu 14/04/16	Mon 09/05/16
32	Opthalmology	18 days	Thu 14/04/16	Mon 09/05/16
33	Diabetes	18 days	Thu 14/04/16	Mon 09/05/16
34	Cardiology	18 days	Thu 14/04/16	Mon 09/05/16
35	Data Review / Acceptance complete	0 days	Mon 09/05/16	Mon 09/05/16
36	**Directorate Action Plans**	**31 days**	**Mon 09/05/16**	**Mon 20/06/16**
37	Draft Plans	24 days	Mon 09/05/16	Thu 09/06/16
38	Conduct review of all directorate plans to consider/understand interdpendencies	0 days	Fri 10/06/16	Fri 10/06/16
39	Actions amended (subject to dependency review)	5 days	Fri 10/06/16	Thu 16/06/16
40	Link Plans to Efficiency Savings Programme (ESP)	2 days	Fri 17/06/16	Mon 20/06/16
41	Directorate Actions Plans Completed	0 days	Tue 21/06/16	Tue 21/06/16

Figure 10: Patient flow (SLR) analysis plan

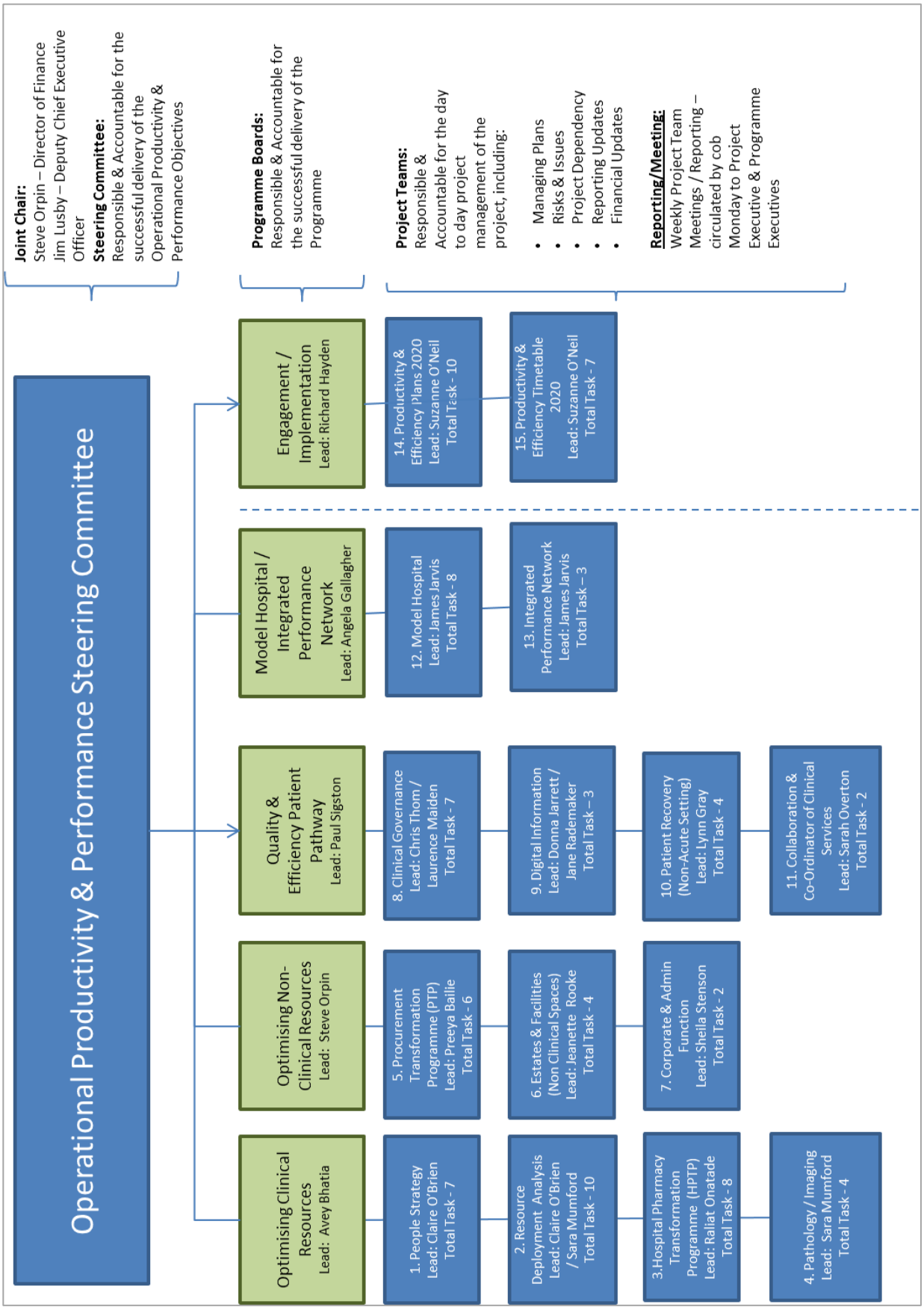


Figure 11: Operational productivity and performance governance structure

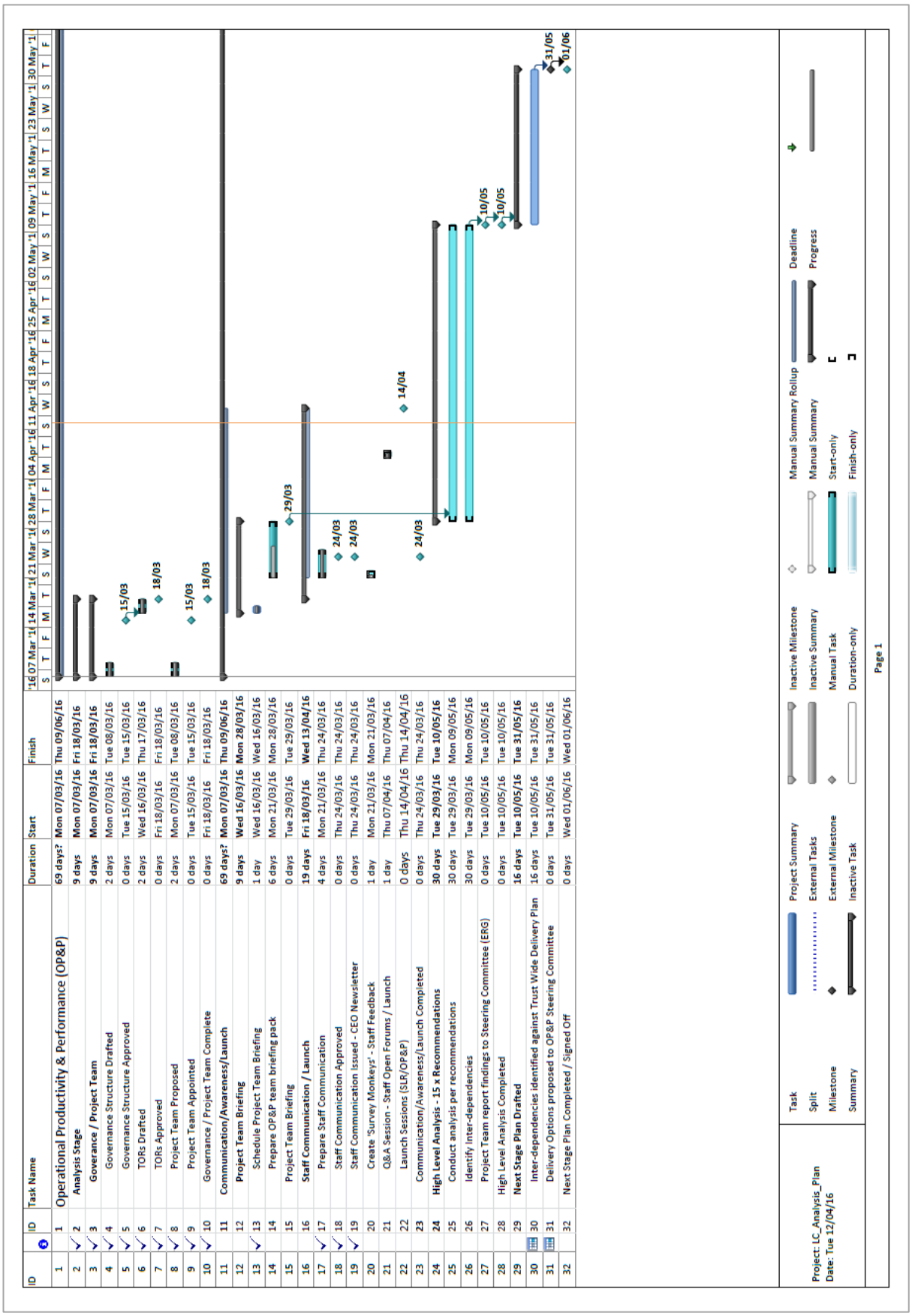


Figure 12: Operational Productivity and performance analysis plan

4.2.2 Agency rules

The Trust will continue with the workstream 'Temporary Staffing' which is led by our Chief Operating Officer to ensure full compliance and monitoring of the rules in association with agency usage. Since the implementation of the initial rules, linked to the use of Non-Framework agencies, the Trust has seen a significant reduction in non-framework agency usage from 57% in April 2016 to 24% in December 2016. Further plans are in place to eliminate the use of non-framework usage.

A team consisting of the following attendees supports the Chief Operating Officer to achieve these standards:

- Associate Directors of Operations
- Associate Directors of Nursing
- HR - Recruitment/ Staff Bank
- Procurement Manager
- Finance Manager
- Head of PMO.

On 17th March 2016, the Trust received the Agency Expenditure Ceilings for all staff groups of £13.6m from NHSI. A review has been conducted against 2016/2017 planned agency spend to ensure compliance to the agency expenditure ceiling with robust plans for recruitment, training programme, reduction in escalated beds and incentives schemes to promote our internal staff bank.

Weekly targets have been set against all areas with agency reliance and reviewed on a weekly basis by the above team; any deviation from these targets is reviewed by the senior management team for that workforce. Plans to close the escalated beds and therefore reduce the reliance upon agency staff have been formulated and reviewed in conjunction with key performance drivers. The agency ceiling has been set for each workforce and each directorate, at this stage of the planning but with the exception of Emergency and Medical Services Directorate; all other directorates have been set a target which has a 10% contingency deduction.

Any changes to the rules are communicated and presented to all key staff and form part of a standard agenda item at the Monthly Clinical Operations and Delivery Committee, which is chaired by the Chief Operating Officer and attended by all senior clinical and non-clinical staff.

It should be noted that the Nursing Efficiencies and Medical Efficiencies workstreams, chaired by the Chief Nurse and Medical Director are key drivers in terms of recruitment and retention strategies for these workforce groups, although the objectives of these workstreams is wider than recruitment/retention these are key drivers in terms of reducing the reliance upon temporary staffing.

A Trust-wide review of all workstreams is undertaken as part of the 'Executive Recovery Group' which meets on a monthly basis, which is chaired by the Deputy Chief Executive Officer and attended by all other Executive members. This committee is supported by the PMO in terms of update reporting, risks and issues management, achieving milestones, KPIs and QIAs.

The Trust submits, on a weekly basis, the 'break glass' submission for all temporary workforce groups.

4.2.3 Procurement

The Trust has recently undertaken a transformation programme of its Procurement Service which sought to improve capacity and capability of the centralised procurement department, introduce improved automation and technology and support efficiencies through a redesign of processes. As part of this review, a number of new non-

pay controls have been put in place to reduce expenditure in certain discretionary categories. These controls will continue to be monitored on a weekly basis and their impact addressed.

The Trust contributes to the central benchmarking initiative recently launched by NHS Improvement and also actively contributes to a benchmarking cohort of over 60 Trusts across England and Wales. Benchmarking is undertaken as a key element of procurement projects and informs opportunity analysis and negotiation. Internal benchmarking and price variance analysis is under development which will monitor and report on variance from agreed pricing. Exceptions will be analysed and discussed with each supplier and losses recovered.

The Trust already works closely with partners such as NHS Supply Chain, Crown Commercial Solutions, London Procurement Partnership and Commercial Solutions to ensure that we have access to the best collaborative arrangements and make full use of the aggregated expenditure of similar organisations. Likewise, we work closely with neighbouring trusts and wider public sector organisations. These relationships will be developed further throughout the year and use of collaborative arrangements monitored.

A comprehensive review of current contracts and committed expenditure such as call-off and standing orders is underway with the intention of renegotiating and ensuring terms and pricing are fit for purpose and fall within benchmarks. Where call-off and standing orders are in place, the intention will be to cancel and, where practical, move towards on-demand purchasing within an agreed contract.

Throughout 2016 we will be implementing a single GS1 enabled Inventory Management Solution for all categories of inventory including supplies, pharmacy, catering and engineering stock. This new solution and related processes will focus on reducing wastage, tightly controlling levels of stock held, providing real time stock evaluation and linking product consumption to patient. The Trust is also in the process of implementing an integrated purchase to pay process which will rationalise the various processes and systems in place for purchasing into a single platform. The new solution will be fully integrated with the financial ledger, providing greater control over the purchasing process and providing improved data which supports contract and supplier management. A 'no-PO, no-pay' policy is in place to support this.

4.3 Capital planning

The Trust has a five year capital programme totalling £78m (see Figure 12 on the following page) which is focussed on delivering the clinical strategy, driving access and operational performance improvements, and reducing backlog and clinical risk to ensure appropriate patient safety and experience within an efficient environment.

The programme reflects plans for essential improvements in backlog estates (£18m) plus renewal of a main theatre block (£15m) at Maidstone Hospital; a replacement equipment programme of circa £25m including linear accelerators for the Cancer Centre; and IM&T modernisation programme (£6m). In addition, the Trust is planning a key strategic development in radiotherapy at TWH to provide additional bunker capacity, which also addresses the current constraint on the replacement linear particle accelerator (linac) programme; and developing additional MRI capacity to reduce reliance on outsourced private sector capacity.

The primary source of capital funding is internally generated cash through deprecation and capital receipts received on the sale of assets, net of repayments of principal on the existing capital loans. Responding to the constraints on external capital the Trust has re-prioritised and scaled down its capital programme; this also demonstrates stretching of the existing asset base (eg linac operational lives have been increased to 13 years from ten years to reflect actual usage).

Capital Summary - Apr 16 Draft	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	5 Year Plan £000
Estates						
Estates Projects - Backlog maintenance	2,000	800	800	800	800	5,200
Ward refurbishment/Decant ward	0	3,000	1,500	1,500	1,500	7,500
Estates Projects - other renewals	598	200	360	400	400	1,958
Energy infrastructure/EPC	2,730	360	250			3,340
Subtotal - internally generated funds	**5,328**	**4,360**	**2,910**	**2,700**	**2,700**	**17,998**
TWH - Lifecycle (IFRIC 12 PFI capital)	553	500	466	593	979	3,091
Staff Accommodation Maidstone		2,276				2,276
New MRI Maidstone - build element		1,650				1,650
TWH Satellite Radiotherapy Bunkers	4,056	3,244				7,300
Maidstone Hospital Theatres' Renewal		3,000	12,000			15,000
	9,937	**15,030**	**15,376**	**3,293**	**3,679**	**47,315**
ICT						
ICT - Infrastructure	735	1,035	663	778	702	3,913
ICT - Clinical System	310	218				528
ICT - Non-clinical systems	928	158	47	26	26	1,185
Core IT System Upgrade PAS (SaCP)	698					698
	2,671	**1,411**	**710**	**804**	**728**	**6,324**
Equipment						
Linac replacement programme		2,400	2,700	2,400	2,400	9,900
Trustwide equipment	2,200	2,187	2,422	2,103	2,503	11,415
Inventory management system	296					296
Fluroscopy/CT machines						0
Donated Equipment	800	300	300	300	300	2,000
MRI Maidstone - equipment		850				850
Crowborough Birth centre - equipment/IT	85					85
	3,381	**5,737**	**5,422**	**4,803**	**5,203**	**24,546**
Total	**15,989**	**22,178**	**21,508**	**8,900**	**9,610**	**78,185**
Capital Sources of Funds						
Internal						
Depreciation	16,295	16,399	15,158	15,065	14,811	77,728
Less: PFI asset depreciation (IFRIC 12)	-3,541	-3,640	-3,739	-3,841	-3,863	-18,624
Less: Capital Loan principal repayments	-2,174	-2,401	-2,677	-3,217	-2,617	-13,086
Net internally generated depreciation	**10,580**	**10,358**	**8,742**	**8,007**	**8,331**	**46,018**
Plus: Asset Sales		2,276				2,276
Plus: Donated asset funding	800	300	300	300	300	2,000
Plus: PFI lifecycle (IFRIC 12) resource	553	500	466	593	979	3,091
	11,933	**13,434**	**9,508**	**8,900**	**9,610**	**53,385**
External: capital investment loans/PDC						
New MRI Maidstone - build & equipment	0	2,500	0	0	0	2,500
TWH Satellite Radiotherapy Bunkers	4,056	3,244	0	0	0	7,300
Maidstone Hospital Theatres' Renewal	0	3,000	12,000	0	0	15,000
	4,056	**8,744**	**12,000**	**0**	**0**	**24,800**
Total	**15,989**	**22,178**	**21,508**	**8,900**	**9,610**	**78,185**

Figure 13: Capital investment summary (five year plan)

The Trust is also accessing charitable funding to support its capital investment, particularly in cardiology and oncology, and also considering other approaches to managing its resource requirement e.g. the use of managed service arrangements (currently used for instance in laboratory services).

Nonetheless the scale of required estate renewal, and operational pressures, means that the Trust has planned for capital investment loans to support its need to increase diagnostic capacity (£2.5m Magnetic resonance imaging (MRI) build/ equipment in 2017/18), its development of a satellite radiotherapy facility at TWH (£7.7m across 2016/17 and 2017/18) and the theatre renewal at Maidstone requiring a new build (£15m across 2017/18 and 2018/19).

The Trust is planning to dispose of a set of 1970s' apartment blocks behind the former site of the nurses' home that it sold in 2013. The capital receipts are planned within the programme in 2017/18 to fund a modern purpose built facility on the Maidstone site to re-provide essential junior doctor, nursing and key worker accommodation in support of the Trust's recruitment and retention initiatives.

5 Link to the emerging Sustainability and Transformation Plan

5.1 Early view on the vision for the local health and care system

Following a range of discussions with CCGs, providers and the Kent Health and Wellbeing Board across Kent and Medway there appears to be an emerging consensus around the following key principles which apply to both physical and mental health, health and social care and care for individuals of all ages:

- A major transformation of primary care, community-based health and social care, and locally-delivered secondary care services into fully integrated and significantly enhanced services is the building block for transformation. These new care models are likely to be Multi-speciality Community Providers operating as Accountable Care Organisations that commission the hospital-based care needed for local people
- These transformations need to be developed in partnership with local people and professionals as a granular process that empowers local communities; not one that is imposed from above
- These developments will, when implemented and successful, have a significant impact on the models of care in hospital and the demand for hospital-based care. The shape of hospital-based services should be driven by the development of local out of hospital care and not the other way round
- In order for the hospital sector to become sustainable it needs to reshape its cost base and service delivery models to be able to deliver high quality and affordable care. New models for hospital care will need to be organised so as to be able to recruit the appropriate workforce. Transforming hospital care will require some change that covers wider footprints than those needed to transform out of hospital care.

5.2 How Maidstone and Tunbridge Wells NHS Trust plans to support this vision

For the Trust this means significant changes on several fronts:

- Out of hospital care
- Hospital-based care
- Centralisation of specialist services.

5.2.1 Out of hospital care

To bring routine care closer to the patient and to be able to sustainably provide it for the ageing population and those making poor lifestyle choices, routine care will need to be provided in a lower cost model. This is deemed to exist in primary care. In order to achieve this transition to care out of the hospital, specialist skills will need to be brought into primary through a combination of outreach services from the hospital and through up-skilling primary care clinicians.

The delivery of a new diabetes model in West Kent planned for 2016/17 is one such example of this type of transition. This involves Level 2 and 3 care being combined and delivered in the community at GP surgery spokes and two hubs. Level 4 outpatient care will remain within the hospital outpatient provision along with inpatient care. It is assumed that over time there will be a skills transfer to GPs trained in this area, supported by clinical nurse specialists, who will be increasingly able to manage patients who would have originally been treated in the hospital as an outpatient.

The West Kent Musculoskeletal Strategy is another such example aimed at delivering a more cost-effective service in 2016/17. This will be achieved through identifying the most appropriate treatment following initial diagnostics

and a triaging process in the community, supported by hospital-based specialists. It is intended this will remove unnecessary outpatient appointments; in some cases, it will allow first attendance to involve treatment; it will move some treatments into the community and will avoid patients seeking improved health 'bouncing' between specialties and treatments.

Already in West Kent the chronic obstructive pulmonary disease service is now largely community based and has been successful at avoiding outpatient appointments in the hospital for this chronic condition. In a similar way optometrists now perform eye diagnostics and treatments in the community, moving more routine cases into a lower-cost model and there remains scope for early stage and stable conditions to be managed outside the hospital. Such arrangements require sound governance processes and oversight by hospital-based specialists.

5.2.2 Hospital-based care

Although routine care will trend towards transitioning into the community, provided by specialist nurses supported by consultant colleagues, more complex care will remain within the hospital both for elective and non-elective patients. The care that transitions into the community, as opposed to the care that remains in the hospital, is less likely to be determined by speciality than acuity of the patient's condition. For example, those on disease modifying drugs or biologics for their condition will require regular monitoring by specialists to determine the effectiveness of the drugs being administered, to minimise their usage as well as monitoring the advancement of their condition. Hospital-based care will still be required for advanced diagnostics and more complex treatments including more complex radiology, scope work and surgery. The hospitals will be for the sickest patients needing significant specialist care.

That said, in some specialties it may still be possible to treat complex chronic conditions in community hubs rather than at the hospital. For example, Level 4 diabetes patients with advanced conditions and complications are already seen within a community based acute setting at Abbey Court in Tunbridge Wells.

The objective for hospital-based services will be to ensure that they are delivered as cost-effectively as possible, meeting all relevant standards and targets and that provision of community care does not compromise or undermine the Trust's ability to provide these crucial hospital-based services. The move to nurse-led care wherever possible, hot lines and clinics to support patients and prevent exacerbations or attendances, virtual clinics and one stop shops and other cost saving measures, for example around procurement, will all be necessary.

5.2.3 Centralisation of specialist services

With a transition of service provision moving from the acute to the community setting, the hospital will potentially have the capacity to expand the specialist service provision it can offer the local population. This is an attractive proposition on many fronts:

- Local specialist service provision removes the need to travel into London for treatment when people are least able to make such journeys
- Provides a lower cost local model for commissioners rather than paying market forces factor when sending patients into London
- Increases the attractiveness of the Trust when recruiting specialists who are increasingly in short supply across all areas
- Helps the Trust become involved in research initiatives with or without tertiary partners, bringing in a source of revenue and, again, increasing the profile of the Trust.

Some areas where the Trust will start planning to develop sub-speciality services for the patients of West Kent and beyond include young dementia services, neuro physiology, electrophysiology, paediatric orthopaedics and paediatric gastro service, thoracoscopy, non-invasive ventilation (NIV) and advanced radiotherapy treatments.

Thoughts and planning will also commence to centralise some services at Maidstone from across West Kent and Medway, aimed at reducing the costs to the overall local health economy, improving the quality of provision, or both. Such examples include the oncology urology work, haematology inpatients, hepatology services and advanced interventional radiology treatments.

5.2.4 Methods by which joint developments will be achieved

Arrangements for nationally driven planning footprints and the requirements for submission of a Sustainability and Transformation Plan that covers a wider footprint, will build on existing arrangements already in place in Kent involving our Trust to deliver joint planning and not replace them.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-13 Efficiency Savings Programme 2016/17 DIRECTOR OF FINANCE

Summary / Key points

- This paper provides an overview of the Efficiency Savings Programme (ESP) process and the governance framework, including
  - Process in place to support and challenge continual identification of new schemes
  - Methodology the trust will adopt to monitor and control progress against 2016/2017 targets
  - Governance, reporting and assurance process

Which Committees have reviewed the information prior to Board submission?

- Finance Committee 25.04.16

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

Noting and review

[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

Briefing paper – Finance Committee
Efficiency Savings Programme (ESP) Update

1. Overview

1.1. The Programme Management Office (PMO) works in partnership with the Clinical and Non-Clinical Directorates to identify efficiency savings opportunities, the key stages are:

- Allocation of Financial Savings Target
- Identification of Efficiency Opportunities
- Workstreams & Planning Considerations
- Assessment of Efficiency Opportunities
- Project Management
- Assurance & Reporting

2. Allocation of Financial Savings Target

2.1. Each Clinical and Non-Clinical directorate financial ESP target is set and communicated to these areas.

2.2. This ESP target allocated to each area represents the stretched target of £26.0m, with an external NHS Improvements target set at £22.0m.

2.3. All internal reporting will show progress against the stretched target, with external reporting to NHS Improvements against the £22.0m target.

2.4. Each directorate must identify schemes and plans to deliver their total ESP target, in the event that directorates identify a greater % of income related ESPs, then further challenge and scrutiny will be applied with dedicated challenge meetings to ensure sufficient cost savings are delivered.

3. Identification of Efficiency Savings Programme Opportunities

3.1. Programme Management Office (PMO) working in partnership with the Clinical Directorates identify efficiency savings programme opportunities, linked directly to workstream themes, directorate specific or external factors such as NHS Better Care, Better Value Indicators, Operational Productivity & Performance (Lord Carter) and NHS Improvements targets.

3.2. Each ESP is assessed in terms of internal and external dependencies, i.e. capital, estates, IT, workforce and commissioning impact.

3.3. Each ESP has KPIs and a financial methodology agreed and held centrally on the ESP database

3.4. Each ESP is categorised in terms of expense category, status (opportunity, fully developed), new / rollover, risk rating, risk adjusted value and implementation date if known. This supports the NHS Improvements submission.

3.5. Each ESP is recorded directly onto the ESP database, providing a central repository of data and real time reporting function

3.6. Access to be granted to clinical and non-clinical directorate staff to improve transparency and visibility of key schemes and to allow clinical and non-clinical directorates to be self-sufficient in terms of standard reporting.

4. Workstreams & Planning Considerations

4.1. Workstreams identified & agreed with the Executive Team.

4.2. Workstreams support the Trust's 'Change Delivery' priority.

4.3. Workstream governance agreed with Executive Sponsor, Clinical Lead, Workstream Lead, Finance Lead, HR Lead and PMO Lead.

4.4. Each Workstream categorise into themes.

4.5. All themes included within clinical & non-clinical directorate plans to support Trust wide priorities and realise recurrent efficiencies.

4.6. Planning considerations are observed when drafting plans to ensure focus on key priorities and performance (operational / financial) targets, as noted in appendix A.

5. Assessment of Efficiency Opportunities

5.1. Directorates

5.2. PMO support the directorates in building project plans, based upon an agreed template which includes agreed milestones and adhere to a standard naming convention.

5.3. Plan template includes all Workstream themes which will ensure Trust wide delivery of ESP objectives

5.4. Directorate plans will be embedded into the overall Workstream plans, ensuring accurate and up to date progress tracking.

5.5. The PID and plans will be equally supported with the Risks & Issues Log, KPIs and Quality Impact Assessment (QIA)

5.6. Clinical directorate PIDs, Plans, Risks & Issues Log, KPIs and QIA are reviewed and signed off by Clinical Director, Associate Director of Operations, Associate Director of Nursing and Executive Lead for the Clinical Directorate

5.7. QIA Clinics are held with the Chief Nurse and Medical Director to allow Clinical Directors to present their directorates QIAs for formal sign off

5.8. Workstreams

5.9. Workstream Plans are produced based upon the agreed themes and apply the naming convention.

5.10. PMO undertake Lessons Learned review against previous financial years workstreams.

5.11. PMO undertake a 'Peer Review' of all PIDs, Plans etc to ensure consistency and factor in any recommendations from the Lessons Learned review

5.12. Workstream PIDs, Plans, Risks & Issues Log, KPIs and QIA are reviewed and signed off by Executive Sponsor, Clinical Lead, Workstream Lead, Finance Lead, HR Lead and PMO Lead

5.13. QIA Clinics are held with the Chief Nurse and Medical Director to allow Clinical Lead and Workstream Lead to present their workstream QIAs for formal sign off

6. Project Management

6.1. PMO team provide a portfolio of project management skills, methodology and documentation to deliver sustainable change, working in partnership with the clinical and non-clinical directorates.

6.2. PMO team provide a central repository of templates/tools to support the Trust's commitment to a consistent and standardised way of working.

7. Governance Meetings

The following meetings take place to support the governance process.

7.1. Clinical Directorate Efficiency Board meetings take place on a monthly basis, a standard agenda has been issued by PMO and Terms of Reference (TORs) agreed. PMO attend and support the senior directorate staff during these meetings. The purpose of these meetings is to focus on progress against current ESP schemes, identification of new ESP schemes and address any potential gaps to the Trust wide ESP target. The meeting will review plans which supports the NHS forward view '9 Must Do's', outstanding QIA action points and opportunities identified from Service Line Reporting (SLR). SLR opportunities support the success criteria linked to the Patient Flow workstream. The data is reviewed on a regular basis and embedded into business as usual activities. Refer to appendix B for TORs

7.2. Workstream Steering Committee meetings take place on a monthly basis, a standard agenda has been issued by PMO and Terms of Reference (TORs) agreed. All steering committees are chaired by the executive sponsor, supported by PMO. Detailed ESP workstream reports are presented and reviewed at the committee meetings. The purpose of these meetings is to focus on the delivery of sustainable change based upon the baseline plans and ensure that the implemented changes are achieving the success criteria and to review progress against the agreed performance KPIs. The detailed ESP workstream reports are then presented to the Executive Recovery Group meeting on a monthly basis. Refer to appendix C for TORs and detailed workstream reports.

7.3. Executive Recovery Group (ERG) meetings take place on a monthly basis, a standard agenda has been issued by PMO and Terms of Reference (TORs) agreed. The chair for this meeting is the Deputy Chief Executive Officer. This group is responsible and accountable for the successful delivery of the Trust Wide delivery programme, including the Efficiency Savings Programme. The Executive Programme Update report is generated directly from the detailed workstream reports and is reviewed during these meetings, please refer to appendix D.

7.4. Executive Directorate Challenge meetings take place on a monthly basis, a standard agenda has been issued by PMO and Terms of Reference (TORs) agreed. The chair for this meeting is the Chief Executive Officer. The purpose of these meetings is to challenge the directorates based upon their progress to plan, financial position and progress against key performance indicators (KPIs) to support the Trust wide delivery plan. Refer to appendix E for TORs

8. Reporting

8.1. Directorate ESP progress reports are available directly from the ESP database. Reports can be generated from the ESP database to show by workstream, if required.

8.2. Detailed ESP workstream reports are generated on a monthly basis by the workstream and PMO lead; these reports are presented at the workstream steering committee monthly meetings. Refer to appendix F

8.3. Executive Programme Summary report is generated on a monthly basis and is an automated update directly from the ESP workstream reports; these reports are presented at the Executive Recovery Group meeting on a monthly basis. Refer to appendix G

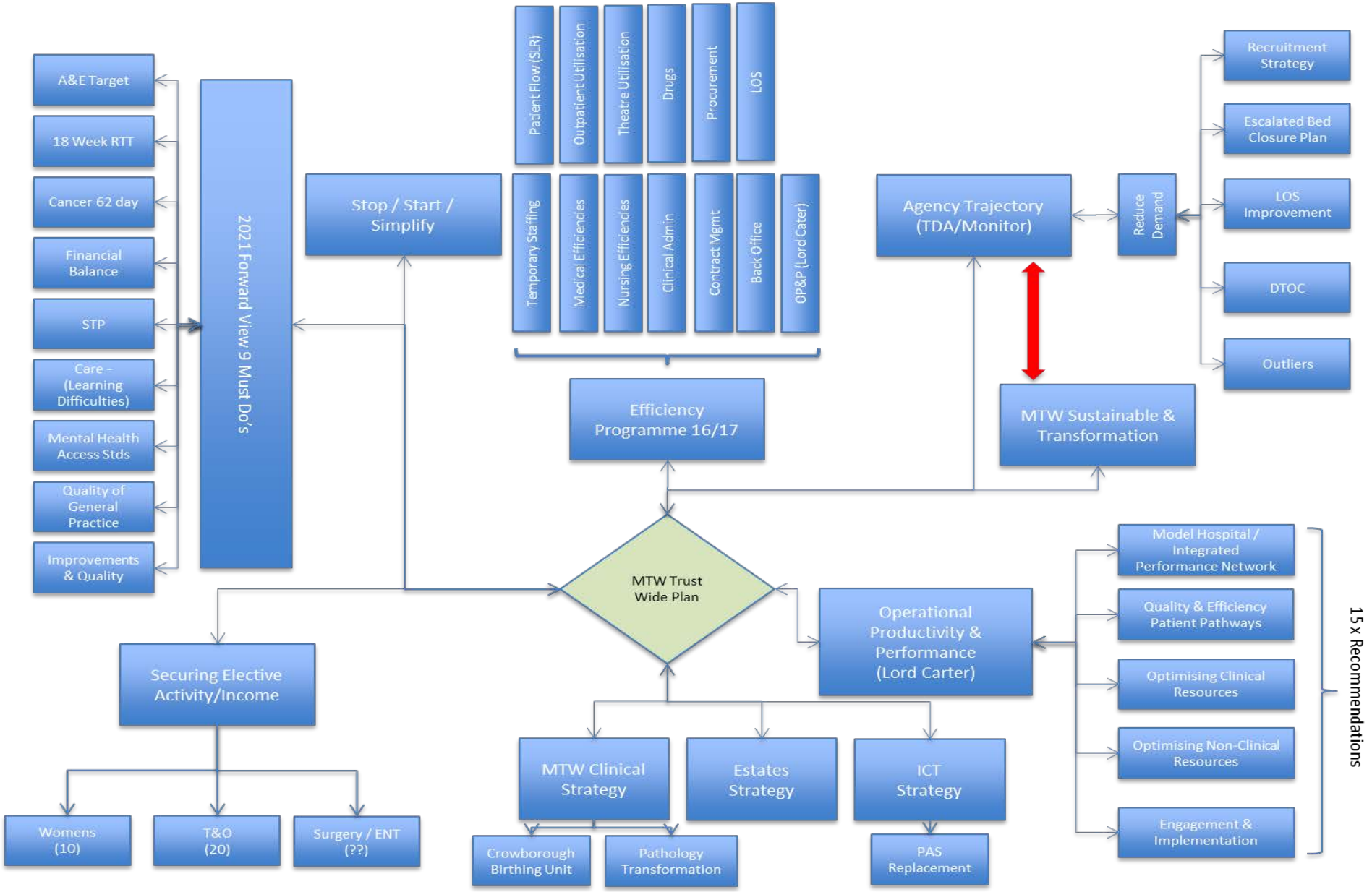
9. Assurance

9.1. PMO team conduct monthly team to team peer reviews to ensure full compliance against processes and procedures.

9.2. PMO conduct a monthly assurance audit against each workstreams and directorates, this initial independent assurance consists of a review of key documentation stored within the standard folder structure and observation in terms of the naming conventions held, this will provide assurance that the Trusts PMO methodology is being observed and utilised. Subject to the findings of the initial review, a detailed independent audit will be conducted by the Programme Managers and overseen by the Head of PMO. The results of this review will be shared with the appropriate teams for resolution and to the monthly ERG.

9.3. NHS Improvement requested a copy of our efficiency savings programme governance and process, please refer to attached presentation.

Appendix A – Trust Wide Plan / Planning Considerations



Appendix B – Clinical Directorate Efficiency Board Terms of Reference

<table>
<tr><td>Title</td><td>Terms of Reference
Clinical Directorate Efficiency Board</td></tr>
<tr><td>Date written</td><td>12th April 2016</td></tr>
<tr><td>Background/Context</td><td>This Group has responsibility for delivering the Efficiency Savings Programme (ESP) for their Clinical Directorate. It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.</td></tr>
<tr><td>Purpose of the Steering Group</td><td>1. This group will review progress against existing ESPs resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress;
2. Ensure project leads are provided the necessary support to deliver
3. Review the status of financial and quality risks and associated mitigating action plans;
4. Support and challenge Leads in delivering savings
5. Monitor and drive workstream delivery
6. Adjust workstream leads priorities/plans to support delivery</td></tr>
<tr><td>Accountability and Reporting Responsibilities</td><td>This board will report to the Executive Directorate Challenge Meetings on a monthly basis and in turn will provide bi-annual updates to TME.</td></tr>
<tr><td>Membership</td><td>The membership of the Steering Group will be:
<table><tr><td>Associate Director of Operations / Associate Director of Nursing</td></tr><tr><td>Clinical Directors / Clinical Leads</td></tr><tr><td>General Managers / Assistant General Managers</td></tr><tr><td>Finance Manager</td></tr><tr><td>PMO Manager</td></tr><tr><td>Project Manager</td></tr><tr><td>Others As Required</td></tr></table></td></tr>
<tr><td>Attendance</td><td>Chair - Associate Director of Operations / Clinical Director
A quorum shall be at least 3 members of the core group.</td></tr>
<tr><td>Frequency of Meetings</td><td>The Efficiency Board will meet monthly / fortnightly, subject to performance.</td></tr>
<tr><td>Programme Management & Administration</td><td>The Programme Management Office (PMO) shall ensure that appropriate programme management and administrative support is provided.</td></tr>
<tr><td>Duties</td><td><u>Agenda</u>
1. Review of previous actions
2. Progress update against existing ESPs
3. Resolution and decisions on escalated issues/barriers to delivery
4. Update on new ESPs
5. Update on any outstanding QIA actions
6. Progress update on Recovery Plans, subject to directorates financial position
7. Review of Service Line Reporting data
8. AOB</td></tr>
</table>

Appendix C – Workstream Steering Committee Terms of Reference

Title	**Terms of Reference** **Workstream Steering Committee Meeting**
Date written	12th April 2016
Background/Context	This Group has responsibility for delivering the Efficiency Savings Programme (ESP) for their Workstream. It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.
Purpose of the Steering Group	1. Provide the strategic direction and oversight for the programme; 2. This group will resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress; 3. Ensure project leads are provided the necessary support to deliver 4. Review the status of financial and quality risks and associated mitigating action plans; 5. Support and challenge Workstream Leads in delivering savings 6. Monitor and drive workstream delivery 7. Adjust workstream leads priorities/plans to support delivery
Accountability and Reporting Responsibilities	This board will report to the Executive Recovery Group (ERG) on a monthly basis.
Membership	The membership of the Steering Group will be: Executive Sponsor Clinical Lead / Workstream Lead Finance Lead / HR Lead PMO Lead
Attendance	Chair – Executive Sponsor A quorum shall be at least 3 members of the core group.
Frequency of Meetings	The Steering Committee will meet monthly.
Programme Management & Administration	The Programme Management Office (PMO) shall ensure that appropriate programme management and administrative support is provided.
Duties	**Agenda** 1. Review of previous actions 2. Overview of ESP detailed workstream report (progress vs. plan) 3. Resolution and decisions on escalated issues/barriers to delivery 4. Executive sponsor provides explanation of variance to plan of exceptional workstreams or initiatives 5. Review of new initiatives / schemes to offset against unidentified ESP financial target, if necessary 6. Documents for approval 7. Documents for decision 8. AOB
Escalation Policy	In the event of deviation from the agreed tolerance levels, the workstream will be escalated to the Executive Recovery Group (ERG) meeting.

Appendix D – Executive Recovery Programme Steering Group Terms of Reference

<table>
<tr><td>Title</td><td>Terms of Reference
MTW Executive Recovery Programme Steering Group</td></tr>
<tr><td>Date written</td><td>4th March 2016</td></tr>
<tr><td>Background/context</td><td>The Efficiency Savings Programme (“ESPs”) target for 2016/2017 has been set and allocated against each Clinical, Non-Clinical Directorate and workstreams; this target represents the stretched target of £26.0m. An external target reported to NHS Improvements has been set at £22.0m.

All internal reporting will show progress against the stretched target of £26.0m, with external reporting showing progress against the £22.0m.

As the Trust delivers ESPs and the financial plan, effective governance, programme and project management disciplines are required to ensure the ESP schemes are on track to deliver and that there is an oversight of activity to ensure achievement of the financial plan is achieved whilst maintaining/improving the level of operational/clinical performance and quality the Trust is currently achieving.</td></tr>
<tr><td>Purpose of the Steering Group</td><td>The primary objective of the Executive Programme Steering group is to oversee the delivery of the Trust savings required to deliver the Trust plan. All Executives are members of the steering group.

The Steering Group will approve new ESP schemes, ensure approved ESP schemes are delivering to plan and challenge underperforming ESPs and support to resolve risk identified.</td></tr>
<tr><td>Accountability and reporting responsibilities</td><td>The Steering Committee will report to Trust Management Executive on a monthly basis and the Finance Committee on a quarterly basis.</td></tr>
<tr><td>Membership</td><td>The membership of the Steering Group will be:

<table><tr><td>Jim Lusby</td><td>Deputy CEO (Chair)</td></tr><tr><td>Steve Orpin</td><td>Director of Finance</td></tr><tr><td>Paul Sigston</td><td>Medical Director</td></tr><tr><td>Angela Gallagher</td><td>Chief Operating Officer</td></tr><tr><td>Avey Bhatia</td><td>Chief Nurse</td></tr><tr><td>Richard Hayden</td><td>Director of Workforce</td></tr><tr><td>Sheila Stenson</td><td>Deputy Director of Finance</td></tr><tr><td>Suzanne O’Neil</td><td>Head of PMO</td></tr></table></td></tr>
<tr><td>Attendance</td><td>A quorum shall be at least 3 Executive members of the core group.

Any project sponsor or manager may be invited to attend, particularly when the Steering Group is discussing projects or areas of risk and operation that are the responsibility of that sponsor or manager.</td></tr>
<tr><td>Frequency of meetings</td><td>The Steering Group will meet fortnightly on a Tuesday morning. The Chair may request additional meetings if necessary.</td></tr>
<tr><td>Programme</td><td>The Programme Management Office (PMO) shall ensure that appropriate programme management and administrative support is provided to the</td></tr>
</table>

Management & Administration	Board to take minutes of the meeting, collate and circulate papers, and ensure follow up actions are delivered.
Duties	**Setting the direction** • To enable the Trust to maintain an overview and visibility at Executive Board level to drive the changes and improvements identified. • Provide support and guidance to Worksteam Leaders and Project Mangers where appropriate. • Establish clear targets and deliverables for workstreams. • Determine focus and priorities of effort and level of resource required to deliver the plans • Approve the approach to programme and project management. • Ensure the schemes continue to reflect the Trusts longer-term objectives and plans. **Confirming approvals** • Approve new schemes, ensure approved schemes are delivering to plan and challenge underperforming workstreams and support to resolved risks identified. • Collective agreement on the initiatives being pursued and collective understanding of progress and issues. **Monitoring progress** • To oversee the development and implementation of all workstream and directorate saving plans. • Monitor and review progress of across directorate workstreams and directorate workstreams to achieve Trust plan. • Consider wider organisational impact of savings initiatives. • Determines appropriate reporting to committees of the Board and the Board. • To set pace of implementation. • Discuss and resolve issues escalated by executive sponsors and other workstreams. • To consider risks escalated from workstreams and determine any action necessary. • All workstreams that are Red rated are to present their summary dashboard for review at the ERG, and suggest what needs to be done to get off the red rating. On alternate weeks workstream is to meet with Turnaround Advisor. **Escalation Policy** • As part of the workstream/project sign off a % tolerance level will be agreed, based upon financial performance. • Deviation in excess of this tolerance will result in a direct escalation to Executive Recovery Group (ERG) and Trust Management Executive (TME) forum.

Appendix E – Executive Directorate Challenge Meeting Terms of Reference

<table>
<tr><th>Title</th><th>Terms of Reference
Executive Directorate Challenge Meeting</th></tr>
<tr><td>Date written</td><td>12th April 2016</td></tr>
<tr><td>Background/Context</td><td>This Group has responsibility to review and challenge progress to date against Directorate Plans to support their Efficiency Savings Programme (ESP) and agreed key performance indicators (KPIs), supporting the Trust Wide Delivery plan. It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.</td></tr>
<tr><td>Purpose of the Steering Group</td><td>1. Review and Challenge the status of plans, performance indicators and financial position and progress to date
2. This group will resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress
3. Ensure leads are provided the necessary support to deliver
4. Review the status of financial and quality risks and associated mitigating action plans.</td></tr>
<tr><td>Accountability and Reporting Responsibilities</td><td>This board will jointly report to Trust Management Executive on a monthly basis and the Finance Committee on a quarterly basis, with the ERG.</td></tr>
<tr><td>Membership</td><td>The membership of the Steering Group will be:
<table><tr><td>Chief Executive Officer</td></tr><tr><td>Deputy Chief Executive Officer</td></tr><tr><td>Chief Operating Officer / Finance Director</td></tr><tr><td>Medical Director / Chief Nurse</td></tr><tr><td>Director of Workforce</td></tr><tr><td>Head of PMO / Deputy Director of Finance</td></tr><tr><td>Directorate Management</td></tr><tr><td>Finance Manager</td></tr></table></td></tr>
<tr><td>Attendance</td><td>Chair – Chief Executive Officer
A quorum shall be at least 3 members of the core group.</td></tr>
<tr><td>Frequency of Meetings</td><td>The Challenge Meeting will meet fortnightly / monthly subject to directorates financial Position.</td></tr>
<tr><td>Programme Management & Administration</td><td>The Programme Management Office (PMO) shall ensure that appropriate programme management and administrative support is provided.</td></tr>
<tr><td>Duties</td><td><u>Agenda</u>
1. Review of previous actions
2. Resolution and decisions on escalated issues/barriers to delivery
3. Review of schemes as appropriate
4. Documents for approval
5. Documents for decision
6. AOB</td></tr>
</table>

Appendix F – ESP Detailed Reports

ESP Detailed Worstream Report

LEADS	CIP Implementation - Executive Lead Update	Date :	15/02/2016	Workstream:	Theatres Utilisation

EXECUTIVE LEAD	PMO	CLINICAL LEAD	PROGRAMME MANAGER	FINANCE MANAGER
Angela Gallagher	Lisa Urquhart	Greg Lawton	Sarah Turner	Richard Sykes

PMO ASSESSMENT	RAG	Rationale
PMO ASSESSMENT RAG RATING & RATIONALE THIS REPORTING PERIOD	GREEN	Documentation and clear structure in place. Service meetings to review utilisation fortnightly and monthly steering committee. Agendas and action plans in place.
PMO ASSESSMENT RAG RATING & RATIONALE LAST REPORTING PERIOD	GREEN	Workstream maintains their governance processes, visible on the shared drives.
DELIVERY RAG RATING & RATIONALE THIS REPORTING PERIOD	RED	M10 position and FOT is below target. Key reason are bed pressures leading to under utilised lists. Actions are being put in place to help mitigate this.
DELIVERY RAG RATING & RATIONALE LAST REPORTING PERIOD	AMBER	M10 marginally below target due to T&O utilisation

STATUS DASBOARD

Finance Position @ Year To Date (M10)	NR	Rec	Total £
Target			£ 1,081.00
YTD Plan			£ 889.00
YTD Actuals			£ 556.10
YTD Variance			-£ 332.90
YTD RAG			RED
FOT			£610
FOT RAG			RED
Overall RAG: This reporting period			RED

Milestone activity progress	No of
Due	69
Achieved	56
Overdue	13
Not Due	1
Overdue	

Risks & Issues	No. of
Low Risk (2-4)	0
Mod. Risk (5-9)	3
High Risk (10-15)	3
Extreme Risks (16-25)	0
No. escalated	2

KPI's	No. of
On or above plan	1
Marginally below plan	1
Significantly below pl	1
Not Known	0
Overall RAG:	

Quality & Safety	
QIA Approved	In Review
Low Risk (2-4)	3
Mod. Risk (5-9)	2
High Risk (10-15)	0
Extreme Risks (16-25)	0
Overall RAG:	In Review

Details for escalation to the Turnaround Board

UPDATE FOR STERRING ROUP

M9 showed an underdelivery against forecast, the workstream had planned for a drop in savings from December however due to unpresedented pressure on the Trust these has been a significant impact on elective work undertaken at TWH due to bed availability.
Detailed review of each service within the Directorate. To be presented at the Steering group.
Presentation of start times to review areas which repeatedly run late.
The 8 tasks over due relate to POA relevant milestones and 6-4-2. POA is now being taken through the POA working group led by Jane Rademaker. This group is planning on developing a vision and strategy for POA in the longer term but has developed short term actions as well.
The booking teams are still to reach 6-4-2 booking levels and are currently booking to a consistent 3 weeks in advance. This is challenged weekly though PTL meetings and on the day cancellations are reviewed.
Critical Care has continued to review start times of the anaesthetists and is discussing with individuals in Job planning meetings.
A revised TCI letter has gone live for ENT and Short stay unit at TWH as a pilot. This includes wording agreed with Comms and AG to encourage patients not to cancel their TCI at short notice.

RISKS & ISSUES

TOP THREE RISKS & ISSUES - Delivery of CIP

Risk ID	Date of Review	Potential Risk	Date Risk Applies	Impact should it occur	Mitigation Actions Required via escalation	Escalated to the CIP Board
1.1	10th June	The Financial gap is not agreed within directorates	May-15	High risk	Meridian are providing a review of the theatre project and potentially further savings	
1.2	Jan-00	Project underdelivering against target	Jul-15	High risk	Escalated through the workstream summaries and remedial plans being devised.	
1.3	15th June	Clinical buy in to the project	Apr-15	Moderate risk	New CD for Critical Care to be clinical champion for the project	No

Goverance

Workstream Sign off	QIA	0	Sign off da	Jan-00
Workstream Sign Off	PID	0	Sign off da	Jan-00
Governance Steering Committee			Last meeting	Jan-00

KPI

			Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
KPI 1	KPI description	Actual	7.30%	6.40%	6.60%	7.30%	8.00%	0.00%	0.00%
	Cancellations on the day by percentage (workstream level)	Expected	4.74%	4.74%	4.74%	7.29%	6.02%	4.74%	4.74%
		Monthly Vari	2.56%	1.66%	1.86%	0.01%	1.98%	-4.74%	-4.74%
	KPI rated	Marginally							
KPI 2	KPI description	Actual	100.00	115.00	0.00	0.00	0.00	0.00	0.00
	Reduction in unused minutes (No of Pat's that could have been treated)	Expected	55.00	55.00	55.00	72.00	64.00	55.00	55.00
		Monthly Vari	45.00	60.00	-55.00	-72.00	-64.00	-55.00	-55.00
	KPI rated	Above							
KPI 3	KPI description	Actual	3.06	3.10	2.90	3.00	3.00	0.00	0.00
	Cases per session (workstream level)	Expected	3.17	3.17	3.17	3.06	3.12	3.17	3.17
		Monthly Vari	-0.11	-0.07	-0.27	-0.06	-0.12	-3.17	-3.17
	KPI rated	Below							

Appendix G

Executive Programme Monthly Update
Reporting Month

Date 18-Apr-16
Year To Date (M10)

Maidstone and Tunbridge Wells Hospitals

Workstream	Delivery RAG Status		PMO Assurance RAG Status		Milestone Status	Escalated Risks & Issues	KPIs		Financial Position	
Theatres Utilisation Executive Sponsor: Angela Gallagher Clinical Lead: Greg Lawton Workstream Lead: Sarah Turner Finance Lead: Richard Sykes PMO Lead: Lisa Urquhart	RAG Last reporting	M10 marginally below target due to T&O utilisation	RAG Last reporting	Workstream maintains their governance processes, visible on the shared drives.	Due 69 Achieved 56 Overdue 13 Not Due 1	The Financial gap is not agreed within directorates	On or above plan 1 Marginally below plan 1 Significantly below plan 1 Not Known 0 KPI RAG RATE 0%		Target £1,081 YTD Plan £889 YTD Actuals £556 YTD Variance -£333 FOT RAG	
	RAG This reporting RED	M10 position and FOT is below target. Key reason are bed pressures leading to under utilised lists. Actions are being put in place to help mitigate this.	RAG This reporting	Documentation and clear structure in place. Service meetings to review utilisation fortnightly and monthly steering committee. Agendas and action plans in place.						
Medical Efficiencies Executive Sponsor: Paul Sigston Clinical Lead: Wilson Bolsover Workstream Lead: Fiona Martin Finance Lead: John Coffey PMO Lead: Fiona Redman	RAG Last reporting	Marginal improvement from previous month. Contribution from vacancy management, staff hourly rate changes, consultant reduced sessions. Notable change is the adjustment for medical spend comparision between years. Focus will be on areas where savings against plan is under or nil.	RAG Last reporting	Steering Group meets monthly, with additional input from working groups, including the Temporary Medical Spend control group led by Angela Gallagher. The group has changed the clinical leadership to Wilson Bolsover where Paul Sigston's diary is unable to accommodate further meetings.	Due 68 Achieved 61 Overdue 7 Not Due 7	Delays within directorate if lack of engagement Inability to recruit to vacant posts	On or above plan 0 Marginally below plan 0 Significantly below plan 3 Not Known 0 KPI RAG RATE		Target £1,621 YTD Plan £1,364 YTD Actuals £1,143 YTD Variance -£221 FOT	
	RAG This reporting	M10 finances were reported with a FOT of £1,052k against a target of £1,600k which is an improvement on previous months.	RAG This reporting	The Steering Group needs further strengthening but with additional time from Wilson Bolsover and increased financial input from John Coffey, the meetings will become more robust. Group to focus on KPIs to provide further assurance.						
Nursing Efficiencies Executive Sponsor: Avey Bhatia Clinical Lead: 0 Workstream Lead: John Kennedy Finance Lead: David Shelton PMO Lead: Lisa Urquhart	RAG Last reporting	0	RAG Last reporting	Agendas are now taken to the fortnightly steering group meeting. Minutes and actions being developed. The group is not always quarate as not all required attendees can make every meeting.	Due 93 Achieved 89 Overdue 4 Not Due 3	Inability to recruit to vacant posts No Engangement of the clinical teams to reduce spend on temporary staffing No increased demand of non elective activity leading to increased workload at No	On or above plan 1 Marginally below plan 0 Significantly below plan 2 Not Known 0 KPI RAG RATE		Target £1,037 YTD Plan £939 YTD Actuals £1,797 YTD Variance £858 FOT	
	RAG This reporting	Currently delivering above original target but YTD slighlty below the forecast delivery. The majority of the savings are non-recurrent fortuitous one off savings however there is still a significant spend on Temporary staffing.	RAG This reporting	Meetings are currently being rearranged to ensure attendance. The key milestones have been achieved however the planned reduction in temporary staffing has not been seen due to escalation and vacancies.						

Maidstone and Tunbridge Wells NHS
NHS Trust

Efficiency Savings Programme (ESP)

Governance and Process

2016/2017

ESP Meeting Structure and Format

Meeting	Frequency	Required Attendance
Clinical Directorate Efficiency Board Meetings	**Monthly / Fortnightly**	Associate Director of Ops Associate Director of Nursing Clinical Director. General Managers Assistant General Managers, Matrons, Finance Manager, PMO Manager, HR Business Partner and Clinical Leads
Workstream Steering Committee Meetings	**Monthly**	Executive Sponsor Clinical Lead(s) Workstream Lead Finance Lead HR Lead PMO Lead
Executive Directorate Challenge Meetings	**Monthly / Fortnightly**	Chief Executive Officer Deputy Chief Executive Officer Chief Operating Officer Finance Director Medical Director Chief Nurse Director of Workforce Head of PMO Plus Directorate Management
Executive Recovery Group Meetings	**Monthly**	Deputy Chief Executive Officer Chief Operating Officer Finance Directorate Medical Director Chief Nurse Director of Workforce Head of PMO

Workstreams

- Workstreams identified & agreed with the Executive Team
- Workstreams support the Trust's 'Change Delivery' priority
- Each Workstream governance agreed with Executive Sponsor, Clinical Lead, Workstream Lead, Finance Lead, HR Lead and PMO Lead
- Each Workstream categorise into themes
- All Themes included within Clinical & Corporate Directorate plans to support Trust wide priorities and realise recurrent efficiencies

ESP Identification

- Programme Management Office (PMO) working in partnership with the Clinical Directorates identify efficiency savings opportunities (ESP), linked directly to the workstream themes, directorate specific or external factors such as NHS Better Care, Better Value Indicators
- Each ESP is assessed in terms of internal and external dependencies, i.e. Capital . Estates , IT , Workforce and CCG
- Each ESP has KPIs and Financial Methodology agreed and held centrally on ESP database
- Each ESP is categorised in terms of Expense Category, Status (Opportunity, Fully Developed etc), New / Rollover, Risk Rating, Risk Adjusted Value and Implementation date if known.
- Each ESP is recorded directly onto ESP Database, providing a central repository of data and real time reporting function

Directorate Initiation Stage

- PMO support the directorates in building project plans, based upon an agreed template which includes agreed PMO milestones and adhere to a standard naming convention.
- Plan template includes all Workstream themes which will ensure Trust wide delivery of ESP objectives
- Directorate plans will be embedded into the overall Workstream plans, ensuring accurate and up to date progress tracking.
- The PID and plans will be equally supported with the Risks & Issues Log, KPIs and Quality Impact Assessment (QIA)
- PMO undertake Lessons Learned review against previous financial years workstreams
- PMO undertake a 'Peer Review' of all PIDs, Plans etc to ensure consistency and factor in any recommendations from the Lessons Learned review
- Clinical directorate PIDs, Plans, Risks & Issues Log, KPIs and QIA are reviewed and signed off by Clinical Director, Associate Director of Operations, Associate Director of Nursing and Executive Lead for the Clinical Directorate
- QIA Clinics are held with the Chief Nurse and Medical Director to allow Clinical Directors to present their directorates QIAs for formal sign off

Workstreams Initiation Stage

- Workstream Plans are produced from the Directorate plans based upon the naming convention
- PMO undertake Lessons Learned review against previous financial years workstreams
- PMO undertake a 'Peer Review' of all PIDs, Plans etc to ensure consistency and factor in any recommendations from the Lessons Learned review
- Workstream PIDs, Plans, Risks & Issues Log, KPIs and QIA are reviewed and signed off by Executive Sponsor, Clinical Lead, Workstream Lead, Finance Lead, HR Lead and PMO Lead
- QIA Clinics are held with the Chief Nurse and Medical Director to allow Clinical Lead and Workstream Lead to present their workstream QIAs for formal sign off

Updating Monthly Finances

- At month end, each Finance Manager will update the actual performance of each ESP within their Directorate
- The actuals are reviewed with the Directorates and PMO for review and sign off
- Monthly performance is provided to the Finance committee and Trust Board

Updating ESP Monthly Financial Performance and Phasing

Updating Monthly Actual Performance

Each month, as part of the month end process, each Finance Manager will review the actual financial performance of their Directorate ESP schemes. This should be shared with Directorate teams and PMO Lead for review and comment.	→ Finance Manager updates Finance database for Actual Financial Performance each month
Head of Financial Management reviews actual financial performance each month with the Finance Managers.	→ Head of Financial Management review
Head of Financial Management and Head of Programme Management Office review actual financial performance each month.	→ Head of Financial Management & Head of PMO review

After month end the reported actuals will be published to Directorates and the Trust Board.

Updating Forecast Performance

The Directorate Efficiency board meeting oversees current and forecast performance for ESPs → Finance Manager reports monthly performance and costs new efficiency ideas → A Change Form is approved by the Associate Director of Ops at the meeting. → Finance Managers validates and updates the financial phasing/ targets on the Finance Tracker

Purpose of meetings and Terms of reference

	Clinical Directorate Efficiency Board
Description	This Group has responsibility for delivering the Efficiency Savings Programme (ESP) for their Clinical Directorate. It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.
Objectives	1. This group will review progress against existing ESPs resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress; 2. Ensure project leads are provided the necessary support to deliver 3. Review the status of financial and quality risks and associated mitigating action plans; 4. Support and challenge Leads in delivering savings 5. Monitor and drive workstream delivery 6. Adjust workstream leads priorities/plans to support delivery
Chair	Associate Director of Operations and Clinical Director
Agenda	1. Review of previous actions 2. Progress update against existing ESPs 3. Resolution and Decisions on escalated issues/barriers to delivery 4. Update on new ESPs 5. Update on any outstanding QIA actions 6. Progress update on Recovery Plans, subject to directorates financial position 7. Review of Service Line Reporting Data 8. AOB
Attendance	• Associate Director of Operations / Associate Director of Nursing • Clinical Directors / Clinical Leads • General Managers / Assistant General Managers • Finance Manager, PMO Manager, Project Managers and others as required
Timing	• Monthly / Fortnightly, to be reviewed

Purpose of meetings and Terms of reference

	Workstream Steering Committee Meetings
Description	This Group has responsibility for delivering the Efficiency Savings Programme (ESP) for their Workstream. It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.
Objectives	1. Provide the strategic direction and oversight for the programme; 2. This group will resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress; 3. Ensure project leads are provided the necessary support to deliver 4. Review the status of financial and quality risks and associated mitigating action plans; 5. Support and challenge Workstream Leads in delivering savings 6. Monitor and drive workstream delivery 7. Adjust workstream leads priorities/plans to support delivery
Chair	Executive Sponsor
Agenda	1. Review of previous Actions 2. Overview of status Dashboard (progress vs. plan) 3. Resolution and Decisions on escalated issues/barriers to delivery 4. Executive Sponsor provides explanation of variance to plan of exceptional workstreams or initiatives 5. Review of schemes as appropriate 6. Documents for approval 7. Documents for decision 8. AOB
Attendance	• Executive Sponsor • Clinical Lead / Workstream Lead • Finance Lead / HR Lead • PMO Lead
Timing	• Monthly

Purpose of meetings and Terms of reference

	Executive Directorate Challenge Meetings
Description	This Group has responsibility to review/challenge progress to date against Directorate Plans to support their Efficiency Savings Programme (ESP). It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.
Objectives	1. Review / Challenge the status of plans and progress to date 2. This group will resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress 3. Ensure project leads are provided the necessary support to deliver 4. Review the status of financial and quality risks and associated mitigating action plans;
Chair	Chief Executive Officer
Agenda	1. Review of previous Actions 2. Resolution and Decisions on escalated issues/barriers to delivery 3. Review of schemes as appropriate 4. Documents for approval 5. Documents for decision 6. AOB
Attendance	• Chief Executive Officer • Deputy Chief Executive Officer • Chief Operating Officer / Finance Director • Medical Director / Chief Nurse • Director of Workforce • Head of PMO • Directorate Management and Finance Manager
Timing	• Fortnightly / Monthly subject to directorates financial Position

Purpose of meetings and Terms of reference

Executive Recovery Group Meetings

Description	This Group has responsibility to review/challenge progress to date against Workstreams Plans to support their Efficiency Savings Programme (ESP). It will review progress of the schemes in delivering the targeted benefits and financial results and resolve barriers to delivery. This will be at both at trust-wide level and the directorate level.
Objectives	1. Provide the strategic direction and oversight for the programme; 2. This group will resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress; 3. Ensure project leads are provided the necessary support to deliver 4. Review the status of financial and quality risks and associated mitigating action plans; 5. Support and challenge Workstream Leads in delivering savings 6. Monitor and drive workstream delivery 7. Adjust workstream leads priorities/plans to support delivery
Chair	Deputy Chief Executive Officer
Agenda	1. Review of previous Actions 2. Overview of Executive Workstream report and detailed workstream reports 3. Resolution and Decisions on escalated issues/barriers to delivery 4. Review of schemes as appropriate 5. Documents for approval 6. Documents for decision 7. AOB
Attendance	• Deputy Chief Executive Officer • Chief Operating Officer / Finance Director • Medical Director / Chief Nurse • Director of Workforce • Head of PMO • Directorate Management
Timing	• Fortnightly / Monthly subject to financial Position

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-14	**Approval of the OBC for additional Radiotherapy LinAc bunker capacity at TWH**	**Director of Finance**

Summary / Key points

The outline business case (OBC) for the additional Radiotherapy Linear Accelerator (LinAc) bunker capacity at Tunbridge Wells Hospital was reviewed at the Finance Committee on 22nd February 2016 and support was given ("The Finance Committee agreed to recommend that the Trust Board give its approval to proceed to formal review by the TDA, but that if external funding was not forthcoming, the project would need to be reconsidered… KR queried whether the Committee was recommending that Commissioner support be obtained before the OBC was submitted to the Trust Board. AJ clarified that the Trust Board could be asked to approve the OBC subject to Commissioner support being obtained"). Since that time, the OBC has undergone refinements and is now submitted to the Board for approval.

If approved, the OBC will be submitted to NHS Improvement (of which the TDA is now a part). The full business case (FBC) will then be developed and submitted to the Trust Board for approval in due course.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee (

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

For approval (prior to final submission to NHS Improvement)

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

Maidstone and Tunbridge Wells NHS Trust

OUTLINE BUSINESS CASE

MTW Additional Radiotherapy Linac Bunker Capacity Project

Maidstone and Tunbridge Wells NHS Trust

Outline Business Case

MTW Additional Radiotherapy Linac Bunker Capacity Project

Issue date	22/04/2016 Post Finance Committee re-submission with adjusted timeframe.
Department	Kent Oncology Centre
Directorate	Cancer & Haematology
Author	S Duck, N Baber, S Smith, P McGinley and K Vaughan
Clinical lead	S Beesley
Executive Sponsor	S Orpin
ID reference	277

Approved by (see Appendix T)	Name	Signature	Date
Director of Medical Physics	S. Duck		
Cancer and Haematology General Manager	D Fitzgerald		
Head of Costing and SLR	P McGinley		
Cancer and Haematology Clinical Director	S Beesley		
Executive sponsor	S Orpin		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	J Rooke		
Director of Health Informatics	D Jarrett		
Director of Workforce	R Hayden		
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group	S Doyle		10.01.2016
Trust Management Executive			
Finance Committee	S Doyle		22.02.2016
Trust Board			

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
SOC	28.09.15	First Issue.	Stephen Duck
OBC	21.12.15	For IAG Approval, proceeded to OBC.	Stephen Duck
OBC	22.01.16	Changes implemented as requested by the IAG; predominantly economic and financial cases.	Stephen Duck
OBC	16.02.16	Changes from initial Finance Committee feedback	Stephen Duck
OBC	20.04.16	Changes made to finance and project plan due to approval schedule changes, changes in PUBSEC costs, location adjustment and PSCP suggestion of project plan alteration.	Sarah Smith Patrick McGinley Kevin Vaughan

Pre- submission checklist

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

Contents

Tables

Glossary of Terms

Abbreviation	Full Title / Description
CIP / CIPs	Cost Improvement Programme(s)
DH / DoH	Department of Health
EKHUFT	East Kent Hospitals University Foundation Trust
FBC	Full Business Case
GMP	Guaranteed Maximum Price
HoTs	Heads of Terms
KCH	Kent and Canterbury Hospital
KOC	Kent Oncology Centre
LAT	Local Area Team (of NHS England)
Linac	Linear Accelerator
LTFM	Long Term Financial Model
MH	Maidstone Hospital
MTW	Maidstone and Tunbridge Wells NHS Trust
NPV	Net Present Value
NRAG	National Radiotherapy Advisory Group
OBC	Outline Business Case
P21+	Procure 21+ Framework
PDC	Public Dividend Capital
PbR	Payment by Results
PFI	Private Finance Initiative
PP	Private Patient
PSCP	Principal Supply Chain Partner (contractor under P21+ Framework)
SLA	Service Level Agreement
SOC	Strategic Outline Case
TWH	The Tunbridge Wells Hospital at Pembury

1. The Executive Summary

1.1. Introduction

The purpose of this OBC is to establish the preferred option to develop the radiotherapy service provided by the Kent Oncology Centre, Maidstone and Tunbridge Wells (MTW) NHS Trust, and to ask the Board of Directors of MTW NHS Trust and subsequently the NHS Trust Development Authority to support the investment. Through the development of this case, the project team have demonstrated that the best value for money and preferred strategic option is for the Kent Oncology Centre to develop a satellite radiotherapy unit located on the Tunbridge Wells Hospital at Pembury site. The satellite will have 2 bunkers and initially one replacement linac; the design will incorporate an option to add a 3rd bunker if future demand requires it.

The amended planned construction completion date is 31st March 2018 with a view of the official opening day being 2nd April 2018 - post medical physics commissioning of the replacement linac.

The investment aims to:

- Provide continuity of the radiotherapy service whilst improving access to specialist techniques for patients living in Kent, Medway and parts of East Sussex,
- Provide radiotherapy services at a location which is as close to home for as many patients as possible,
- Improve efficiency, cost effectiveness and maximise income from the radiotherapy service in order to maximise resources available to meet needs,

The case is primarily focussed on meeting the needs of the Trust's current catchment population while giving the service the flexibility to respond to an increase in demand from the East Sussex catchment. An analysis of accessibility, travel time and patient choice has shown that a minimum of 402,991 people in the scope population would benefit from a linac situated at the Tunbridge Wells site.

'Achieving world-class cancer outcomes, a strategy for England 2015-2020' has recommended faster diagnostic tests for suspected cancer to reduce patients reaching advanced stages before diagnosis. The achievement of this strategy may significantly increase demand of curative radiotherapy at MTW as currently some areas of Kent and East Sussex unfortunately have a low percentage of patients being diagnosed early.

The potential disruptive innovation of local radiotherapy services in Kent and East Sussex by private providers is fast becoming apparent. The recent acquisition of Cancer Partners UK (radiotherapy and chemotherapy treatment centre at Kings Hill) by Genesis Care, Australia's largest provider of Radiotherapy services, is motive to recognise that strategic positioning of a satellite service at Tunbridge Wells will help to ensure that MTW continues to be the primary provider of radiotherapy services for Kent with extended scope into East Sussex.

This business case will also respond to the uncertainty over the future of the Kent & Canterbury Hospital site that hosts the Kent Oncology Centre at Canterbury.

The capital cost of the preferred option is estimated at £7,463,272 with a thirty year NPV of £1,602,777

It has been suggested by the preferred PSCP that the project cost will come within the proposed build and infrastructure envelope. Approval to release funding of £550K will be desirable as soon as possible so that the PSCP appointment can be made to progress the design phase and subsequent FBC finalisation (see 1.5 for summary). Once appointed this will incur a design cost to the Trust pre-finance release of approximately £550,000. If this payment is not possible before 1st May 2016, the project will run behind plan which will have a further impact on the radiotherapy linac replacement programme and inflation costs. In addition, there is a likelihood of a hasty design phase which, of we have been advised, will increase the cost of the General Maximum Price (GMP) as the cost risk will be higher for the Principle Supply Chain Partner (PSCP).

1.2. The considered investment options

The OBC, approved by the MTW Finance Committee in February 2016, showed that additional decant bunkers are required within the Kent Oncology Centre to meet the investment aims described above by avoiding a loss in capacity when a treatment unit is being replaced (a process that can take between 7-12 months).The agreed options for meeting the investment aims were:

1. Do minimum,
2. A new unit at TWH consisting of 2 bunkers with associated clinic space,
3. 2 additional bunkers at MH with associated clinic space, and
4. 1 additional bunker at MH with associated clinic space.

1.3. Costing and Appraisal Summary

Option	Detail	Year	Revenue cost £ (-ve = cost)	Income £ (= increase)	Net Loss/ Surplus £ (-ve = loss)	Build and infrastructure costs £ (-ve = cost)	NPV over 30 Years £ (-ve = net present cost)	Benefits Ranking 1st highest	Risk Ranking 1st Lowest
1a	Do minimum extended working day		-88,700	-160,760	-249,460	0	-4,840,422	4th	4th
1b	Do minimum weekend-lite working		-595,23,4	-160,760	-755,994	0	-14,669,005	4th	4th
2	Two new bunkers at TWH	Year 1	0	0	0	-7,463,272	1,602,777	1st	1st
		Year 2	-765,686	1,224,330	458,644				
		Year 3	-765,686	1,224,330	458,644				
		Year 4	-765,686	1,224,330	458,644				
3	Two new bunkers at MH	Year 1	0	0	0	-10,750,659	-172,378	2nd	2nd
		Year 2	-182,566	600,952	418,386				
		Year 3	-182,566	600,952	418,386				
		Year 4	-182,566	600,952	418,386				
4	One new bunker at MH	Year 1	0	0	0	-9,301,147	-50,429	3rd	2nd
		Year 2	-147,519	600,952	453,433				
		Year 3	-147,519	600,952	453,433				
		Year 4	-147,519	600,952	453,433				

Options Appraisal summarised in the Economic Case 2.3

Options 3 and 4 require a new electrical substation at Maidstone Hospital due to limitations of the electrical supply costing £2,232,052 (excl. VAT) included in the above costs (see Appendix S); however the strategic benefits of option 2 significantly outweigh options 3 and 4. It is highly recommended to consider the innovative option 2 which will help to cement the market share of radiotherapy services at MTW. It has been deemed that Options 1a and 1b are unsustainable; the analysis of this is detailed in the economic case 2.3.2 – 2.3.3.

- Option 1a is unsustainable in the medium and long term due to staff retention issues and is critically dependent on the current staff working a split shift and on overworking the ageing linacs.
- Option 1b has high revenue costs in relation to income and when discounted over 30 years produces the highest negative NPV. The staffing model is for a 7 day extended day.
- Option 2 is the preferred option both strategically and economically
- Option 3 and 4 are options which may address capacity but do not address long term strategy and have a lower NPV. There is also the question of available space for bunkers at Maidstone due to the helipad development.
- Option 4 has only one bunker in comparison to the preferred Option 2 and Option 3.

Currently the Trust receives c £549k per annum in private radiotherapy income. This income is at risk; the breakdown of how this affects the overall income is detailed within the options appraisal (tables 12a – 15).

1.4. Critical dates for managing capacity

The primary key date by which the additional capacity would have needed to be completed and ready for the installation of a replacement linac was February 2017. As the construction completion time for this OBC is April 2018, the linac replacement program is currently behind schedule. If the KOC is to avoid a reduction in capacity during the replacement program, the construction of the TWH linac bunker should commence as soon as the FBC is agreed by the Trust Board, TDA and Local Planning Office.

A delay with the approval of the FBC and subsequent construction of the TWH bunkers will require the program to continue with the replacement of a linac at Maidstone. This will lead to a radiotherapy capacity reduction as there is currently no spare bunker.

1.5. Critical finance required prior to completion of the full business case:

The project has received £50K for architects drawings and planning permission which was agreed by the Trust in December 2015; preparation of planning approval in progress. The PSCP were appointed on 15th March 2016 to commence design to 1:200 and planning permission submission only. The schedule of accommodation is shown in Appendix S.

The following require finance is required by 1st May 2016 in order to progress to the completion of the full business case to comply with TDA requirements:

- £550K for pre-construction design costs – required as soon as possible following OBC approval by the Trust Board (1st May 2016). This will allow for:
  - Estates Team Costs for Design prior to FBC completion as per TDA checklist.
  - PSCP Costs for Design prior to FBC completion as per TDA Checklist including:
    - Full Technical drawings including healthcare planning
    - Full design of M&E
    - Ground Reports
    - Ventilation Calculations
    - Radiation Shielding
    - Planning Permission
  - Oncology Project Management Expenses.

1.6. Structure and content of the document

The Outline Business Case has been prepared using the agreed standards and format from HM Treasury for Business Cases, as set out in the HM Treasury Green Book. The approved format is the Five Case Model, which comprises the following key components:

Strategic Case	The strategic case sets out the case for change, together with the supporting investment objectives for the scheme
The Economic Case	The economic case demonstrates that the organisation has selected the most economically advantageous offer, which best meets the existing and future needs of the service and optimises value for money (VFM)
The Financial Case	The financial case confirms funding arrangements, affordability and the effect on the balance sheet of the organisation
The Commercial Case	The commercial case sets out the content of the proposed deal
The Management Case	The management case details the plans for the successful delivery of the scheme to cost, time and quality.

The Strategic Case

1.7. Introduction

As set out by the HM Treasury, the purpose of the Strategic Case is to demonstrate that the proposed investment provides strategic fit with the local, regional and national priorities. The Strategic Case should set out robust evidence to support case for change, followed by clear Investment objectives and scope of the project.

1.8. Organisational overview

MTW manages the Kent Oncology Centre based at Maidstone and Canterbury providing specialised cancer services for the adult population in Kent, Medway and parts of East Sussex.

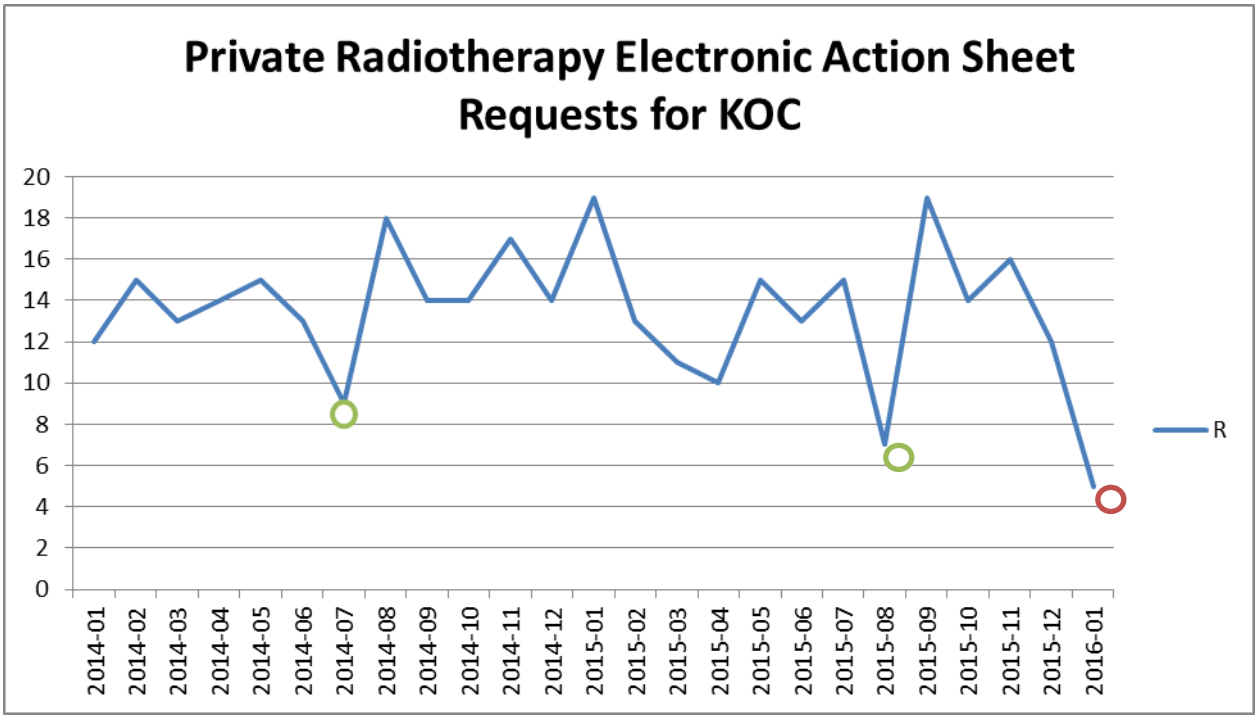
The main function of the KOC is to provide both NHS and Private Patients with Oncology Outpatient appointments and Chemotherapy and Radiotherapy treatments. The KOC has Service Level Agreements to provide Oncology Consultant led services with East Kent, Medway, Dartford and Gravesham and East Sussex NHS Trusts. The business model is for patients to have outpatient appointments and Chemotherapy services at their local hospital and travel to Canterbury KOC or Maidstone KOC for radiotherapy treatments.

The radiotherapy department at MH is owned and operated by MTW in a relatively new, purpose built, facility housing 6 treatment units. At Canterbury, the KOC is hosted by East Kent hospitals University Foundation Trust at their Kent & Canterbury site with radiotherapy provided by 3 treatment units owned and operated by MTW. The KOC has primarily been the sole provider of radiotherapy services in Kent; however in December 2015, a Private provider opened a facility offering outpatient appointments, chemotherapy and radiotherapy treatments in Kings Hill. As this is part of MTW's existing catchment area it is anticipated that this will have an adverse financial impact upon MTW through reduced private patient income.

The strategic aim of the case is to ensure the maximum capacity availability for the rolling Linac replacement programme, protection of private patient radiotherapy and outpatient income, and provision of local radiotherapy and oncology outpatient facilities in line with NHS five Year Forward View. Additionally the Trust is planning to be responsive to the uncertainty of the Kent & Canterbury Hospital site, as well as increasing oncology clinic room space. All of these are to ensure that KOC remains the primary radiotherapy service provider in Kent.

Early evidence of this impact is shown in Table 1 below, which records the volume of Private Patients from the Electronic Action Sheet on KOMS. Dips in activity are usually associated with August each year. December's figures were the lowest recorded in the last 2 years. This highlights the real threat to the Private Patient Income stream.

Table 1 Private Patient Requests 2014-2015



Typical summer dip with subsequent peak

Atypical but anticipated decline in referrals post Kings Hill site opening with absent post-Christmas peak.

In Jan 15, KOC received 19 requests for private radiotherapy – this has reduced to 5 in Jan 16 - a 74% reduction.

The KOC is CHKS accredited which includes certification to the ISO 9001:2008 quality standard. Accreditation consists of meeting a number of standard measures relating to customer focus, business planning, governance processes, competencies, service developments and internal audits. Evidence for many of these measures is required by CQC compliance inspections.

The KOC consists of a number of departments which include: Radiotherapy, Medical Physics (Health Physics, Engineering, Radiotherapy Physics and Computer Science), Chemotherapy, Cancer Data Management, Oncology Outpatient Services (Administrative support), Palliative Care and Clinical Trials.

MTW oncology outpatient appointments are in excess of 30,000 outpatient attendances per year. With the existing radiotherapy facilities at Maidstone and at Canterbury, the current catchment area of the Centre covers a population of approximately 1.9M

Table 2 The population served by MTW's KOC

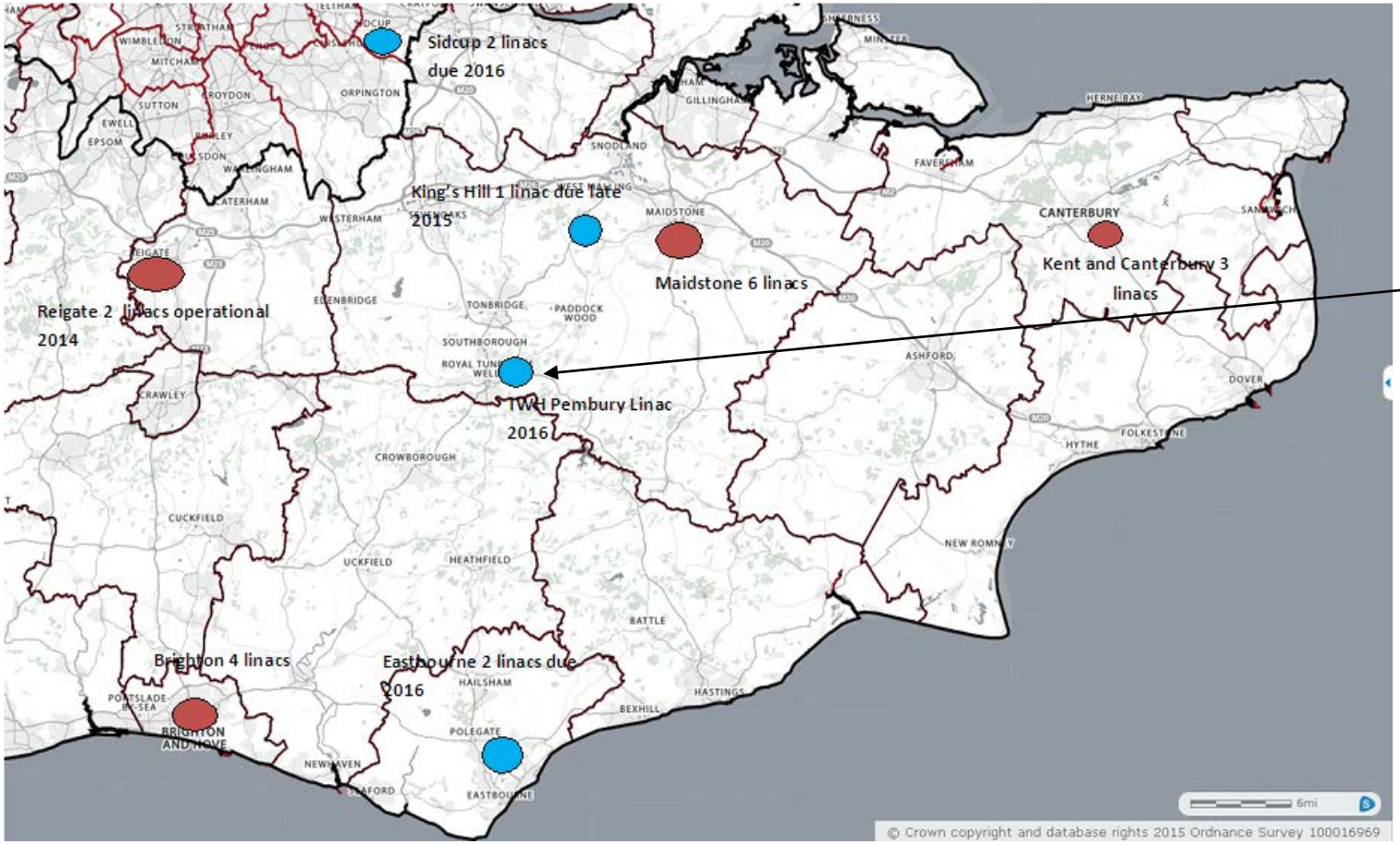
District	Population	Percentage of this population served by MTW's KOC	Population covered
Ashford	124	100%	124
Canterbury	156	100%	156
Dartford	100	97%	97
Dover	109	100%	109
Gravesham	104	100%	104
Maidstone	162	100%	162
Sevenoaks	118	100%	118
Shepway	103	100%	103
Swale	144	100%	144
Thanet	137	100%	137
Tonbridge & Malling	127	100%	127
Tunbridge Wells	114	100%	114
Eastbourne	99	13%	13
Hastings	89	82%	73
Lewes	103	0%	0
Rother	94	77%	72
Wealden	147	27%	40
Medway	271	78%	211
Total	2301K	82%	1889k

1.8.1. Local Map

The following map shows the location of radiotherapy units currently operating and planned radiotherapy units in the surrounding region.

Operational radiotherapy unit

Planned radiotherapy unit



1.8.2. National Policy Context

Key national policies promote the development of radiotherapy services in order to resolve inadequate patient access and inequitable capacity for radiotherapy for the UK population. The documents highlight the importance of delivering radiotherapy as part of an integrated cancer pathway through a network of units adjacent to appropriate clinical services, plus alignment with a dedicated cancer centre. National policy context includes the following:

Table 3 National policy context for radiotherapy service

National Publication	Key themes and context for case
NHS Five Year Forward View (October 2014)	The NHS Five Year Forward View strategy requires a more uniform and better treatment and care for patients with cancer: 'A future that see far more care delivered locally but with some services in specialist centres where that clearly produces better results'. (pg9) 'Some of the Improvements we need over the next five years are more specific to England. In faster diagnosis and more uniform treatment for cancer'. (pg7) 'Improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer'. (pg37)
White Paper: The New Era of Thinking and Practice in Change and Transformation. A Call to Action for Leaders of Health and Care. NHS Improving Quality. (July 2014)	'In an increasingly disruptive era, organisations are finding that cost efficiencies can happen exponentially and that technology cycles are quicker than the corporate decision cycles, threatening existing business models'. (pg 14)
Achieving World-Class Cancer Outcomes. A Strategy for England 2015-2020 The Independent Cancer Taskforce (July 2015) *(Membership including Professor Sir Mike Richards Chief inspector of Hospitals CQC and Sean Duffy, National Clinical Director for Cancer, NHS England)*	Strategic Priorities: • Drive a national ambition to achieve earlier diagnosis: This will require a shift towards faster and less restrictive investigative testing. • Make the necessary investments required to deliver a modern high quality service, including implementing a rolling plan to replace linear accelerators (linacs) as they reach 10-year life and to upgrade existing linacs when they reach 5-6 years (pg. 6) 'Diagnosing substantially more cancers earlier could be transformative in terms of improving survival reducing mortality and improving quality of life. Earlier diagnosis makes it more likely that patients will receive treatments such as surgery and radiotherapy which contribute to the majority of cases where cancer is cured.' (Pg27) Recommendation 29: From autumn 2015, NHS England should commence a rolling programme of replacements for LINACs as they reach 10-year life, as well as technology upgrades to all LINACs in their 5th year. All LINACs that are already ten years old should be replaced by the end of 2016 at the latest.(pg. 37)
Radiotherapy Services in England (Department of Health and The National Radiotherapy Advisory Group, 2012	Recommendations for: The increase of radiotherapy capacity across England to meet rising demand in order to deliver minimum of 55,206 radiotherapy attendances per million of population by 2016; and 60,057 by 2020.

National Publication	Key themes and context for case
	The implementation of new forms of radiotherapy, including Intensity Modulated Radiotherapy (IMRT), and four-dimensional Image Guided Radiotherapy (3D/4D IGRT) to a higher proportion of patients. Additional radiotherapy capacity is achieved through locally-based linked units closely aligned to an existing cancer centre. This is to promote local access to services, but also ensure consistency of integrated cancer treatment pathways. To improve outcomes from radiotherapy, there must be equitable access to high quality, safe and timely radiotherapy care.
Recommendations for achieving a world-class radiotherapy services in the UK (The Tavistock Institute, 2014)	At least 52% of cancer patients should receive radiotherapy as part of their treatment. There is significant variation in access to radiotherapy across England due to inequitable location of radiotherapy facilities.
NHS Standard Contract for Radiotherapy (all ages)	Describes aims and objectives and required specifications for radiotherapy services
Commissioning Intentions 2015/16 for Prescribed Specialised Services. NHS England.	For NHS England and its providers, collaborating to adopt the most efficient service models through delivering change is a key priority.
Vision for Radiotherapy, 2014-2024. NHS England in partnership with Cancer Research UK.	NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments The report emphasises the importance of local access to radiotherapy and acknowledges that radiotherapy is critical to improving patient outcomes. Radiotherapy service developments should take account of technological advances and innovations to deliver standardised radiotherapy pathways in order to deliver the same standard of treatment to patients regardless of where they live. The report places further emphasis on the need to deliver local treatments through a network of linked radiotherapy units.
NHS Outcomes Framework (Department of Health, 2015/16)	As stated in the NHS Standard contract for radiotherapy: The appropriate delivery of radiotherapy treatments to patients with cancer will ensure that the outcomes from treatment will meet the requirements of the 5 domains of the NHS Outcomes Framework. Domain 1 Preventing people from dying prematurely; Domain 2 Enhancing quality of life for people with long-term conditions; Domain 3 Helping people to recover from episodes of ill health or following injury; Domain 4 Ensuring that people have a positive experience of care; and Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.
Hard Truths. The Journey to Putting Patients First. Volume One of the government response to the Mid Staffordshire NHS	This crucial document suggests patient consultation throughout the process and to also consider safe staff working levels.

National Publication	Key themes and context for case
Foundation Trust Public Enquiry. (Department of Health, January 2014)	Making a reality of compassionate, patient-centred care and making people partners in their own care; - Building a culture committed to patient safety; and - Supporting staff to care through staff wellbeing, values based recruitment and safe staffing. (Pg. 29) NHS Values: Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. (Pg. 31)
Radiotherapy: developing a world class service for England Report to Ministers from National Radiotherapy Advisory Group, 26 February 2007.	Participants at a patient workshop about choice indicated that up to 45 minutes travelling time was acceptable (although less would be preferable). No more than 45 minutes should therefore be seen as good practice although it is recognised that this is not achievable in all areas. (29)

1.8.3. Commissioning context

Radiotherapy services are commissioned directly by NHS England Specialised Commissioning on an annual basis. Each commissioned service has a service specification which defines what NHS England expects organisations to comply with. Providers must offer evidence based care and ensure that resources are used in a safe and effective manner. NHSE is currently managing a budget deficit due to the growth in patient numbers requiring treatment. As a result there is no funding for any new technologies unless it costs less than the current treatment or is cost neutral. NHSE's Commissioning intentions acknowledge that around 40% of people with cancer will have radiotherapy and that evidence suggests this should be about 50%, resulting in a gap in unmet patient demand.

NHSE have clearly stated that providers should offer patients care close to home, in a safe, effective and efficient manner. Therefore any expansion of services, relocation of existing resources as long as it met with this criterion would not be adversely viewed by NHSE.

This business case will also respond to the uncertainty over the future of the Kent & Canterbury Hospital site that hosts the Kent Oncology Centre at Canterbury.

1.8.4. Trust Strategy Context

Trust Policy/Strategy	Key themes and context for case
MTW Vision, Mission and Values.	Mission 'Our purpose is to provide safe, compassionate and sustainable health services'. Vision To provide the highest, consistent, quality care to our patients, whether in or outside hospital setting. Objectives 1 To transform the way we deliver services so that they meet the needs of patients' 2 To deliver services that is clinically viable and financially sustainable'

	3 To actively work in partnership to develop a joint approach to future local health care provision'
MTW Clinical Strategy	Strategically, Radiotherapy is now seen as able to be available, not just in centres but also more locally. We already provide a service in Canterbury; this document assesses the option to provide a bunker for a LINAC at TWH, thus consolidating our market position in East Sussex. Further options would be subject to demand, affordability and commissioner support.
MTW Quality Strategy	Changing models of care: Increasingly patients and those who commission services on their behalf are asking us to deliver care closer to their home, our challenge is to work with local partners in the NHS, social care, voluntary sector and the private sector to develop a whole system approach to co-design new models of care Our strategic objectives for quality are: 1. To ensure that quality drives the Trust's clinical strategy. 2. To ensure all staff within the organisation are aware of potential risks to quality and that they also take a pro-active part in improving it. 3. For the Board and Trust Management Executive to have and demonstrate the necessary leadership, skills and knowledge to ensure delivery of the quality agenda and promote a quality focussed culture throughout the Trust. 4. For all staff to have clear roles, responsibilities and accountabilities in relation to quality governance. 5. For the Trust to be able to demonstrate effective engagement of patients, staff and other key stakeholders on quality. 6. To have clear, well defined and understood processes for escalating and resolving issues and managing quality performance. 7. To ensure appropriate quality information is being analysed and challenged to drive improvement. 8. Regularly review and audit the robustness of information on quality. 9. To be transparent in all aspects of quality.

1.8.5. National radiotherapy contract and specification

The NHS standard contract for radiotherapy includes expected aims and objectives of radiotherapy services and the service specification for the radiotherapy contract. The services proposed under this SOC will comply with the aims objectives and specification.

Radiotherapy services will be developed over time to ensure that:

- Safety: Radiotherapy is delivered according to national standards
- Uptake: 52% of all cancer patients should be offered radiotherapy at some point in their pathway.
- Access: Local calculations based on Malthus predictions should be used to increase the number of attendances per million population by 2016. Up to 47,000 attendances per million population.

- Access: Earlier access to radiotherapy should be demonstrated by greater use of radical (rather than palliative) radiotherapy

- Capacity: An additional 13% capacity is identified as available to meet fluctuations in demand and technical development requirements. This is essential to be able to meet waiting times targets.

- Wait for First Treatment: Radiotherapy: 62 day from urgent referral to treatment and 31-day wait from decision to treat to treatment for all cancers and second or subsequent treatment: It is also expected that departments meet the Joint Collegiate Council for Oncology (JCCO) standards for radiotherapy treatment which should be regularly monitored by each service.

The specification for radiotherapy within the NHS standard contract requires that:

- Accurate treatment is delivered in the context of a safety-conscious culture.
- Treatment is delivered within an evidence based approach and according to locally agreed protocols.
- Strong clinical and operational governance arrangements exist.
- All patients with cancer who require radiotherapy (including urgent and palliative radiotherapy) as part of their treatment receive this in a timely manner.
- There is access to modern radiotherapy techniques, e.g. Intensity Modulated Radiotherapy (IMRT) and Image Guided Radiotherapy (IGRT) which together form the basis of 4D adaptive radiotherapy which should be the standard of care for many patients. Services not able to offer this will be expected to have plans in place to move to routine IGRT over the next 12 months.
- Providers should ensure linacs are in operation for a maximum of 10 years.
- Appropriate verification systems are routinely used to ensure accuracy and correct alignment (e.g. imaging and in-vivo dosimetry)
- The radiotherapy capacity is adequate to meet the current demand, to improve cure rates prevent and relieve symptoms, and improve patients' experience by minimising any long-term side effects of treatment
- Information included in the mandated national radiotherapy dataset (RTDS) must be collected and submitted according to national guidelines.
- The department has robust mechanisms in place for monitoring treatment outcomes
- The provider must participate in the national peer review programme for Radiotherapy and audits should be produced and acted upon.
- Where any radiotherapy is used concurrently with other treatments (such as brachytherapy or chemotherapy), it should be integrated appropriately and scheduled to meet the patients' needs.
- Radiotherapy is accessible to all patients with cancer who require it regardless of gender, age, ethnicity, disability, religion or belief, sexual orientation or any other non-medical characteristics.

1.8.6. The specification in relation to satellite units.

The specification for radiotherapy within the NHS standard contract recognises the importance of reducing patient travel times and sets out specific requirements in relation to satellite radiotherapy units, which are that:

- The service, if operating a satellite service type model, will be required to set up and maintain formal links with a designated Cancer Centre and radiotherapy department which should include governance

arrangements, staff training and development, the use and role of networked technology, and clinical cross-cover arrangements.

- The service should be set up to support compliance with the NICE Improving Outcomes Guidance for all cancer services, and fulfil membership of the relevant multi-disciplinary teams as required.
- There must be protocols in place for handover of responsibility between clinicians to ensure smooth transition in support for patients throughout the cancer pathway; protocols must be network wide and easily accessible to all healthcare staff involved in the delivery of Radiotherapy
- Radiotherapy staff will be expected to meet the requirement for attendance at MDTs.
- Subcontracting arrangements should not be entered into without the agreement of the commissioners. There should be clear and formal agreements between the provider and any sub-contractor in the form of a service level agreement, detailing the part played by the sub-contractor in the radiotherapy service, and the arrangements for clinical accountability and responsibility between the two parties.
- All work processes should be protocol led and clearly defined both within the provider and with any other service provider. Any deviation from these protocols will be clearly documented and investigated with regular reviews, and where appropriate updated. Any satellite unit must demonstrate compliance with the clinical governance and leadership arrangements of the designated Cancer Centre.

1.9. Objectives of the proposed investment

- ❖ Provide continuity of the radiotherapy service whilst improving access to specialist techniques for patients living in Kent, Medway and parts of East Sussex,

- ❖ Provide radiotherapy services at a location which is as close to home for as many patients as possible,

- ❖ Improve efficiency, cost effectiveness and maximise income from the radiotherapy service in order to maximise resources available to meet needs,

1.10. The current situation

The table below (table 3) lists the current location of the treatment units at the Kent Oncology Centre and indicates whether they meet the NHS specification for maximum age (in 2015) and the ability to deliver 4D Adaptive Radiotherapy.

The table demonstrates that the Kent Oncology Centre has 6 linacs that need replacing over the next 2 years if the Centre is to remain compliant with the NHS specification.

Given the significant capital investment that a replacement of 6 linacs would represent (circa £14 million) and limitations on the capital program, the following linac replacement program (see section 2.4.1 below) has been proposed which spreads the 6 linacs out over 5 years.

Table 4 Current status of the treatment units at the Kent Oncology Centre.

Location	Equipment	Within 10y Age (2015)	4D adaptive capability	Replacement due date	Comments
Canterbury	LA1C	Yes	Yes	2020	
Canterbury	LA2C	Yes	Yes	2025	
Canterbury	LA3C	No	No	2014	
Maidstone	LA1M	Yes	No	2016	
Maidstone	LA2M	Yes	Yes	2019	
Maidstone	LA3M	Yes	No	2017	
Maidstone	LA4M	No	No	2015	
Maidstone	LA5M	Yes	Yes	2016	
Maidstone	LA6M	Yes	Yes	2016	Upgraded to 4D adaptive in 2013 under government "Innovations" program.

A typical radiotherapy treatment unit

1.10.1. Replacement programmes

The table below (table 4) outlines the current proposed linac replacement program which reduces the impact on the Trust's capital program by extending the age of the linacs to 12-14 years which is significantly beyond the 10 years recommended in the NHS specification.

Table 5 Linac replacement programme

Site	Equipment	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Age replaced	Note
Canterbury	LA1											1
Canterbury	LA2	R									-	2
Canterbury	LA3			R*							13	3
Canterbury	CT sim										-	4
Canterbury	Ortho-volt.										-	5
Maidstone	LA1						R				13	6
Maidstone	LA2									R	12	7
Maidstone	LA3								R		14	8
Maidstone	LA4				R						12	9
Maidstone	LA5					R					12	10
Maidstone	LA6							R			14	11
Maidstone	CT sim		R									12
Maidstone	Shared CT										-	13
Tunbridge Wells	Build bunker/s			✓								14

Notes relating to linac replacement programme

Note 1: Canterbury LA1 10 years old in 2020
Note 2: Replacement was delayed because of shielding constraints and estates issues at EKHUFT. This has now been resolved. The treatment unit was used clinically from 23rd November 2015
*Note 3: LA3 moved back from 14/15 as a consequence of LA2 delay and now delayed due to discussions over the future of the KCH site.
Note 4: Replaced in 2013
Note 5: Will be removed from service in 2015 - no replacement planned.
Note 6: 10 years old in 2016/17
Note 7: 10 years old in 2019/20
Note 8: 10 years old in 2017/18
Note 9: 10 years old in 2015/16
Note 10: Delayed, due to knock-on from Canterbury. 10 years old 2016/17
Note 11: Extended replacement from 2016 due to Innovations upgrade.
Note 12: Limited impact on the commissioning of the linear accelerators expected. Not currently in the capital plan. Shared Radiotherapy/Radiology scanner will be available to maintain service during extended breakdown.
Note 13: Installed 2013/14.

Note 14: Option for bunker development which would allow the replacement program at Maidstone to continue whilst maintaining a full complement of treatment units in west Kent.

The table shows that the KOC will still need to commission at least one linac every year out to 2023 and beyond if it is to maintain the ages of the linacs to less than around 13 years (30% beyond the recommended age).

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

- There is no bunker in which to house a replacement unit (at Maidstone or Canterbury) -which means that an existing linac would need to be removed from clinical use every year for the foreseeable future,
- There is currently significant uncertainty within EKHUFT and the local healthcare economy regarding the future of the Kent & Canterbury site that houses the KOC at Canterbury – closure of the KCH site appears to be a real possibility.
- Additional investment is required on the KOC at Canterbury site because the KCH is not designed to provide the infrastructure and shielding requirements of modern linear accelerator and the fabric of the building is also deteriorating, with water leaks throughout the department becoming common.
- Each linac replacement is time-consuming, taking around 7-12 months to complete depending on the complexities of the estate (and involves removing the existing linac, upgrading the bunker , installing and commissioning the replacement unit and training the staff),
- There is very little slack in the program which means that a delay in one replacement has a knock-on effect on the whole replacement program, pushing the age of the linacs ever upwards (as has already been exhibited by the delay to LA2 at Canterbury – see notes 2,3 and 10 above).

It may be necessary, therefore, to consider future demand and options for providing spare bunkers in which to house replacement linacs, along with opportunities to expedite the program, to ensure that the replacement program is not delayed further.

1.11. Demand and capacity projections

1.11.1. Predicting demand for radiotherapy attendances

The starting point for assessment of demand is the demand forecasts made jointly by the DH and NRAG in the report 'Radiotherapy Services in England' (2012). The Trust has used these in conjunction with a tool called the Malthus Programme.

The Malthus programme is the tool recommended by the National Cancer Action Team (NCAT) for modelling radiotherapy demand in England. The model uses information on treatment schedules obtained from published evidence and by consensus amongst Clinical Oncologists. This information is combined with cancer incidence statistics at the local commissioner level from the National Cancer Intelligence Network.

The joint DH and NRAG demand model calculates that there will be a need for a significant increase in the demand for radiotherapy up to 2020, and it makes broad recommendations for sufficient supply to meet the minimum demand of 55,206 radiotherapy attendances per one million of population (PMP) by 2016; and 60,057 attendances PMP by

2020.The Malthus model includes the more defined local attendance (PMP) rates for the population served by KOC, adjusted for the local age and disease profile of our population.

1.11.2. Current population served by the KOC

The current population served by the KOC is just over 1.9 million (M)
This population comprised in 2014/15 of patients, by CCG of the patient's home address, as follows:

Table 6 KOC catchment population and activity by CCG of patient's home address. 2014/15

CCG	Total CCG Population (ONS) (K)	RT attendances delivered by KOC to this population (2014/15)	% of CCG pop's needs served by KOC	Pop. served (K)	% of KOC activity
West Kent CCG	467	16245	100%	467	24%
Dartford Gravesham and Swanley CCG	252	8477	100%	252	13%
Canterbury and Coastal CCG	202	7615	100%	202	11%
Medway CCG	271	7372	78%	211	11%
South Kent Coast CCG	204	7273	100%	204	11%
Thanet CCG	137	4959	100%	137	7%
Hastings and Rother CCG	182	4549	72%	130	7%
Ashford CCG	122	3975	100%	122	6%
Swale CCG	110	3733	100%	110	6%
High Weald Lewes and Havens CCG	169	1525	26%	44	2%
Bexley CCG	237	616	7%	18	1%
Eastbourne Hailsham and Seaford CCG	183	500	8%	14	1%
Bromley CCG	318	280	3%	8	<1%
North Horsham and Mid Sussex CCG	225	108	1%	3	<1%
Thurrock CCG	161	56	1%	2	<1%
Greenwich CCG	264	32	0%	1	<1%
Other	-	46	-	1	<1%
Total	3,729	67,469	-	1,928	100%

The Malthus model was run with National Cancer Action Team validated decision trees. The population used was as described above. The Malthus model gives the following results for the catchment population covered by MTW's KOC.

Table 7 Required radiotherapy attendances for the MTW KOC catchment population using the DH model

	2015	2016	2017	2018	2019	2020
Kent Oncology Centre – Current catchment population (M) with ONS demographic growth	1.93	1.94	1.95	1.97	1.98	1.99
Attendances rate burden per million of populations	50540	51935	52294	54173	54958	56443
Attendances required in the population (calculated using Malthus with National Cancer Action Team validated decision trees)	97443	100766	102102	106431	108646	112271
Attendances delivered	67469					

1.11.3. Additional variables to consider regarding demand

The KOC Strategic Planning Team considered that the best assessment of radiotherapy demand was the Malthus Model. That model assesses demand using published evidence and consensus amongst Clinical Oncologists combined with cancer incidence statistics at the local level from the National Cancer Intelligence Network. However three additional factors were considered important enough to warrant changes to the Malthus model outputs in developing the reference radiotherapy demand projection for the KOC.

- On the advice of the NHS England Specialist Commissioning team, consideration of the effect of prostate hypo-fractionation regimes has been considered.
- Potential new developments at the Sussex Oncology Centre that will impact upon KOC population catchment have been considered.
- A new unit at Queen Mary's Hospital, Sidcup.

The combined effect of these additional developments is a 16% reduction applied the Malthus modelled demand for the KOC population.

However, 'Achieving world-class cancer outcomes, a strategy for England 2015-2020' has recommended a faster diagnosis of cancer to reduce the number of patients diagnosed with advanced stage cancer. The achievement of this strategy will increase the number of patients requiring curative radiotherapy. Appendix M shows the national trends of late diagnosis of cancer. Parts of Kent and East Sussex are shown as having one of the lowest percentages of patients being diagnosed early. If the diagnostic strategy is successful, KOC may see a significant increase in radiotherapy demand.

Hypo fractionation

NHS England in their commissioning intentions for prescribed specialised services for 2015-16 state that 'in relation to radiotherapy for prostate cancer, in line with the emerging clinical evidence an updated commissioning policy may result in a reduced number of fractions being delivered for patients. The policy will be for immediate implementation. Providers should note this significant potential change when assessing demand and planning capacity.'[1]

The conventional fraction regime for radical prostate cancer comprises 37 fractions. Advanced trials have been carried out nationally and internationally of treating radical prostate cancer with 20 fractions and NHSE now intend to commission 20 fractions as the new treatment standard. Radical prostate cancer patients account for around 13% of the total number of patients treated by MTW, and Radiotherapy Services estimate that around 55% of these patients will undergo a reduction in fractionation. It is prudent, therefore, to apply a 9% reduction on the overall Malthus modelled demand to account for this change in fractionation regime. For planning purposes it is assumed that this adjustment will be phased in over two years from 2016/17 with one third of the reduction to occur in 2016 and the remaining two thirds in 2017.

Developments at Sussex Cancer Centre.

The Sussex Cancer Centre is looking to gain approval to develop a two linac facility at Eastbourne; potentially opening in 2016 (the *latest information available suggests that the facility at Eastbourne has been delayed).* However, this puts the catchment population of Eastbourne and the population to the west of Hastings and parts of Rother and the Weald at risk for the KOC. The Eastbourne development's Full Business Case (FBC) (p16) states that 'the unit in East Sussex will not increase the current catchment population of the Sussex Cancer Centre. Given it is the intention of the SCC not to increase its catchment population, the KOC Strategic Planning Team considers it prudent to only marginally reduce current demand from Sussex, (by 3%) to allow for the Eastbourne development. It is assumed for planning purposes that this reduction in demand will be phased in over two years from 2016/17 with one third of the reduction to occur in 2016 and the remaining two thirds in 2017.

New radiotherapy facilities in Queen Mary's Hospital, Sidcup

A new Cancer Centre in Sidcup has a planned completion date in 2016. It is a partnership project between Oxleas NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust.

The Queen Mary's Cancer Centre will include two new linear accelerator machines for radiotherapy treatment, as well as chemotherapy treatment facilities and an information and support service for cancer patients and their families which will be provided by Dimbleby Cancer Care and Macmillan Cancer Support

The unit will be able to provide 16,000 radiotherapy and 4,600 chemotherapy treatments a year, allowing patients to receive treatment close to home. The Sidcup Unit is planned to avoid patients from Bexley and surrounding areas from having to make the trip to central London.

Currently residents of Dartford, Gravesham and Swanley CCG receive their radiotherapy treatment at Maidstone Hospital. While the Sidcup unit will be closer than Maidstone for some of this CCG population, the Sidcup unit will not have the capacity to both repatriate Bexley activity from London as intended and provide for the Dartford Gravesham and Swanley population.

[1]NHS England. Commissioning Intentions 2015/16 for Prescribed Specialised Services

The project team have concluded he Sidcup development may reduce the catchment of the KOC by approximately 4% overall. For planning purposes it is assumed that this reduction will be phased in over two years from 2016/17 with one third of the reduction to occur in 2016 and the remaining two thirds in 2017.

1.11.4. Adjusted radiotherapy attendances

The table below shows the projected demand for radiotherapy attendances at the KOC before and after the adjustments described above to the Malthus model.

Table 8 Adjusted Required radiotherapy attendances for the MTW KOC catchment population using the DH model; for hypo-fractionation and changes in Sussex and Sidcup.

Modelled population demand for radiotherapy	2015	2016	2017	2018	2019	2020
Attendances required in the population (calculated using unadjusted Malthus with National Cancer Action Team validated decision trees)	97443	100766	102102	106431	108646	112271
Adjusted Malthus. Adjusted for prostate hypo-fractionation and catchment change as a result of Sussex Cancer Centre and Sidcup developments (from 2016)	97443	94849	85991	89636	91502	94554

1.11.5. Identifying linac capacity needs

Required linac numbers based on recommended attendances

Having determined the population demand for radiotherapy attendances (adjusted for the factors discussed above), the NRAG recommendation for linac attendances per year (7,600) can then be used to calculate the number of linacs required each year to meet demand:

Table 9 Linacs required to meet demand

		2015	2016	2017	2018	2019	2020
b	Adjusted for prostate hypo-fractionation and catchment change as a result of Sussex Cancer Centre and Sidcup developments (from 2016)	97443	94849	85991	89636	91502	94554
e	Recommended machine productivity (NRAG)	7300	7600	7600	7600	7600	7600
h	Linacs required to meet forecast requirement (Radiotherapy Services England 2012) using Malthus Model with DH National Cancer Action Team validated decision trees) with current productivity. With local adjustments for as per (b)	13	12.6	11.4	11.9	12.2	12.6

The impact of the replacement program on linac capacity

The KOC operates 9 linacs at present (for details see table 3). There are, however, only 9 bunkers to house these linacs which means that the KOC's ability to deliver radiotherapy is reduced by 11% every time a linac is replaced – the current replacement program calls for 1 linac to be replaced every year just to limit the age of the units to around 13 years.

Replacement times vary, but can typically take around 7 months from 'switching off' one machine to 'switching on' the new one for patient treatment. Overall, therefore, the KOC linac capacity will reduce by 6% (7/12 * 11%) and the centre will then meet 65% of the radiotherapy demand determined above.

1.12. Unlocking capacity by adding additional bunker(s)

However, replacement bunker/s would enable the KOC to increase productivity, and meet some of the unmet modelled demand without initially purchasing additional (i.e. only purchasing replacement linacs) linacs. The following table shows the attendances that could be provided using current linac stock kept in date with decant facility available.

Table 10 Attendances potential with current linac stock with a decant bunker facility and satellite

		2015	2016	2017	2018	2019	2020
a	Demand adjusted for prostate hypo-fractionation and catchment change as a result of Sussex Cancer Centre developments (from 2016)	97443	94849	85991	89636	91502	94554
b	Attendances delivered	67469	-	-	-	-	-
c	Percentage of modelled demand delivered	69.20%					
d	KOC productivity used for this planning (attendances per machine) 7496 in 2014/15 and 7600 in 2016 onwards.	7496	7600	7600	7600	7600	7600
e	Additional productivity associated with a TWH satellite linac working 8am to 8pm rather than 9am to 5pm		3500	3500	3500	3500	3500
f	Capacity to deliver attendances with additional productivity and extended hours on satellite (d*9) + e	-	71900	71900	71900	71900	71900
g	Percentage of required attendances 9 linacs with a decant bunker is forecast to deliver. *Forecast requirement as per Radiotherapy Services England 2012, using Malthus Model with DH National Cancer Action Team validated decision trees). With local adjustments (Eastbourne / Sidcup & hypo fractionation)*		75%	83%	79%	78%	75%

1.13. The replacement program at the Kent & Canterbury Hospital

LA3 at the KCH is the next scheduled replacement (in 2016/17) in the KOC program because it is the oldest in the fleet. Replacement by age is normally recommended to mitigate the risks of catastrophic and possibly expensive failure and because it is probable that the equipment will be below the specification required for modern radiotherapy. Increased failure rates and below specification equipment reduce the capacity of the centre to provide standard radiotherapy.

There are, however, a number of risks, that need to be considered before proceeding with the replacement of LA3 and for which the building of additional bunkers within the KOC would mitigate:

- KCH could close. It is understood that EKHUFT has a strategic need to reduce their 3 major sites (Queen Elizabeth the Queen Mother, Margate, William Harvey Hospital, Ashford and the Kent & Canterbury Hospital, Canterbury) down to 2. The KCH is the oldest hospital and does not have the buildings, facilities or infrastructure required to replace the DGHs at Margate or Ashford,

- If KCH closes, then the radiotherapy department would be orphaned on an estate without the medical infrastructure required to operate safely or the linacs would need to be moved to another purpose built satellite site,

- Upgrading the infrastructure and building will always be expensive. The replacement of the linear accelerators on the KCH site is complex because the buildings were not designed for linacs – having been built in 1937 before medical linacs existed, and significant investment in upgrading the facilities to meet the requirements of modern treatment units is, therefore, required. The replacement of LA3, for example, would require around £700k (inc vat) to be spent on the bunker to make it suitable for the replacement unit,

- The fabric of the building is deteriorating rapidly which means that additional investment (over that described above) will also be required shortly.

There are, therefore, compelling reasons for delaying the replacement of LA3 until the future of the KCH is clearer – if KCH is to remain, then the additional investment in the buildings may then be justified at a later date, alternatively if KCH closes then there is an opportunity to review the disposition of linacs within east Kent (possibly including a satellite at Margate) to better meet the needs of the local population.

The risks with this approach are described above: the linac does not meet the standards for modern radiotherapy and is prone to significant failure, both reduce capacity and in the worst case LA3 would be removed from use for extended periods, reducing the number of working linacs in the KOC from 9 to 8 – this was the position at Canterbury during the replacement of LA2) but relying on business continuity arrangements is not sustainable in the longer term for the reasons described above.

This approach would halt the replacement program because the number of linacs could subsequently reduce to just 7 if LA3 suffered a major failure which would then certainly be unsustainable for the KOC.

Building additional bunkers at the KOC, would, however, allow the replacement of LA3 to be delayed and the replacement program to continue because a linac would not be removed from use and existing capacity would be maintained.

There would be no delay in the replacement program, assuming that the additional bunkers could be completed in time to take a replacement unit in 2016/2017.

1.14. Additional factors to consider when unlocking capacity through adding bunkers

1.14.1. Private provision of radiotherapy

Currently 4% of radiotherapy activity at KOC is due to private attendances bringing in an income of £549K per annum. While this may make the unit easier to fund, the NRAG and Malthus model (above) shows the level of demand for radiotherapy required to fill the capacity is not dependent on private activity.

The geographical distribution of private patients accessing the KOC is variable, with west Kent private patient attendances at 7% - higher than the overall figure of 4%.

The size and distribution of the private patient market is important when considering the location of the additional bunkers discussed above, especially because Cancer Partners' UK has launched a new cancer diagnostic and treatment centre at Kings Hill (about 5 miles west of Maidstone hospital) in December 2015. The specialist centre provides outpatient consultation and screening services along with diagnostic and chemotherapy suites and the latest generation linear accelerator (Linac). Given this competitive development so close to the Maidstone and Tunbridge Wells hospital sites, it is prudent to evaluate its potential impact on the proposals discussed here.

Private Radiotherapy Market Assessment

Radiotherapy is a highly cost effective and clinically effective treatment for cancer. It accounts for just 5% of the national spend on cancer treatment in the UK and yet is the second most effective treatment for cancer (next to surgery). Of all patients cured of their cancer, 40% will have received radiotherapy as part of their curative treatment and 16% of all cures can be attributed entirely to their radiotherapy. More than one third of the United Kingdom's cancer patients who would benefit from radiotherapy are currently not accessing the essential treatment modality at the right time. *(Source: Genesis Care, owners of Cancer Partners UK)*

Private providers are already providing overflow support to National Health Service (NHS) hospitals, PP providers are expecting to provide even greater support for the NHS as it attempts to meet the rising tide of patient demand.

Extract from Varian (The global leaders in linac supply) annual report 2014

The radiation oncology market is growing globally due to a number of factors. The number of new cancer cases diagnosed annually is projected to increase from an estimated 14.1 million in 2012 to over 20 million by 2025, according to the International Agency for Research on Cancer (the "IARC") in the World Health Organization. The IARC's World Cancer Report predicts that the increase in new cases will mainly be due to steadily aging populations in both developed and developing countries. Technological advancements have helped to improve the precision and applicability of radiotherapy and radiosurgery, potentially expanding the use of radiotherapy and radiosurgery equipment to treat a broader range of cases. Technological advances in hardware and software are also creating a market for replacing an aging installed base of machines that are unable to deliver new, higher standards of care.

Candesic team http://www.candesic.com/ have published some research in 'Health Care Investor 'in 2012 on opportunities for private hospital providers in radiotherapy cancer care in the UK. At FBC a more detailed market assessment can be undertaken.

Developments at King's Hill by Cancer Partners UK are likely to impact on private work at Maidstone due to the close geographical location to Kings Hill. For modelling purposes this business case assumes that any new satellite at

TWH will not attract more private work, but will maintain rather than lose, current private share in West Kent. For options that do not include a satellite at Tunbridge Wells, it is assumed that the Trust proportion of Radiotherapy Private Practice will reduce to effectively 0%. As table 1 above demonstrates, there has already been a recorded fall in Private patient requests.

1.14.2. Accessibility to clinic rooms

Currently radiotherapy patients who are about to start treatment or who are being treated are seen in outpatient clinic rooms at either Canterbury or Maidstone - these radiotherapy appointments are necessary to cover consent, queries, patient well-being and care and clinical trials . In order to offer an equitable service to all patients it is proposed that any new facility would need to ensure that there are sufficient clinic rooms to support patients and improve their radiotherapy experience.

Due to growth in outpatient numbers due to increased survivorship and new lines of treatment extending life, the number of patients requiring follow up continues to increase whilst the existing number of outpatient rooms remains static. Both the Tunbridge Wells and Maidstone outpatient departments are at almost 100% outpatient room utilisation. The Oncology department at Maidstone has a separate outpatient department which is also heavily utilised – and demand is increasing.

In order to ensure that there is adequate clinic capacity to see patients in a timely manner and to alleviate outpatient pressure at MH and TWH; clinic room capacity would also need to consider the provision of oncology outpatients.

Medical Cover for the Unit

Locating outpatient clinics in the satellite unit will ensure that for the majority of the time there is a Consultant Oncologist present who can deal with any medical emergencies and general queries from patients or staff about patients on treatment.

1.14.3. Increasing capacity in HODU at TWH

There has been a consistent increase in the capacity and demand for the Haemato-Oncology Day Unit (HODU) chemotherapy services. Increased clinical space on the TWH site is required to help facilitate patient flow through the day unit and to meet this increase in demand.

Currently there is a room in HODU at TWH occupied by the palliative nursing team. Moving the palliative care team to a more appropriate location would create a further clinical room on HODU. In addition, there would be room alongside the HODU team for the Acute Oncology Service (AOS)/ Cancer of Unknown Primary (CUP) team to have a base. This will promote parity of services across the hospital sites, increase AOS/CUP nurse specialist availability at HODU and support the direct AOS / medical referral agreement for patients assessed on the unit.

1.15. Case for change - Benefits

The measurable benefits associated from achievement of each of the investment objectives are summarised below:

To provide continuity for the radiotherapy service, maintaining standards for patients living in Kent, Medway and parts of East Sussex.

- the ability to meet likely demand and extent to which capacity can be expanded if demand exceeds expectations,
- extent to which spare capacity can be utilised for extending catchment populations,
- the ability to respond to changes in the strategic direction of EKHUFT
- respond to potential loss of radiotherapy service to private providers

To provide the services at a location which is as close to home for as many patients as possible,

- the number of patient journeys with significantly reduced travel time,

Analysis has shown that:

- A satellite centre at Tunbridge Wells Hospital would save approximately 179k miles per annum in patient journeys or an average of 212 miles per patient for 845 patients. See Appendix A.
- A satellite centre at Margate would save approximately 255k miles per annum in patient journeys or an average of 308 miles per patient for 828 patients. See Appendix A.
- An analysis of accessibility, travel time and patient choice has shown that a minimum of 402,991 people in the scope population would benefit from a linac situated at the Tunbridge Wells site, with approximately 58,000 of this population group who would currently have a 45 minute or more journey to access radiotherapy having significantly reduced travel times. See Appendix B.

To improve efficiency, cost effectiveness and maximise income from the radiotherapy service in order to maximise resources available to meet needs.

- Extent to which the option increases the number of locations where there are both radiotherapy services and chemotherapy and other cancer services and impact on clinical model.

1.16. Case for change – Risks

- Eastbourne and Sidcup radiotherapy developments
- Lack of Radiotherapy Service capacity due to ageing machine downtime
- Lack of Radiotherapy service capacity due to replacement projects utilising a would-be used bunker
- Not compliant to national strategy or specialist guidelines (Table 2).
- King's Hill private radiotherapy development

The following Project risks are identified and mitigation is discussed within point 6.5:

- Activity demand lower than projections.
- Funding loan is not approved.
- Additional staffing not available
- Delay meaning capacity not in place in time
- Parking facilities for patients and staff.

1.17. Constraints (should be externally imposed)

- All options must deliver all key national standards in terms of nature and quality of radiotherapy treatment.
- Affordability.
- Current equipment is provided by a single provider and is specifically set up to be compatible across all functions. This would need to be the case in future
- Delivery Programme for Linacs
- Planning acceptability
- Site Logistics

1.18. Dependencies

- Support of NHS England as the commissioner
- TDA approval
- Receipt of Local Authority Planning Approval for the preferred location taking account of the consultation process.
- Agreement of TWH PFI provider to whom the site is licensed - awaiting feedback from Kevin and Stephen Duck.

2. The Economic Case

2.1. The long list of options

A key component of developing a business case is the option appraisal exercise. It is only by comparing the alternatives that the real merits of any particular course of action are exposed. In order to achieve this, the TDA and HM Treasury recommend beginning with identifying a 'long list' of options, containing all the initial ideas about possible solutions. It is recommended that this should include not only the conventional solutions, but also any more innovative suggestions, however unlikely they may at first appear. Imaginative thinking is encouraged through brain storming and the range of options considered should be as wide as possible.

This exercise of generating the long list was undertaken by the Project Team in April 2015 and is summarised below and recorded in Appendix P.

The long list of options was developed and categorised under the headings of Scope, Technical Solutions, Service Delivery, Implementation and Funding. A summary of inclusions, exclusions and possible options are detailed in the table below:

Table 11 The long list of options

Long list options		Finding
	Options of scope	
1aa	No change – continue with current arrangements	Carry forward
1b	Change provision of radiotherapy	Carry forward
1c	Change provision of radiotherapy and treatment planning	Carry forward
1d	Change whole cancer pathways e.g. including surgery, brachytherapy, chemotherapy	Discount
	Options of service solution	
2a	No change – continue with current arrangements	Carry forward
2b	Reduce demand by changing patient pathways (less fractions, less complex e.g. IMRT, less imaging)	Carry forward
2c	Provide more capacity through productivity/ efficiency changes (longer days / weekends)	Carry forward
2d	Build more capacity- one bunker and one linac	Carry forward
2e	Build more capacity -two more bunkers with one linac	Preferred
2f	Build more capacity -two more bunkers and two more linacs	Carry forward
	Options of service delivery	
3a	No change –continue with current arrangements	Carry forward
3b	Build additional bunker/s at Maidstone hub	Carry forward
3c	Build additional bunker/s at Canterbury hub	Discount
3d	Satellite adjacent to clinical facilities at Margate	Carry forward
3e	Satellite adjacent to clinical facilities at Dartford	Carry forward
3f	Satellite adjacent to clinical facilities at Ashford	Carry forward
3g	Satellite adjacent to clinical facilities at Tunbridge Wells	Preferred
3h	Satellite at other stand-alone location	Discount
	Options around implementation	
4a	Maintain current linac replacement programme	Carry forward
4b	Expedite current linac replacement programme	Preferred
4c	Slow current programme down by a year	Discount
	Options around funding	
5a	NHS	Preferred
5b	Private	Carry forward
5c	Charitable funding	Discount

2.2. The short list of options

A key component of developing a Business Case is the option appraisal exercise. It is only by comparing the alternatives that the real merits of any particular course of action are exposed. In order to achieve this, the TDA and HM Treasury recommend beginning with identifying a 'long list' of options, containing all the initial ideas about

possible solutions. It is recommended that this should include not only the conventional solutions, but also any more innovative suggestions, however unlikely they may at first appear. Imaginative thinking is encouraged through brain storming and the range of options considered should be as wide as possible.

This exercise of generating the long list was undertaken by the Project Team and is recorded in Appendix P.

The next stage in the process was for the long-listed options to be reduced to a more manageable 'short list' of options for in-depth appraisal and evaluation. The HM Treasury's 5 Case Model calls for a do nothing / minimum option to be short-listed and appraised even where it is not considered to be a realistic option. Its function is to provide a benchmark so that the value of the alternative 'do something' options may be judged by reference to current service provision.

Table 12 The short list of options

Option	Description
1a/1b	No change/ do minimum (extended day or weekend working)
2	A TWH satellite facility - A satellite facility at TWH with 2 new bunkers with space for a third bunker
3	A Maidstone Hub option - Maidstone facility with 2 new bunkers
4	A less ambitious option at the Maidstone Hub - Maidstone facility with 1 new bunker

2.3. Options appraisal

2.3.1. Appraisal Summary

Option	Detail	Year	Revenue cost £ (-ve = cost)	Income £ (= increase)	Net Loss/ Surplus £ (-ve = loss)	Build and infrastructure costs £ (-ve = cost)	NPV over 30 Years £ (-ve = net present cost)	Benefits Ranking 1st highest	Risk Ranking 1st Lowest
1a	Do minimum extended working day		-88,700	-160,760	-249,460	0	-4,840,422	4th	4th
1b	Do minimum weekend-lite working		-595,23,4	-160,760	-755,994	0	-14,669,005	4th	4th
2	Two new bunkers at TWH	Year 1	0	0	0	-7,463,272	1,602,777	1st	1st
		Year 2	-765,686	1,224,330	458,644				
		Year 3	-765,686	1,224,330	458,644				
		Year 4	-765,686	1,224,330	458,644				
3	Two new bunkers at MH	Year 1	0	0	0	-10,750,659	-172,378	2nd	2nd
		Year 2	-182,566	600,952	418,386				
		Year 3	-182,566	600,952	418,386				
		Year 4	-182,566	600,952	418,386				
4	One new bunker at MH	Year 1	0	0	0	-9,301,147	-50,429	3rd	2nd
		Year 2	-147,519	600,952	453,433				
		Year 3	-147,519	600,952	453,433				
		Year 4	-147,519	600,952	453,433				

- Option 1a is unsustainable in the medium and long term. due to staff retention issues and is critically dependent on the current staff working a split shift and extending the day by 3 hours Mon - Fri and on overworking the aging linacs

- Option 1b has high revenue costs in relation to income and when discounted over 30 years produces the highest negative NPV. The increased revenue costs are based upon an extended 3 hours Monday to Friday and 12 hour days on both Saturday and Sunday. A variant based on a 6 day week has been modelled as a sensitivity test and is estimated to cost some £300k per annum
- Option 2 is the preferred option both strategically and economically
- Option 3 and 4 are options which may address capacity but do not address long term strategy and have a lower NPV. There is also the question of available space for bunkers at Maidstone due to the helipad development.
- Option 4 has only one bunker in comparison to the preferred Option 2 and Option 3.

2.3.2. Option 1: Do minimum

Carry on with current replacement programme (including LA3 at Canterbury), shutting old machines down and delaying each new machine operational start date by approximately 7 months. Each time a linac needs replacing the KOC will move from 9 operational linacs to 8 operational linacs. The KOC would treat on extended days (option a) or over the weekend (option b) to maintain capacity. This option simply implements the already agreed linac replacement program with staff working extended days and/or weekends in order to address the reduction of a linac during replacement as there is no spare bunker. This is unsustainable in the long term.

SWOT Analysis – Do minimum – 1a and 1b	
Strengths	• Lower Estate costs. • Minimal physical disruption to environment. • Sweating high value capital assets. • May meet the personal needs of some patients.
Weaknesses	• High revenue rates working weekends. • Ineffective for patient's radiotherapy schedules. • Significant investment in deteriorating facilities at KCH • Reduced capacity to provide radiotherapy treatment. • Managing capacity during unscheduled (due to breakdown) downtimes will not always be possible without compromising the outcome of treatment for some patients. • Increase in revenue in the instance of a breakdown as staff will need to work overtime at weekends to meet demand. • An inefficiency of 6% is built into entire radiotherapy facilities due to a lack of a decant bunker. • Lack of business continuity due to 1 less linac – could potentially have less patients through the system and potential to miss access targets. • Maintenance and machine reliability as assets are sweated – increased risk of machine breakdown with the associated impact upon patients and treatment • Machine breakdowns will take longer outside normal working hours due to reduced support staff and delays in obtaining manufacturer support and pars from equipment suppliers. Reduced access to the linacs for maintenance and system upgrades. No capacity for the new RT techniques that are more complex and require additional time on the linacs. • Patients may refuse to travel between the existing sites when it is necessary to balance demand. • Transport issues -would not be able to accommodate transport patients as this does not operate outside normal hours as public transport poor.

	• Reduction in evening access to linacs will significantly compromise essential routine quality control checks. • Patients may not be able to access transport outside normal hours or at the weekends. • Increased staffing for longer working days and unsociable hours, including weekends and early, mid and late shifts. • Requirement for additional administration team • Unable to recruit staff as conditions are poorer than other centres. • More attractive to work in London or other centres offering better hours. • Higher staff turnover due to unsatisfied staff which will threaten business continuity. • Increased staff stress and poorer morale due to workload and overtime with the potential of increased clinical incidents and decreased efficiency. • There will be a requirement for doctors if all units running extended hours. If not site specific radiographers will be required who are rare across the country so would take 1 year to train for each anatomical site. • Poorer communication, less discussion and a reduced ability to problem solve (a very important part of radiotherapy) due to the lack of staff overlap during core hours
Opportunities	• Better modality of treatment in new linac. • Could increase capacity (although would require more staff).
Threats	• Decreased capacity for 7 months whilst a linac is out of action every year. • Opportunity for other providers to enter the market as service degrades – increased loss of market share. • The current level of private patients for West Kent patients is 7%. For modelling purposes this business case assumes that options excluding a satellite unit at TWH (this option) will, due to developments at King's Hill by Cancer Partners UK, see the Trust proportion of Radiotherapy Private Practice reduce to effectively 0%. • The age of the linacs at replacement will be significantly outside the 10 years specified in the NHSE Radiotherapy standard contract which could encourage more outside providers to enter the market. • KCH may close, orphaning the newest accelerators in poor facilities with inadequate clinical cover.

Table 13a Summarising option 1a – Extended Days, staff working overtime.

Option 1a Do minimum – treat on extended working days	Yr 1	WTE worked
Revenue costs	(£)	
Maintenance contract linac- after year 2	0	
Maintenance contracts equipment - after 1 year	0	
Overtime/unsocial hours - servicing during weekends	-42,700	0.89
Additional linac serving costs (weekend working)	-26,000	
Overtime/unsocial hours - shifts	-20,000	0.22
(b) Total revenue cost	-88,700	1.11
Income		
Loss of Maidstone PP Income (Kings Hill)	-459,315	
Conversion of PP income Loss to NHS Patients	298,555	
(c) Total income	-160,760	
Total	-249,460	

The income received is from converted lost private patients to NHS, lost overall income. The revenue is primarily staff are working evenings to allow for the linac replacement program to continue (8 linacs in place of 9). The revenue is lower during the evenings than weekends as the staff rota will be telescoped to aid cover and therefore no additional RT staff required. The revenue is for physics staff to complete quality assurance checks on the machines as they will no longer be able during the week due to the machines being used (see Appendix G). This is not a sustainable solution due to reasons described in the options appraisal SWOT analysis above. Additionally, if a linac was to breakdown, staff will need to work weekends to cope with demand which will incur a higher revenue cost.

Table 13b Summarising option 1b. Staff working overtime at weekends and extended days Monday to Friday.

Option 1b Do minimum – treat over the weekends	Yr 1	WTE worked
Revenue costs	(£)	
Maintenance contract linac- after year 2	0	
Maintenance contracts equipment - after 1 year	0	
Additional staffing required to operate a radiotherapy-lite service during the weekends.	-595,234	
(b) Total revenue cost	--595,234	
Income		
Loss of Maidstone PP Income (Kings Hill)	-459,315	
Conversion of PP income Loss to NHS Patients	298,555	
(c) Total income	-160,760	
Total	-755,994	

The income received is from converted lost private patients to NHS, lost overall income. The revenue is primarily from staff working weekends to allow for the linac replacement program to continue (8 linacs in place of 9).

2.3.3. Option 2: A TWH satellite facility with 2 bunkers and associated clinic rooms

Build a bespoke radiotherapy unit at TWH with 2 bunkers and 4 outpatient consulting rooms. Replace 1 linac machine into the unit from MH or KCH (The cost of the replacement linac is separate from this case because it is already part of the existing capital replacement program). The trust has carried out a feasibility report and has identified a site; this is located between the hospital's main access road and the car park on the east side of the campus (see Appendix C for embedded file).

Medical cover (Consultants/ Registrars/ etc.) will be provided from existing resources at MH to support the unit as part of the expansion in Consultant numbers due to the growth in outpatient follow up appointments.

SWOT Analysis – A Tunbridge Wells satellite facility	
Strengths	• Improved geographical access to patients who live nearer to the TWH site than MH or other providers. • A satellite centre at Tunbridge Wells Hospital would save approximately 179k miles per annum in patient journeys or an average of 212 miles per patient for 845 patients. See Appendices A and B. • 2 bunkers allow for service expansion and provide a spare bunker for the replacement program. • Capacity is maintained during the replacement program (removing the 6.4% bunker inefficiency). • No loss of Private patient income in the TWH area. • Improved business continuity because the TWH site provides an alternative operational site should there be a major environmental impact on the MH site. • Increased outpatient facilities for PP and NHS patients. • The additional 4 rooms will allow the Directorate to cope with the increase in cancer patients experienced year on year (e.g. 2014/15 year 7000 follow up appointments over annual plan). • There is an opportunity to develop a future 3rd bunker. • There is sufficient power available to the site. • Allows the replacement of LA3 at Canterbury to be delayed until the strategic direction within EHUFT is clearer. • Brings the replacement age of the linacs closer to the 10 year requirement in the NHSE Radiotherapy standard contract.
Weaknesses	• Some disruption to the TWH patient car parking during the construction process. • Site physically separated from the main hospital which may impact on patients who need to use other trust facilities. • Patients requiring more advanced treatment techniques and specialist staff would need to travel to Maidstone or Canterbury (as they do now). • To maintain treatment continuity during breakdowns would require patients to travel to MH. (Routine quality assurance would be performed outside of treatment hours which would minimise downtime).
Opportunities	• Growth in RT activity (NHS and PP) due to increased catchment area. • Opportunity to create a state of the art facility which is purpose built for NHS and PP patients. • Increased chance of this option meeting the NRAG recommendations for unmet need.

	• Potential for palliative care for patients at the TWH site as an expansion in the future including ambulant and chemo-radiotherapy. • Opportunity to change to a paper light model of working for treatment planning and deliverance of RT (radiotherapy). • Opportunity to bring the replacement program forward if additional linac funding becomes available at a later date. • The satellite model would become the exemplar template which would be deployed to other geographical areas of the KOC catchment area.
Threats	• Lack of ambulatory patients with tumours that are appropriate for treatment at the satellite centre (breast and urology) who would choose to go to TWH. • MTW will need to increase the workforce when it is already difficult to recruit qualified and experienced staff to support the existing MTW business needs. • The build is significantly delayed which may have a knock-on effect on the replacement program if LA3 at Canterbury is not replaced as scheduled.

Table 14 Summarising option 2

Option 2 TWH Satellite 2Bu. 1 Rep. Linac	Yr 1	Yr 2	Yr 3	WTE worked
Revenue costs	(£)	(£)	(£)	
Clinical Physics staffing	-14,736	-176,835	-176,835	3.90
Computer Science Staffing	-3,081	-22,335	-22,335	0.60
Radiotherapy Treatment	-21,083	-253,200	-253,200	5.70
Nursing	-3,768	-45,214	-45,214	1.68
Admin & Clerical	-4,804	-57,657	-57,657	2.75
Building maintenance	-4,374	-47,692	-47,692	
Domestics	-1,384	-16,603	-16,603	
Heating, lighting, utility	-7,060	-84,724	-84,724	
Rates	-3,709	-44,506	-44,506	
Luton box van	-667	-8,000	-8,000	
Cleaning equipment	-483	-5,800	-5,800	
Vending machines (2)	-260	-3,120	-3,120	
Depreciation	-11,488	-137,856	-137,856	
Loan Interest	-13,536	-162,431	-155,593	
(b) Total revenue cost	-90,433	-1,065,973	-1,059,135	
Income				
Efficiency Income (No Linac Downtime)		761,712	761,712	
Additional NHS Income (TWH Area)		660,883	660,883	
(c) Total income		1,422,595	1,422,595	
Total	-90,433	356,622	363,460	

The additional income received is from the extra 3,500 fractions as well as additional billable reviews and planning attendances due to the wider scope at TWH. The total activity is 4,317 billable events. It is assumed that the bunker becomes available on 2nd April and so the Income and expenditure in year has been appropriately as pro rate, as has depreciation. The Loan that will be needed has been assumed to have 2 payments per year on 15th September and 15th March so that there are full year charges in the year of opening. This explains why there is a loss, as staff are put in place before income generating activities commence, with the full value of the recurrent surplus from Year 2 onwards.

The efficiency income is the extra bunker capacity. The revenue is predominantly from extra employed staff required to work the extended day at TWH for the extra 3,500 fractions and the requirement of specialist staff to supervise a satellite unit. It is anticipated that there will be no reduction in private patent income due to location and bespoke private facilities provided.

The TWH satellite is best suited and targeted for patients who are able to walk unaided, therefore there is no requirement for the addition of extra porters or transport staff.

Option 3: Development at the Maidstone Hub – 2 bunkers and associated clinic space.

Build 2 extra bunkers at Maidstone Hospital with the associated 4 outpatient clinic rooms and staff facilities. Replace 1 Linac machine into the unit from MH or KCH (The cost of the replacement linac is separate from this case because it is already part of the existing capital replacement program).

SWOT Analysis – Development at the Maidstone Hub	
Strengths	• There is estate available to build 2 additional bunkers. • Requires fewer additional staff that the satellite options due to an expansion of the existing team. • 2 bunkers allow for service expansion and provide a spare bunker for the replacement program. • Capacity is maintained during the replacement program (removing the 6.4% bunker inefficiency). • Economies of scale for staffing if the expansion happens at MH. Satellite units may be more costly to run. • Treatment continuity can be maintained during breakdowns by transferring patients to the other machine. • Addresses the need to improve the electrical infrastructure at the MH site - existing pressures on the generators would be reduced. • Allows the replacement of LA3 at Canterbury to be delayed until the strategic direction within EHUFT is clearer. • Brings the replacement age of the linacs closer to the 10 year requirement in the NHSE Radiotherapy standard contract.
Weaknesses	• Lack of available space due to the helipad and potential Macmillan Information Centre new build. • Lack of power supply at the Maidstone site to support extra Linacs - circa £2.5million to implement a high voltage substation. • Opportunities for expansion on MH site are limited.

	• High initial capital cost of 2 bunkers. • Does not support the maintenance or expansion of PP income. • No increase in patient access to services e.g. TWH patients have to travel to MH or Canterbury depending on capacity. • Lack of car parking space at MH. • MTW will need to increase the workforce when it is already difficult to recruit qualified and experienced staff to support the existing MTW business needs. • Strategically, this may be seen as increasing the number of linacs at MH at the direct expense of patients in east Kent.
Opportunities	• Increase the number of outpatient clinic rooms to meet growing demand of cancer patients. • Opportunity to bring the replacement program forward if additional linac funding becomes available at a later date.
Threats	• Risk that planning permission is not granted. • The build is significantly delayed which may have a knock-on effect on the replacement program if LA3 at Canterbury is not replaced as scheduled. • The current level of private patients for West Kent patients is 7%. For modelling purposes this business case assumes that options excluding a satellite unit at TWH (this option) will, due to developments at King's Hill by Cancer Partners UK, see the Trust proportion of Radiotherapy Private Practice reduce to effectively 0%.

Table 15 Summarising option 3

Option 3 Maidstone Hub 2Bu. 1 Rep Linac	Yr 1	Yr 2	Yr3	WTE worked
Revenue costs	(£)	(£)	(£)	
Building maintenance	-3,974	-47,692	-47,692	
Domestics	-1,384	-16,603	-16,603	
Heating, lighting, utility	-3,076	-84,724	-84,724	
Rates	-2,052	-24,627	-24,627	
Cleaning equipment	-483	-5,800	-5,800	
Vending machines (2)	-260	-3,120	-3,120	
Depreciation	-21,240	-254,879	-254,879	
Loan Interest	-20,223	-242,674	-232,457	
(b) Total revenue cost	-52,692	-680,119	-669,902	
Income				
Efficiency Income (No Linac Downtime)	0	761,712	761,712	
Loss of Maidstone PP Income (Kings Hill)	-459,315	-459,315	-459,315	
Conversion of PP income Loss to NHS Patients	0	298,555	298,555	
(c) Total income	-459,315	600,952	600,952	
Total	-512,007	-79,167	-68,950	

The efficiency income is the extra bunker capacity and converted lost private patients to NHS. The revenue is from facilities required to maintain the two bunkers which is more than the option for one bunker at MH (option 4).It is assumed that current staff will rotate for the linac replacement and therefore extra permanent or overtime staff are not required. It is anticipated that there will be a reduction in private patent income due to location. There is no additional income calculated as the scope of area has not increased.

For Options 3, the loss of PP is assumed for the full year, but replacement has been based on opening the new bunker/s and on the same basis as Option 2 equates to 1,951 billable events, 1,582 of which are fractions. No commissioner support has been given at this stage but the case is being presented to them.

Option 4: Maidstone Hub development with 1 new bunker

Build 1 extra bunker at Maidstone Hospital with the associated 4 outpatient clinic rooms and staff facilities. Replace 1 linac machine from MH or KCH (the cost of the replacement linac is separate from this case because it is already part of the existing capital replacement program).

SWOT Analysis – A less ambitious development at the Maidstone Hub	
Strengths	• There is estate space to build 1 additional bunker. • Minimal staffing issues due to an expansion of the existing team. • Economies of scale for staffing if the expansion happens at MH. Satellite units may be more costly to run. • Treatment continuity can be maintained during breakdowns by transferring patients to the other machine. • Addresses the need to improve the electrical infrastructure at the MH site - existing pressures on the generators would be reduced.
Weaknesses	• Only one bunker space • Lack of available space due to the helipad and potential Macmillan Information Centre new build. • Would require the replacement of LA3 at Canterbury to proceed. • Lack of power supply at the Maidstone site to support extra Linacs, cost of circa £2.5million to implement a high voltage substation. • Opportunities for expansion on MH site are limited. • High initial capital cost of 1 bunker. • Will not support the maintenance or increase of PP income. • No increase in patient access to services e.g. TWH patients have to travel to MH or Canterbury depending on capacity. • Lack of car parking space at MH. • Provides a spare bunker for the replacement program but no opportunity for service expansion to satisfy unmet need identified in NRAG report. • MTW will need to increase the workforce when it is already difficult to recruit qualified and experienced staff to support the existing MTW business needs.
Opportunities	• Increase the number of outpatient clinic rooms to meet growing demand of cancer patients.
Threats	• Risk that planning permission is not granted. • The build is significantly delayed which may have a knock-on effect on the replacement program if LA3 at Canterbury is not replaced as scheduled. • The current level of private patients for West Kent patients is 7%. For modelling purposes this business case assumes that options excluding a satellite unit at TWH will, due to developments at King's Hill by Cancer Partners UK, see the Trust proportion of Radiotherapy Private Practice reduce to effectively 0%. • The age of the linacs at replacement will be significantly outside the 10 years specified in the NHSE Radiotherapy specification which could encourage more outside providers to enter the market.

Table 16 Summarising option 4

Option 4 Maidstone Hub 1Bu. 1 Rep Linac	Yr 1	Yr 2	Yr 3	WTE worked
Revenue costs	(£)	(£)	(£)	
Building maintenance	-1,987	-23,846	-23,846	
Domestics	-692	-8,302	-8,302	
Heating, lighting, utility	-7,060	-84,724	-84,724	
Cleaning equipment	-242	-2,900	-2,900	
Rates	-2,052	-24,627	-24,627	
Vending machines (2)	-260	-3,120	-3,120	
Depreciation	-19,176	-230,106	-230,106	
Loan interest	-17,457	-209,487	-200,688	
(b) Total revenue cost	-48,926	-587,112	-578,293	
Income				
Efficiency Income (No Linac Downtime)		761,712	761,712	
Loss of Maidstone PP Income (Kings Hill)	-459,315	-459,315	-459,315	
Conversion of PP income Loss to NHS Patients		298,555	298,555	
(c) Total income	-459,315	600,952	600,952	
Total	-508,241	13,840	22,659	

The efficiency income is the extra bunker capacity and converted lost private patients to NHS. The revenue is from facilities required to maintain the one bunker is less than the option for two bunkers at MH (option 3).It is assumed that current staff will rotate for the linac replacement and therefore extra permanent or overtime staff are not required. It is anticipated that there will be a reduction in private patent income due to location. There is no additional income calculated as the scope of area has not increased.

For Options 4 similarly to Option3, the loss of PP is assumed for the full year, but replacement has been based on opening the new bunker/s and on the same basis as Option 2 equates to 1,951 billable events, 1,582 of which are fractions. No commissioner support has been given at this stage but the case is being presented to them.

Table 17 Qualitative benefits assessment

Option		Option 1a and 1b Do minimum		Option 2 TWH Satellite 2Bunkers. 1Replacement. Linac		Option 3 Maidstone Hub 2Bunkers. 1 Replacement Linac		Option 4 Maidstone Hub 1Bunker. 1 Replacement Linac	
Potential benefit	Weight	Score	Weight * score	Score	Weight * score	Score	Weight * score	Score	Weight * score
Supports meeting required demand	20	1	20	3	60	3	60	2	40
Flexible solution for the future	15	0	0	4	60	3	45	1	15
Minimal disruption to services	20	0	0	5	100	5	100	5	100
Achievable in timescale	15	5	75	5	75	4	60	4	60
Patient accessibility	10	0	0	4	40	2	20	2	20
Efficient services	5	1	5	2	10	3	15	3	15
Sustainable	5	0	0	4	20	4	20	2	10
Improves quality of experience/ outcomes/ safety	10	0	0	4	40	3	30	3	30
Total score	100		100		405		350		290
Rank 1 = most benefit			4		1		2		3

Option 2 clearly demonstrates as being the most beneficial option and scores the highest for all of the benefits criteria.

Table 18 Comparing the non-monetary risks of each option

Risk	Option 1a and 1b Do minimum			Option 2 TWH Satellite 2Bu. 1Rep. Linac			Option 3 Maidstone Hub 2Bu. 1 Rep Linac			Option 4 Maidstone Hub 1Bu. 1 Rep Linac		
	Likelihood (0-5)	Impact(0-5)	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score
Failure to meet demand	5	4	20	2	1	2	2	1	2	2	1	2
Inadequate adjacency	5	3	15	5	2	10	5	1	5	5	1	5
Project deliverability delay	3	4	12	3	4	12	3	4	12	3	4	12
Shortfall in required staff	4	4	16	3	2	6	3	2	6	3	2	6
Obtaining project funding	1	4	8	2	4	8	3	4	12	3	4	12
Lack of commissioner support	4	4	16	2	4	8	3	4	12	3	4	12
Other provider taking business (Kings Hill, Eastbourne)	4	3	12	3	3	9	4	3	12	4	3	12
Total score			99			55			61			61
Rank 1 = least risk			4			1			2			2

Option 2 scores the lowest in every risk factor and scores the lowest or equal lowest in every risk described.

Table 18 Summarising short list information for option appraisal

Given the scale of the investment and the nature of the demands on the Trust's internally generated capital resource, it is planned to seek loan funding from the TDA. This has been modelled using the assumption of funding from the Public Works Loan Board information for a loan repaid over 25 years (the maximum permitted) in two equal instalments each year, at the given interest rate. An appropriate interest payment has been incorporated into the costs for each option requiring capital investment and is shown in the revenue cost tables. The Loan workings are shown in Appendix O.

2.4. Optimism Bias and Sensitivity Analysis

The HM Treasury Green Book guidance highlights that there is a "demonstrated, systematic tendency for project appraisers to be overly optimistic." In order to redress this tendency, HM Treasury recommends that all projects are subject to empirically based adjustments to the estimates of the project's costs benefits and duration. These adjustments are termed Optimism Bias (OB).

Pending some confirmation from TDA on treatment of Optimism Bias in the model, it was felt that it would be important to highlight what the current case shows and assess how the NPV and I&E positions would be affected by the application of OB calculations.

HM Treasury's Green Book identifies an Upper and Lower Bound for different categories of Capital Expenditure; in discussion with Estates, we have assessed the bunker as a Standard Building development for Options 2, 3 and 4. For Options 3 & 4, the HV substation is Standard Civil engineering and IT is Equipment within all relevant Options.

The bounds for Capital Expenditure are shown in the Table below;

Table 19 Optimism Bias Bounds for capital projects

Project Type	Upper Bound OB %	Lower Bound OB%
Standard Building	24	2
Standard Civil Engineering	44	3
Equipment	200	10

For the NPV the modelling has included costs excluding VAT, as per Green book guidance. This figure includes a contingency figure for Options 2, 3 and 4. The planning contingency is 5%, which is above the Lower Bound for the Building and substation, where applicable. The two cost elements are much more significant than the equipment cost.

The project team consider that all of the options (2,3,and 4) that involve building additional bunkers are Standard types of project as they are not innovative, nor have unique characteristics and the construction does not have a high degree of complexity or difficulty. As such the upper bound of % adjustment is 24% and the lower bound is 2%. The use of Procure21 will mitigate the risks but it is not possible to give a single figure and for the purposes of comparison within the case at this stage, all of the options are multiplied by the upper bounds of Capital Expenditure. It is expected that as the case finalises that the OB will fall, but also that the fall will be the same for all Options.

The inclusion of the HV substation for Options 3 & 4 is considered to be a Standard Civil Engineering project type, with an Upper Bound of 44% and a lower bound of 3%.

Options 2, 3 & 4 include IT at £114k, which is treated as Equipment, with an Upper Bound of 200% for OB

For all options, the Duration OB is considered to be covered by sensitivity analysis on the benefits for Option 2 and Costs and benefits for Options 3 and 4, using the Upper Bound figure.

Table 20 Optimism Bias Comparison

(£)	Capital Expenditure	Planning Contingency	OB at Lower Bound	OB at Upper Bound
Option 2 TWH two bunkers	7,463,272	317,819	252,741	1,942,361
Option 3 MH two bunkers	10,750,659	470,784	354,178	3,445,194
Option 4 MH one bunker	9,301,147	408,190	325,198	3,097,434

Option 2 clearly has the lowest increase in OB as this option does not include the HV substation.

Option 3 - As the OB at the Lower Bound figure is closer to the 5% contingency than in Option 2, the impact on Option 3 is to reduce the NPV by less than the preferred Option, and significantly adversely affect the NPV at the Upper Bound level.

Option 4 - As with Option 3, the OB at the Lower Bound figure is closer to the 5% contingency than in Option 2, the impact on Option 3 is to reduce the NPV by less than the preferred Option, and significantly adversely affect the NPV at the Upper Bound level

2.5. The preferred option

The project team considered option 2 the preferred option. This option was chosen due to the highest Net Present Value, the best strategic fit, the number of opportunities/strengths and the option which will provide the best service (in the context of locality) for the local population.

In addition, Options 3 and 4 require the costly addition of an additional High Voltage sub-station which is may increase the time frame for the project and include a variety of additional risks.

2.6. Quality assessment

This section outlines the Trust's approach to ensuring quality and safety of the service in terms of building environment, requirements around infection control, privacy, dignity, disability and equality. Additional detail around the environmental sustainability of the proposed radiotherapy unit is also included. As the provider of the service MTW has a responsibility to review the quality aspects of the business case. Options were assessed for benefits and for risks. A Quality Impact Assessment that assesses the key areas affected by the investment has been collated. The key quality dimensions that were assessed are Clinical Effectiveness, Safety and Patient Experience.

Work stream: Potential Reconfiguration of Linac Machines and Satellite Units.

Scheme/Project: To potentially reconfigure the placement of Linac Machines and provide a satellite Unit at Tunbridge Wells.

Clinical Effectiveness	Have clinicians been involved in the service re-designed? If yes, list who. Dr Sharon Beesley, Clinical Director for Cancer and Haematology and Clinical Oncologist. Full discussion at the Cancer and Haematology Care Group meetings attended by all Consultants in oncology. This has also been discussed at the Cancer and Haematology departmental governance meetings and is included in the Annual Business Plan.
	Has any appropriate evidence been used in the redesign? (e.g. NICE guidance) Yes, the national predicted patient demand for radiotherapy activity levels (known as MALTHUS modelling Actual activity levels achieved in the last 5 years. National benchmarking with other satellite radiotherapy units. National trends in growth in oncology patients from a variety of sources including Macmillan and the Royal Colleges.
	Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate. The radiotherapy department monitors a number of key performance indicators including efficacy of treatment, number of fractions of radiotherapy per patient, incidence of side effects (minimal). The Directorate regularly audits radiotherapy practise and there are a number of regular annual clinical audits on radiotherapy treatments. Complication rates are audited on a regular basis and discussed at the clinical governance meetings and monitored on the Trust Dashboards. The directorate participate on Mortality and Morbidity meetings continually learn and improve on clinical outcomes. Both the Radiotherapy and Physics departments are ISO 9001:2008 certified and CHKS accredited. Clinical Quality is a large part of the accreditation process.
	Are there any risks to clinical effectiveness? If yes, list There are minimal risks to clinical effectiveness by having a satellite TWH linac: • The patient experience may be affected if the satellite unit does not offer the exact same treatments as the main oncology centre. • This would be mitigated by moving any patient who requires a treatment to the main site. • The satellite unit will have a standard operating procedure for each treatment protocol. • This will ensure that there is no risk to clinical effectiveness. • Staffs will rotate through the KOC sites (where appropriate) and therefore all staff will remain competent minimising risk.
	Have the risks been mitigated? Yes – the satellite unit will be subject to the same clinical protocols that already exist in the department. These are all mitigated by standard operating procedures and risk assessments are already in place where required.
	Have the risks been added to the departmental risk register and a review date set? Yes.
	Are there any benefits to clinical effectiveness? If yes, list Patients will be treated closer to home by expanding the number of locations that radiotherapy machines are sited at. There is a percentage of the population that are either unable or unwilling to travel for Radiotherapy treatments. A satellite unit will facilitate more patients having what is the most cost effective form of cancer treatment.

	It is also a non-invasive treatment which improves the patients' experience of treatment. The satellite unit can also be used for support clinics which further optimise the patient experience. The team will continue their current practises and activity levels and therefore income levels. There will be capacity by extending working days to increase activity and treat more cancer patients thereby improving quality of life for patients.
Patient Safety	Has the impact of the change been considered in relation to: Infection Prevention and Control? *Yes – the department follows the trust policy on infection prevention and has regular visits from the infection control team.* Safeguarding vulnerable adults/ children? *Yes – children will not use this service and vulnerable adults will be managed in accordance with Trust policy.* Current quality indicators? *Yes, the scheme will use all of the quality indicators on the Trust KPI dashboard in particular:* *Patient activity levels, performance against the cancer targets and other access targets, new to follow up ratios, infection control rates, and morbidity and mortality data. Furthermore the Radiotherapy team have a number of national returns to professional bodies which monitor quality which will be unaffected by this change.* Quality Account priorities? *Yes, the scheme will adhere to all of the quality account priorities (see above also).* CQUINS? *None known about at the time of writing.*
	Are there any risks to patient safety? If yes, list There are no known risks to patient safety at the time of writing as the radiotherapy service is highly governed and there are a number of inherent patient safety checks that are performed prior to administration of radiotherapy.
	Have the risks been mitigated? Yes, all of the existing risks have been mitigated appropriately.
	Have the risks been added to the departmental risk register and a review date set? Yes
	Are there any benefits to patient safety? If yes, list Yes- patients using the satellite unit will have a quality service delivered in an appropriate time scale in a geographically convenient location.
Patient Experience	Have the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not. Yes, the impact of the redesign has been assessed. There should be no impact on the patients/ carers or members of the public apart from the radiotherapy patients being offered a superior service to the one that is currently available within the existing resources. I.E. care will be delivered closer to home and unmet patient need could be met.
	Has the impact of the change been considered in relation to: Promoting self-care for people with long-term conditions? Patients treated and consulted at the new radiotherapy centre will be managed by current MTW staff who will always promote self-care when applicable in addition to their treatment. Tackling health inequalities? The radiotherapy department is open to all patients who access health services and can accommodate all types of patients as per the Trust's Access Policy.

	Does the redesign lead to improvements in the care pathway? If yes, identify Yes, patients will be seen in a location closer to home and meet unmet patient need for treatment.	
	Are there any risks to the patient experience? If yes, list No.	
	Have the risks been mitigated? *N/A.*	
	Have the risks been added to the departmental risk register and a review date set? *N/A.*	
	Are there any benefits to the patient experience? If yes, list Yes, see above.	
Equality and Diversity	Has the impact of redesign been subject to an Equality Impact Assessment? Yes	
	Are any of the 9 protected characteristics likely to be negatively impacted? (please attach Equality Impact Assessment) No.	
	Has the negative impact been added to the departmental risk register and a review date set? N/A.	
Other	Has a cost benefit analysis been completed as part of the assessment of the business plan? There is a cost associated with a satellite unit however there is more than adequate income from the service to cover these costs.	
Service Impact	What is the overall impact on service quality – please tick one box	
	Improves service quality	✓
	Maintains service quality	
	Reduces service quality	

Clinical lead:	Dr Sharon Beesley
Project lead:	Stephen Duck
Date of completion:	19/06/2015
Date for review:	19/06/2015

2.7. Building standards

The Health Building Note 02-01 (Cancer treatment facilities) and Health Technical Memoranda (HTM) are to be used as a basis for the functional design plans, and to define the type and number of rooms within the agreed schedules of accommodation. Additional guidance will be sought by assessing the proposed design against the Macmillan Quality Environment Mark (MQEM) which assesses the building environment for people affected by cancer.

2.8. Infection control

The prevention and control of infection is a priority for MTW, and it is important that infection control requirements are designed in at the planning stages of any healthcare facilities, including new builds, refurbishments or change-of-use projects.

The MTW Infection Control Team will be involved in planning and design stages for the new radiotherapy unit. The Team will continue to be involved throughout the construction process and to the final stage of the project (handover to clinical use).

The design plans have been drawn up in consideration of the HBN 00-09: 'Infection control in the built environment'. As part of the project the building contractors will work together with the Infection Control Team on a number of infection control aspects including, but not limited to:

Ensuring functional layout of rooms prevent cross-contamination with organisms that can lead to potential infections in patients;

Ensuring finishes to floors, walls, ceilings, doors, windows, and any other fixtures and fittings are compliant with HBN and HTM standards;

Ensuring that any ventilation and air transfers systems are safe and limit the risk of carrying infections around the building.

3. The Commercial Case

3.1. Workforce impact

The workforce model for the unit will comprise medical, nursing, radiotherapy, medical physics and administrative staff groups. The model is based on the recommendations set out in national documents and reflects the standard staffing adopted for radiotherapy units across the UK.

Table 21 Summary of the unit additional workforce for Option 2 (per Agenda for Change band and per WTE)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Other	Total
Radiotherapy Staff				1.20	1.50	1.50	1.50		5.70
Admin	2.00		0.75						2.75
Clinical Physics				0.31	0.69	2.20	0.70		3.90
Computer Sciences					0.60				0.60
Nursing	0.48			1.20					1.68.40
Total	2.48		0.75	2.71	2.79	3.70	2.20		14.63

The table above, details the additional staffing requirements to open the TWH satellite for the extended working day for the extra capacity plus the staff required to ensure safe staffing for a satellite service. As the number of linacs will not change within the centre, it is assumed that the existing staff, equivalent to 1 linac (covering the normal working day) will transfer from MH to TWH, however there is a need for some additional staff to ensure a safe and efficient satellite service as well as the additional treatment hours in extending the normal working day (Appendix E).

Assumptions are:

- Radiotherapy is providing an 8-8 service Monday to Friday. Staff from 1 linac will also move across to TWH.
- Nursing cover to support the clinics is between 9 – 5.
- Patients are generally fit and well and will not require nursing care whilst waiting for transport.
- The cost of physics commissioning will included within the capital costs for the linac replacement programme

3.2. Procurement options

The trust will provisionally manage the procurement through a framework agreement - Procure 21+. This is a national framework agreement with six Principal Supply Chain Partners (PSCPs) and their supply chains, selected by OJEU tender process for capital investment construction schemes. Any NHS client or joint-venture may use the framework for a capital construction scheme without having to go through the OJEU process themselves.

An assessment and decision of the procurement process will be completed by the Trust's estates and facilities department and will be detailed within the FBC.

The project team have engaged with the Procure 21+ Investment Advisor and the scheme has been registered by the project team. A High Level Information Pack has been distributed to the PSCPs in January; the PSCPs who have declared an interest in the scheme have been interviewed with an appointment of the PCSP made in March 2016. This appointment was to take the project to 1:200 plans and submit planning permission only until finance for the design to GMP are approved and released by the Trust.

3.2.1. Procure 21+ Training

Procure 21+ has provisionally been assessed as suitable for the project by the Trust's Estates and Facilities department; members of the project team have completed basic Procure 21+ training in December 2015 in order to support their role in the process. This is prior to the appointment of the Principal Supply Chain Partner (PSCP) to ensure full benefit of the process is realised.

4. The Financial Case

Option	Detail	Year	Revenue cost £ (-ve = cost)	Income £ (= increase)	Net Loss/ Surplus £ (-ve = loss)	Build and infrastructure costs £ (-ve = cost)	NPV over 30 Years £ (-ve = net present cost)	Benefits Ranking 1st highest	Risk Ranking 1st Lowest
1a	Do minimum extended working day		-88,700	-160,760	-249,460	0	-4,840,422	4th	4th
1b	Do minimum weekend-lite working		-595,23,4	-160,760	-755,994	0	-14,669,005	4th	4th
2	Two new bunkers at TWH	Year 1	0	0	0	-7,463,272	1,602,777	1st	1st
		Year 2	-765,686	1,224,330	458,644				
		Year 3	-765,686	1,224,330	458,644				
		Year 4	-765,686	1,224,330	458,644				
3	Two new bunkers at MH	Year 1	0	0	0	-10,750,659	-172,378	2nd	2nd
		Year 2	-182,566	600,952	418,386				
		Year 3	-182,566	600,952	418,386				
		Year 4	-182,566	600,952	418,386				
4	One new bunker at MH	Year 1	0	0	0	-9,301,147	-50,429	3rd	2nd
		Year 2	-147,519	600,952	453,433				
		Year 3	-147,519	600,952	453,433				
		Year 4	-147,519	600,952	453,433				

4.1. Affordability

Income efficiency as 2 bunkers will mean no Linac downtime: this equates to an average income per RT attendance of increased activity of 4,042. In essence the downtime associated with capital upgrade is eliminated. It is assumed that the Linac at TWH will attract private patients to offset the income loss at Maidstone when Kings Hill opens. Additional income assumed due to the TWH catchment area. An estimate of this activity is 3,500 fractions plus additional income from planning and reviews. This would mean an additional session 5 days a week. This additional staffing has been included within the revenue costs.

Once engagement and further project planning has been agreed by PSCP and stakeholders, the financial impact will be further detailed within the FBC.

The financial assumptions are also detailed elsewhere, but can be summarised as follows;

4.2. Capital

The OB1 form at Appendix G shows the capital cost for the preferred Option. The Departmental Costs total £2,963,276 excluding VAT. The On Costs are calculated as adding a further 31.69% to the Departmental costs, giving a total Works cost at December 2014 of £3,902,276 excluding VAT. In order to fully estimate the Building cost for the Option, Fees and Non works costs such as Planning applications and Building Regulations are added.

Fees do not attract VAT but all the other adjustments do. A further Planning contingency of 5% is included, which is also subject to VAT.

This gives a comprehensive Capital cost if the work was to commence immediately, so there is a final adjustment made to inflate the figure to the quarter in which the work is expected to start, which in this case is Q1 2017, so the figures are then uprated by a factor of 223/195, or 14.4%. The total capital is £7,463,272.

The preferred option 2 requires an investment above £5 million at PUBSEC223 levels and therefore needs TDA approval. MTW is part way through an agreed recovery plan, and does not have the ability to generate this level of capital internally, and will also therefore need to seek external finance (e.g. loan) from the TDA to support this scheme.

The preferred option demonstrates the highest NPV over 30 years which demonstrates that it the largest benefit and is the best value solution. In addition Option 1a (do nothing) is both an unsustainable option and more costly than the preferred option. Therefore, the preferred option provides both a much more sustainable solution compared to do nothing and has a net benefit.

Within the preferred Option 2 the NPV has been calculated by assuming that the timing of the capital expenditure will be in line with the dates in Table 20, that is the start date is 20th February 2017, and will be completed on 31st March 2018. Clearly there are timing risks associated with the confirmation of approval, contractual arrangements and receiving permissions which will have to be managed. The capital cost in the OB1 has been updated to PUBSEC level 223 in line with a start date in Q1 2017. The other options are being similarly updated.

4.3. Revenue Costs

In calculating the Revenue costs for each option, the following assumptions have been made;

4.3.1. Option 1a

The Staff costs represent the current cover arrangements so that the sum of £88,700 is for overtime, unsocial hours and additional linac serving costs (at the weekend) during the linac replacement programme.

The loss of Private Patient Income to King's Hill represents a total of £459,315. The Trust assumes that this capacity will be replaced by the same number of treatment fractions for NHS patients. As this is a do nothing option, there is no associated capital cost.

The resulting NPC of £-4,840,422 is the second highest figure of the options, and represents a cost over time rather than a benefit. The period for discounting is 30 years and the discount rate is 3.5% in line with Treasury Green Book requirements. As stated elsewhere, the option is unsustainable, and does not address any capacity problems.

4.3.2. Option 1b

This is a variant of the Do nothing option with the significant difference that the present weekend cover arrangements are replaced by a much fuller service, albeit not one that is the same as the present Monday to Friday service.

The Staff costs include the current weekend cover arrangements plus an extended day costing £595,234. The breakdown of this can be seen in Appendix F.

The resulting NPC of -£14,669,005 represents the highest net cost over 30 years.

4.3.3. Option 2

The preferred Option has the highest NPV over 30 years and is ranked first on that basis, which complements the other results for qualitative benefits and non-monetary benefits in Tables 16 and 17.

The Capital spend is spread equally over the construction period of 20th February 2017 to 31st March 2018, which may be a simplification of the actual construction profile but would need further work up in order to be confirmed, and the PUBSEC uplift reflects that the building will start in Q1 2017.

The income assumptions differ from the do nothing in that having the extra bunker will eliminate the downtime associated with current Linear Accelerator replacement, which equates to 6% inefficiency. This is calculated as an income sum of £761,712. In addition the location in TWH has been estimated to increase access to the population resulting in a net increase in £462,618 of NHS work from Year 2. This is net of the loss of MTW PP income and activity.

As the development is assumed to be funded from an externally financed loan, the interest on the loan and its repayment have been included in the costs, and depreciation has been calculated over 30 years, in line with the accounting treatment of bunkers at Maidstone Hospital, and has been confirmed with Estates Dept. at MTW. The calculations of this can be seen in Appendix O.

The revenue cost for staff are based on the additional staff needed to run satellite unit, and the numbers and grading of staff are detailed in Table 19. These staff are expected to start on 2nd March 2018 and both Income and Revenue costs are calculated from this date. Capital charge costs are calculated from the end of construction on 31st March 2018.

A discount value of 3.5 % has been used in calculating the NPV. The resulting NPV of £1,602,777 is the highest of the options, without applying any Optimism Bias. As the Option has the lowest capital cost (when the HV substation is added in) it is no surprise that Table 19 shows the smallest range and lowest upper bound figure. The indicative figures for the Upper and Lower bounds are from Green Book.

NPV breakdown of the options can be seen in Appendix N.

4.3.4. Option 3

This Option at Maidstone involves building 2 bunkers at Maidstone Hospital and installing a High Voltage substation as there is insufficient capacity thin the current infrastructure to support the increase in treatment fractions.

As with the preferred option, the investment is over £5 million in total and will need both TDA approval and a loan from the TDA to deliver the solution. The Bunker is depreciated over 60 years, and the substation is depreciated over 30 years. At the moment the calculation uses the same assumptions over timing as Option 3 but in reality, the real timetable may be delayed compared to Option 2 given that the Option includes the substation and as planning permission has not yet been sought; so that the additional costs for maintaining current provision is added to Year 0, with capital in Years 1 and 2. A final calculation will be made to confirm but it is estimated that the relative size of difference in NPC will not change polarities, nor affect order.

The Income calculation assumes a loss of PP activity in line with Option 1 but additional efficiency at the same rate as Option 2.

The additional staffing required is lower than the satellite unit at TWH, primarily because additional support is already on site.

4.3.5. Option 4

This Option at Maidstone involves building 1 bunker at Maidstone Hospital and installing a High Voltage substation as there is insufficient capacity thin the current infrastructure to support the increase in treatment fractions.

As with the preferred option, the Option assumes that the investment is over £5 million in total and will need both TDA approval and a loan from the TDA to deliver the solution. There is a high initial capital cost for this option despite the result being one additional bunker to the KOC; in comparison to options 2 and 3. The Bunker is depreciated over 60 years, and the substation is depreciated over 30 years. At the moment the calculation uses the same assumptions over timing as Option 3 but in reality, the real timetable could be delayed compared to Option 2 so that the additional costs for maintaining current provision is added to Year 0, with capital in Years 1 and 2. A final calculation will be made to confirm but it is estimated that the relative size of difference in NPV will not change polarities, nor affect order.

The Income calculation assumes a loss of PP activity in line with Option 1 but additional efficiency at the same rate as Option 2.

The additional staffing required is lower than the satellite unit at TWH, primarily because additional support is already on site.

4.4. Summary of Financial Case

The options have been assessed over a 30 year period using a 3.5% discount rate as required by Green Book.

The highest NPV is Option 2, the preferred Option. The calculations have been recalculated by the Optimism Bias upper and lower bounds which confirm the order.

The analysis has shown that only two options result in a positive NPV over 30 years; however the preferred option will result in two radiotherapy linac bunkers in comparison to the one bunker with option 4.

The Income in Option 2 is assumed to relate to 3,500 fractions of treatment as well as a number of billable reviews and planning attendances. The total activity is 4,317 billable events. It is assumed that the bunker becomes available on 2nd April 2018 and so the Income and expenditure in year has been appropriately as pro rata, as has depreciation. The Loan that will be needed has been assumed to have 2 payments per year on 15th September and 15th March so that there are full year charges in the year of opening. This explains why there is a loss in Year 1 but a recurrent surplus from Year 2 onwards.

Within the NPV model over 30 years, the circular costs associated with capital, and the non-cash adjustment depreciation have been excluded from the calculation as per Green Book guidance, and the Option 2 has the largest positive NPV. This indicates that the benefits in the form of increased income are greater than the associated costs. The Bunker has been depreciated over 60 years and for Option 3 & 4 the substation has been depreciated over 30 years, and IT over 10 years in all Options.

For Options 3 and 4, the loss of PP is assumed for the full year, but replacement has been based on opening the new bunker/s and on the same basis as Option 2 equates to 1,951 billable events, 1,582 of which are fractions. No commissioner support has been given at this stage but the case is being presented to them.

5. The Management Case

5.1. Project management arrangements

The technical leadership and project management will be provided internally by MTW NHS Trust.
The governance arrangements are covered by the MTW Governance arrangements whereby the project board (see below) will report into the CDDM which is chaired by the Clinical Director for Cancer and the Maidstone Program Board which is chaired by the Chief Operating Officer.
The main aims are to:

- Ensure the decision making can be integrated with MTW normal management processes as much as possible
- Clinical leadership and project management support can be targeted effectively and efficient
- Best practice is applied in terms of project management (PRINCE 2) and governance

As part of the project, business assurance and benefits realisation key performance indicators (6.5) along with risk and contingency plans (6.6) have been developed and will be updated as the project develops.

The Procure 21+ process has been initiated in order to minimise the project timescales, and PSCP contractors have been interviewed and evaluated.

This has resulted in an adapted Proposed Project Time Frame as follows to avoid significant delay:

- 01/05/16 Release of finance to continue design phase to GMP.
- 03/05/16 Commencement of stage 3 design
- 09/09/16 Receipt of Gross Maximum price
- 19/09/16 FBC submission to Finance Committee and Trust Board
- 06/09/16 Anticipated Planning Approval decision date
- 06/01/17 TDA FBC Approval
- 20/02/17 Contractor start on site
- 20/10/17 Installation of Linear Accelerator
- 20/11/17 Physics Commissioning
- 31/03/18 End of Construction Period
- 02/04/18 Facility Opens

5.2. Project Governance

The Project Board is to ensure that the Project is managed effectively, efficiently and timely. The Project Board will report into the Maidstone Program Board, chaired by the Chief Operating Officer for MTW, and the Cancer & Haematology Directorate Board.

5.2.1. Project Board and Project Team Membership

The members of the Project Board are as follows:

- Director of Finance
- Director of Estates and Facilities (Project Director)
- C&HD Clinical Director
- Director of Medical Physics (Oncology Project Director)
- Director of ICT
- Directorate Quality Manager (Oncology Project Manager)

The members of the Principles Group are as follows:

- Director of Estates and Facilities
- Sweett Client Project Manager
- Framework Manager, Kier Health
- Operations Director, Kier Southern

The members of the Core Team are as follows:

- Sweett Client Project Manager
- Directorate Quality Manager, MTW
- Head of Estates Strategy, MTW
- Head of Quality, Fire and Security MTW
- Kier Project Team Leader
- Project Director, WSP Group
- Studio Associate Director, IBI Group
- Managing Surveyor, Kier Southern

The Members of the oncology project group are as follows:

- Director of Medical Physics, Oncology Project Director (chair)
- Clinical Director of Cancer and Haematology Directorate
- Clinical Lead for radiotherapy, Consultant Oncologist
- Consultant Clinical Oncologist (incl. deputising for Clinical Director)
- General Manager of Cancer and Haematology Directorate
- Directorate Quality Manager, Oncology Project Manager (deputy chair)
- Operations Manager of Cancer and Haematology Directorate
- Head of Radiotherapy Physics
- Head of Radiotherapy Services
- Head of Health Physics and Imaging Group
- Cancer Lead Nurse
- Head of Computer Science Operations
- Senior Registrar in Oncology

5.2.2. Project Group Sub-Committees

The project board will consist of reporting sub-committees at varying stages of the project including:

Operations Group
Trust emergency planning
Contractor and Site Liaison Team
Commissioning Team
Radiotherapy Technique Group

Design Team/ User Group including:

- Directorate Quality Manager, MTW
- Head of Estates Strategy, MTW
- Head of Quality, Fire and Security MTW
- Operations Manager of Cancer and Haematology Directorate

- Head of Radiotherapy Physics
- Head of Radiotherapy Services
- Head of Health Physics and Imaging Group (Trust RPA)
- Cancer Lead Nurse
- Head of Computer Science Operations
- Senior Registrar in Oncology
- Clinical Lead for radiotherapy, Consultant Oncologist
- Consultant Clinical Oncologist (incl. deputising for Clinical Director)
- Head of Category Management
- Materials Management
- General Manager Facilities (TWH)
- Infection Prevention and Control
- Estates Manager
- EME Services Manager
- Clinical Applications Training & Support Manager

5.3. Project plan and timetable

Table 22 Project Plan.
(Appendix D Gantt Chart)

No	Activity	Start	Finish	Total Duration
1	**Key Dates / Project Diary**	**23 Mar 16**	**21 Dec 16**	**38w**
2	Trust Board Meeting Dates	23 Mar 16	21 Dec 16	
3	Planning Committee Dates	29 Jun 16	20 Dec 16	
	Project Board Meetings			
4	Stakeholder Engagement Meetings S1 (Weekly)	06 Apr 16	27 Apr 16	
5	Stakeholder Engagement Meetings S2 (Weekly)	05 May 16	26 May 16	
6	Stakeholder Engagement Meetings S3 (Fortnightly)	09 Jun 16	19 Jul 16	
7	**PSCP Procurement**	**09 Mar 16**	**27 Jun 16**	**14w 4d**
8	Appoint PSCP / Issue Letter of Intent	14 Mar 16	14 Mar 16	
9	LOI Issued / Commence 1:200 Stage Design	14 Mar 16	14 Mar 16	
10	Team Planning	09 Mar 16	15 Mar 16	1w
11	Organise / Diarise Launch Workshop	10 Mar 16	15 Mar 16	4d
12	Hold Initial Principals meeting	17 Mar 16	17 Mar 16	1d
13	Prepare Revised Draft Programme	18 Mar 16	18 Mar 16	1d
14	Client Team Programme Review	21 Mar 16	24 Mar 16	4d
15	Agree Revised Timeline	24 Mar 16	24 Mar 16	1d
16	Diarise Launch Workshop	29 Mar 16	05 Apr 16	1w 1d
17	Prepare Initial Work Activity Schedule	29 Mar 16	01 Apr 16	4d
18	Hold Launch Workshop	06 Apr 16	06 Apr 16	1d
19	Scheme Affordability Review	06 Apr 16	22 Apr 16	2w 3d
20	Trust Review initial 1:200 for OBC	18 Apr 16	26 Apr 16	1w 2d
21	Trust Approve Stage 3 Detailed Design	25 Apr 16	29 Apr 16	1w
22	Client Approves Affordability	03 May 16	03 May 16	
23	OBC Submitted to TDA for Approval	03 May 16	03 May 16	
24	TDA Review Period	03 May 16	27 Jun 16	7ew 6ed
26	**Principle Scheme Design**	**24 Mar 16**	**29 Apr 16**	**5w**
27	Trust Issue Final S.O.A	24 Mar 16	24 Mar 16	1d
28	Trust Prepares / Issues Client Brief	29 Mar 16	01 Apr 16	4d
29	Stage 3 Cost and Activity Review	04 Apr 16	22 Apr 16	3w
30	Prepare and Issue 1:200 Designs	04 Apr 16	29 Apr 16	4w
31	**STAGE 3 - Design and Cost to FBC**	**03 May 16**	**20 Jan 17**	**36w 1d**
32	PSCP Commence Stage 3 Design	03 May 16	03 May 16	
33	Principle Scheme Design (Planning Stage)	03 May 16	27 May 16	3w 4d
34	**Planning Submission**	**31 May 16**	**06 Sep 16**	**14w**
35	Planning Application (Anticipated submission)	31 May 16	31 May 16	
36	Planning Consulation Period	31 May 16	26 Aug 16	12w 4d
37	Anticipated Planning Decision Notice	06 Sep 16	06 Sep 16	
38	**Design Development & Planning Control**	**03 May 16**	**07 Nov 16**	**26w 3d**
39	Survey Work	03 May 16	16 May 16	2w
40	Detail and Technical Designs (RIBA S4 1:50/1:20)	16 May 16	19 Aug 16	13w 4d
41	Detailed Services Design	16 May 16	19 Aug 16	13w 4d
42	Production Information (RIBA S4/5 Details)	22 Aug 16	07 Nov 16	11w
43	**Cost and Business Case Development**	**31 May 16**	**20 Jan 17**	**32w 2d**
44	**Route to GMP**	**31 May 16**	**09 Sep 16**	**14w 3d**
45	Cost Reviews and Reports	31 May 16	31 May 16	
46	Initial Market Testing	31 May 16	15 Jul 16	6w 4d
47	Principle Design Cost Review	18 Jul 16	18 Jul 16	
48	Continued Market Testing	18 Jul 16	09 Sep 16	7w 4d
49	PSCP Confirm GMP	09 Sep 16	09 Sep 16	
50	**Development of FBC**	**15 Aug 16**	**20 Jan 17**	**21w 3d**
51	Outline Full Business Case	15 Aug 16	25 Aug 16	1w 4d
52	Project Board - FBC Initial Review	26 Aug 16	26 Aug 16	1d
53	Trust Team Review and Confirm GMP	30 Aug 16	15 Sep 16	2w 3d
54	Project Board - FBC Sign Off	16 Sep 16	16 Sep 16	1d
55	Prepare Board Papers	25 Aug 16	16 Sep 16	3w 1d
56	Submit Board Papers	19 Sep 16	19 Sep 16	
57	Trust Board Meeting / Approval	27 Sep 16	27 Sep 16	
58	Preparation of Contract Documents	12 Sep 16	30 Sep 16	3w
59	Review / Comment on Formal Agreements	03 Oct 16	21 Oct 16	3w
60	TDA Review Period	03 Oct 16	06 Jan 17	12w 4d
61	Engross Agreement	09 Jan 17	20 Jan 17	2w
64	Kier Mobilisation period	23 Jan 17	17 Feb 17	4w
68	Start on Site	20 Feb 17	20 Feb 17	

5.4. Business assurance and benefits realisation arrangements

The benefits identified, set out below, will be monitored throughout the development of the scheme, via post implementation reviews (PIR), to maximise the opportunities for them to be realised.

Table 23 Outcomes Assurance

Benefit Owner	Benefit	Baseline value	Target Value	Measurement	Timing	Responsibility (measure and report)
Cancer directorate	Increased overall radiotherapy attendances to a level of 73769. This being 7800 more attendances that in 2014/15	7800 * attendance *tariff (£300 estimate*) = £x M per annum extra tariff)		SLA finance data	6 months after go live	Directorate finance manager
Cancer directorate	Maintain PP radiotherapy at least 4% despite competition from the new King's HILL private radiotherapy centre	Maintain value of pp radiotherapy as per 2014/15 adjusted for price changes		SLA finance data	6 months after go live	Directorate finance manager
Cancer Directorate	Shorter travel times for patients	Qualitative benefit	200 travel miles saved on average for each patient treated at the TWH	Strategy with information patient data set	6 months after go live	Strategic Information
Cancer Directorate	Robust and flexible provision of radiotherapy capacity	No breaches of radiotherapy waiting times		Performance inflation	Monthly directorate Information dashboard	Performance Information

5.5. Risk Management and Contingency plans

The project used a standard MTW risk matrix scoring to develop a project risk register.

Table 24 Project Risk Log

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
1. Governance								
1.1	Ensuring clinical, scientific and technical standards are maintained at the satellite.	18.06.15	4	3	12 (Amber)	Include the Tunbridge Wells Satellite into the quality management system scope; including equipment maintenance and clinical processes. Ensure relevant and robust process audits are undertaken by trained QMS auditors. Senior staff rotation to the satellite and clinical oncologist presence. Communication facilities in place to enable radiographers and/or medical physics staff to contact senior and more experience staff when required. Review of clinical incidents and issues at the monthly quality and governance meetings.	4 (Blue)	
2. Operations								
2.1	Moving patient notes between Maidstone and Tunbridge Wells in a timely manner.	18.06.15	3	2	6 (Green)	Courier bag currently goes to TWH daily Continue information governance processes to ensure compliance. Include notes transfer into quality management system audit schedule. Review clinical and non-clinical incidents at the directorate quality and governance committee. Ensure processes/systems are continually in place; including responsible persons. Utilise IT systems to ensure effective and efficient systems.	3 (Blue)	

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
2.2	Patients decline to be treated at TWH when capacity is available.	18.06.15	2	4	8 (Green)	Local marketing of the new facilities available prior to launch to drive public appeal of TWH RT treatment Promotion of positive facilities i.e. linac, car parking, setting on an individual basis. Ensure consultants fully support and encourage the use of TWH facilities when relevant. Ensure patient information in relation to the linac is finalised prior to launch Monitor clinical incidents and complaints at the directorate quality and governance with actions to remedy.	6 (Green)	
2.3	Patients decline radiotherapy because they do not wish to travel to Maidstone for planning.	18.06.15	2	4	8 (Green)	Ensure consultants encourage the need for RT planning. Oncology Consultants and supporting staff to clearly explain that only 1 trip for planning is required. Ensure patient information in relation to the linac is finalised prior to launch including detailed information on the need for RT planning. Arrange robust transportation pathways for patients who require trust transportation. Monitor clinical incidents and complaints at the directorate quality and governance with actions to remedy.	6 (Green)	
3. Workforce								
3.1	Existing staff decline to work at TWH	18.06.15	2	4	8 (Green)	The requirement to work at Tunbridge Wells will be included within the job description of new staff. Consideration and calculation of natural staff turnover. If it's high and staff are not staying consider a recruitment and retention premia as per agenda for change. Meet with staff to gather feedback & reasons why then form and implement an action plan. Promotion of benefits of working at Tunbridge Wells to be suggested to staff including transport links to London. Staff bus is already in place which facilitates moving staffs between sites.	4 (Blue)	

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
3.2	Fail to recruit additional qualified staff	18.06.15	3	3	9 (Green)	The radiotherapy and physics departments already have strong links with the universities/professional bodies. These will be maintained. The existing practice of encouraging newly qualified staff to work for MTW NHS Trust will continue. Promotions and Benefits of working for MTW marketed (Recruitment Drives) Encourage MTW students to continue their career working for MTW The annual workforce strategy will include succession planning which would plan for natural staff turnover. The Directorate has permission to recruit to the department's vacancy and turnover percentages which reduces the amount of time that vacancies are empty. The Directorate will investigate options for managing overtime & additional hours to existing members of staff. The Directorate management team would regularly review the staffing situation and take actions to ensure that all units were safely staffed. Senior team members would also be asked to act down and cover the treatments on machines. In times of staff shortages clinical treatments would be prioritized and other activities such as audits/ staff appraisals etc. would be delayed.	6 (Green)	
4. Design, Planning & Buildings								

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
4.1	Delay in obtaining planning permission or planning permission denied.	18.06.15	3	3	9 (Green)	If planning permission is delayed the Trust Estates team will proactively work with the Council to resolve the issues. All queries will be responded to in a timely manner. All requests for information/ changes to the project design would also be responded to in a timely manner in order to avoid further delay. Ensure plans drawn and submitted in a timely manner. Ensure benefits to the public are fully realised within planning application. Ensure collaboration with the council planning team to discuss other options prior to planning submission. If denied planning permission, consider alternative option for RT provision.	4 (Blue)	
4.2	Significant disruption to patient car park facilities and site roadways during construction.	18.06.15	1	5	5 (Green)	Provide parking elsewhere during construction Ensure full collaborative working with the trust car parking team during the planning stages of the build; this will include appropriate staff and patient notification.	5 (Green)	
4.3	Parking facilities for patients and staff when centre open.	24.11.15	1	5	5 (Green)	It is anticipated that an extra 4 car parking spaces will be used for patient parking and 8 staff parking will be required (Appendix K). It is anticipated that the good practice performed at Maidstone hospital of allocated parking for oncology patients will continue at Tunbridge Wells. This will be situated in the car park to the upper rear of the centre. A drop off area will be incorporated into the plan for taxis and hospital transport. This will be at the front of the building with access to the ground floor of the building. There will be the addition of zebra crossings to the front of the building to enable safe crossing for patients who may have caught the public bus to the hospital.	3 (Blue)	

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
5. Information Technology								
5.1	Failure of IT link between Maidstone and Tunbridge Well's satellite.	18.06.15	5	1	5 (Green)	Ensure collaborative working with the trust and directorate IT teams during the planning stage. Ensure an individual project plan and IT risk log is completed by the directorate computer sciences department. Ensure IT connection possible prior to business case finalisation and purchasing. If connectivity not possible, consider other option for RT provision.	4 (Blue)	
6. Treatment unit and equipment commissioning								
6.1	Lack of available Medical Physics staff to commission the new linac	22.06.15	3	2	6 (Green)	In line with mitigating actions points 3.2: Links with the universities/professional bodies to encourage newly qualified staff to work for MTW NHS Trust Promotions and Benefits of working for MTW marketed (Recruitment Drives) Encourage MTW students to continue their career working for MTW Create a robust workforce strategy to plan for natural staff turnover and begin recruitment process prior to staff leaving. Offer staff overtime if necessary.	6 (Green)	
7. Facilities management								
7.1	Site security	18.06.15	5	2	10 (Amber)	Ensure collaborative working and agreement with the trust security teams and construction teams during build and post build to ensure appropriate security of the site. Ensure security systems are incorporated in the architect's drawings prior to planning permission submission and building regulation submission. Adhere to the trust lone worker policy and ensure keypad lockable doors are added to areas with information sensitive information.	6 (Green)	

ID	Risk description	Date added	Consequence/Severity	Initial Likelihood 1-5	Risk Score Severity x	Summary of Mitigating Action and timescale	Revised risk score	Lead officer
7.2	Breakdown/unavailability of drop-gate van bringing supplies from the main site.	18.06.15	3	2	6 (Green)	Ensure alternative means of delivery will be available for continuity purposes; to be included in the Business Continuity Plan.	2 (Blue)	
8. Communication, stakeholders								
8.1	Lack of stakeholder buy-in.	18.06.15	3	2	6 (Green)	Local marketing of the new facilities available prior to launch to drive public and clinical community appeal of TWH RT treatment by the trust communications department. Promotion of positive facilities i.e. linac, car parking, setting on an individual basis. Ensure consultants fully support and encourage the use of TWH facilities to all stakeholders when relevant. Ensure stakeholder information in relation to the linac is finalised prior to launch. Promotion at patient locality groups. Meetings with specialist commissioners by senior trust management throughout the business case and on-going. Lack of engagement from specialist commissioners and trust board - chose another option for additional radiotherapy provision. MTW staff- engage and communicate with all internal stakeholders on a regular basis including project board meetings, operational meetings, Chief Exec's newsletters, etc.	4 (Blue)	

5.6. Arrangements for post project evaluation

Post Project Evaluation (PPE) will be undertaken to improve future project briefing, project management, and implementation for future projects.

PPE will include:

1. Process issues - in 5 case model called the Post evaluation review (PER)
This review appraises how well the project was managed. The project evaluation, should be undertaken as soon as possible after the implementation of the service to capture lessons learnt

2. Outcome issues - in 5 case model called the Post implementation review (PIR)
This review ascertains whether the anticipated benefits have been delivered. This will be timetabled to occur 12 months from the commencement of live running. It will be used to measure the performance of the completed facility against the benefits identified within this Business Case.

The following template will be completed as part of the PPE.

POST PROJECT EVALUATION TEMPLATE

Name of Directorate …
Evaluation manager
Project Title & Reference
Total Cost …
Start date …
Completion date …
PPE Due Date …

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
…

Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.
…

SECTION 2: PROJECT PROCESS EVALUATION
Project documentation issues …

Project execution issues…

Project governance issues…

Project funding issues…

Human resource issues…

Information issues…

What worked well in developing case? …

What could be improved in developing a case? …

Summary of recommendations for developing a case…

SECTION 3: ACHEIVEMENT OF OBJECTIVES
Did this Investment meet objectives?
Objective 1
…
Objective 2
…
Objective 3
…
How were they achieved?
…
SECTION 4: BENEFITS
Benefits planned in original Business Case (See benefits profile – attached below)

Benefit 1
Benefit 2
Benefit 3
…
Actual Outcome
(Please comment on variances or delays etc.)
…
How were benefits and outcomes evidenced? Please give details of such.
…
SECTION 5: VALUE FOR MONEY
What methodology was used to assess quality and value for money of service provided? What were the conclusions?
…
SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED
What problems were encountered during implementation of the project, and how where such resolved?
…
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.
…

Maidstone and Tunbridge Wells NHS Trust

Appendix A Impact of travel for satellite site options

Impact of Travel for each of the Satelite Options

Assumptions:

The distances shown are in miles and as the crow flie and does not take account of road infrastructure.
The tables do not adjust for patients required to travel further than their existing local radiotherapy centre based on clinical need.
Patiens treated on their closest site have been excluded from the patient numbers section and average miles per patient.
Activity information is based on M1-10 [2011-12] activity figures extrapolated to 12 months
Total annual number of patients to be treated in 2011-12 estimated at 2,885 per annum
The 'Total Estimated Miles Saved' shows the estimated miles that could be saved by treating patients at the closest site.

1 / Impact of Satelite being located at Tunbridge Wells Only

	Closest Site to Patient	Site Treated At: Canterbury	Site Treated At: Maidstone	TOTAL	Total Expected Impact	Notes
Total Estimated Miles Saved	TWH	1,916	178,724	180,639	178,724	As no additional capacity is being created on the Canterbury side of the patch it is anticpated that patient will continue to tavel to Maidstone where their closest site would be Canterbury (293 patients). The patients shown as travelling to Canterbury and Maidstone when this is not the closest site currently available have been excluded as this could be linked to clinical need (14+78 patients)
	Canterbury		88,182	88,182		
	Maidstone	7,868		7,868		
Total Patients Treated	TWH	14	845	859	845	
	Canterbury		293	293		
	Maidstone	78		78		
Average Miles saved per Patient	TWH	133	212	210	212	
	Canterbury		301	301		
	Maidstone	101		101		

Shows patient journey where closest site = site treated at
Shows where there is an expected saving in travel

2 / Impact of Satelite being located at Margate Only

	Closest Site to Patient	Site Treated At: Canterbury	Site Treated At: Maidstone	TOTAL	Total Expected Impact	Notes
Total Estimated Miles Saved	Margate	158,607	28,719	187,327	255,377	By creating a site at Margate it is anticpated that the extra capacity will enable patients treated at Maidstone, when their closest site is Caterbury, to be treated at either Margate or Canterbury. The 92 patients being treated at Canterbury where their closest site is Maidstone have been excluded as it is assumed clinical need exists.
	Canterbury		68,051	68,051		
	Maidstone	9,434		9,434		
Total Patients Treated	Margate	535	34	569	828	
	Canterbury		259	259		
	Maidstone	92		92		
Average Miles saved per Patient	Margate	296	855	329	308	
	Canterbury		263	263		
	Maidstone	102		102		

Shows patient journey where closest site = site treated at
Shows where there is an expected saving in travel

3 / Impact of Satelite being located at Dartford Only

	Closest Site to Patient	Site Treated At: Canterbury	Site Treated At: Maidstone	TOTAL	Total Expected Impact	Notes
Total Estimated Miles Saved	Dartford	802	191,492	192,295	191,492	Only patients who are closer to Dartford but currently treated at Maidstone are assumed to move to Dartford given the option. All other patients are assumed to continue treatment at Canterbury and Maidstone due to limitations of capacity at Canterbury and clinical need.
	Canterbury	0	88,182	88,182		
	Maidstone	8,856	0	8,856		
Total Patients Treated	Dartford	6	700	706	700	
	Canterbury		293	293		
	Maidstone	86		86		
Average Miles saved per Patient	Dartford	134	274	273	274	
	Canterbury		301	301		
	Maidstone	103		103		

Maidstone and Tunbridge Wells NHS Trust

Appendix B Population affected by site location

Red – Over 45 travel time

Green – Resolution of travel time with a linac at Tunbridge Wells.

Parish Location (over 2500 population)	Closest Radiotherapy Centre (existing or proposed)	2011 census	Canterbury Radiotherapy Centre		Tunbridge Wells Hospital		Maidstone Hospital	
		Population	Journey Distance (Miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)
Ash	Canterbury	3365	10	24	57	79	41	55
Ash-cum-Ridley	Maidstone	6641	43	56	20	36	14	24
Ashford	Canterbury	50756	14	23	40	53	23	29
Aylesford	Maidstone	10660	31	42	17	35	3	9
Aylesham	Canterbury	3999	16	8	55	60	39	46
Battle	Tunbridge Wells	6673	44	79	**21**	**31**	27	47
Bearsted	Maidstone	8209	28	40	23	37	7	15
Biddenden	Tunbridge Wells	2574	26	49	18	32	17	39
Birchington	Canterbury	9961	13	21	58	71	42	48
Borough Green	Maidstone	3672	38	49	15	27	10	17
Boughton Monchelsea	Maidstone	3313	32	51	14	31	5	19
Boxley	Maidstone	9554	27	38	23	39	7	17
Broadstairs	Canterbury	24903	19	32	66	87	49	65
Canterbury	Canterbury	45351	0	0	47	64	31	42
Chatham	Canterbury	(Medway)	29	45	25	41	10	19
Chartham	Canterbury	4261	4	14	25	41	33	45
Charing	Canterbury	2766	15	30	27	49	17	30
Chestfield	Canterbury	3214	7	21	47	61	31	40
Chevening	Tunbridge Wells	3092	56	64	14	24	20	38
Cliffe Woods	Maidstone	5370	38	45	38	45	16	23
Coxheath	Maidstone	4082	31	52	12	25	4	13
Cranbrook	Tunbridge Wells	6717	33.5	61	13	25	15	35
Crowborough	Tunbridge Wells	20607	55.9	80	**10**	**22**	23	46
Cuxton	Maidstone	2627	33	40	14	25	10	18
Darenth	Maidstone	4851	43	52	26	35	23	28
Dartford	Maidstone	48311	44.6	64	27	40	23	35
Deal	Canterbury	20823	21.6	36	69	91	53	70
Ditton	Maidstone	4786	31	45	14	28	3	8
Dover	Canterbury	31022	16.1	26	60	73	44	51
Dymchurch	Canterbury	3725	30.1	49	40	73	38	48

Parish Location (over 2500 population)	Closest Radiotherapy Centre (existing or proposed)	2011 census	Canterbury Radiotherapy Centre		Tunbridge Wells Hospital		Maidstone Hospital	
		Population	Journey Distance (Miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)
East Grinstead	East Surrey and Sussex 29 mins Tunbridge Wells 39 minutes	29084	64	81	17	39	37	49
East Malling & Larkfield		14185	35	47	13	25	4	10
East Peckham	Tunbridge Wells	3306	41	56	7	14	7	18
Eastchurch	Maidstone	3022	32	46	39	57	22	35
Edenbridge	East Surrey and Sussex 30 mins Tunbridge Wells 35 minutes	8907	63	78	15	35	35	48
Eythorne	Canterbury	2594	12	21	59	74	43	52
Faversham	Canterbury	19316	10.3	22	39	53	23	33
Folkestone	Canterbury	46698	16.8	32	53	64	38	42
Gillingham	Maidstone	(Medway)	29.3	45	28	52	12	23
Goudhurst	Tunbridge Wells	3327	33	63	9	17	13	33
Gravesend	Maidstone	84795	39.5	53	32	42	18	30
Hadlow	Tunbridge Wells	3983	40	56	7	16	9	19
Halling	Maidstone	2821	34	43	19	34	9	16
Harbledown	Canterbury	2174	2	9	45	58	30	37
Hartley	Maidstone	5359	42	53	21	39	16	27
Hastings	Brighton 71 minutes (existing) East Bourne 39 mins (proposed) Tunbridge Wells 46 minutes (proposed)	90300	52	88	27	43	36	71
Hawkinge	Canterbury	8002	13	24	54	63	38	41
Hawkhurst	Tunbridge Wells	4911	34	66	14	23	19	44
Headcorn	Maidstone	3387	32	58	18	36	13	25
Herne Bay and Whitstable	Canterbury	59802	9	21	51	65	35	50
Herne and Broomfield	Canterbury	8440	8	25	50	65	34	40
Hextable	Maidstone	4092	48	58	23	34	20	28
Hildenborough	Tunbridge Wells	4954	45	64	7	19	14	31

Parish Location (over 2500 population)	Closest Radiotherapy Centre (existing or proposed)	2011 census	Canterbury Radiotherapy Centre		Tunbridge Wells Hospital		Maidstone Hospital	
		Population	Journey Distance (Miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)
Hoo St Werburgh	Maidstone	8945	39	49	29	50	17	27
Horten Kirby and South Darenth	Maidstone	3492	44	57	24	35	21	27
Higham	Maidstone	3962	35	42	42	25	14	20
Hythe	Canterbury	14516	20	40	51	63	35	43
Iwade	Maidstone	3087	25	35	32	47	16	23
Kemsing	Maidstone	4218	42	58	14	30	15	25
Kingshill	Maidstone	7435	35	46	13	23	8	14
Kingsnorth	Maidstone	11243	23	36	30	54	27	31
Lenham	Maidstone	3370	18	34	30	44	14	24
Leybourne	Maidstone	3218	33	43	14	25	4	11
Longfield and New Barn	Maidstone	4919	41	50	29	40	17	29
Lydd	Maidstone	6567	32	56	37	68	39	49
Lyminge	Canterbury	2717	11	23	51	62	35	40
Maidstone	Maidstone	80440	28	44	15	31	0	0
Marden	Maidstone	3724	36	61	13	26	8	23
Maresfield	Tunbridge Wells	3636	63	88	**16**	**30**	31	56
Margate	Canterbury	50354	17	27	62	84	46	62
Mayfield	Tunbridge Wells	2614	45	88	**12**	**26**	25	51
Medway	Maidstone	231016	28	44	25	42	12	28
Meopham	Maidstone	6722	40	49	36	20	14	24
Minster on Sea	Maidstone	14789	30	40	36	53	20	28
Minster	Canterbury	3569	13	26	59	71	42	45
New Romney	Canterbury	6996	28	45	35	65	40	47
Newington	Maidstone	2551	24	33	30	45	14	20
Orpington	Sidcup Tunbridge Wells	15,311	52	57	21	26	25	33
Otford	Tunbridge Wells	3465	44	62	16	27	16	29
Paddock Wood	Tunbridge Wells	8253	44	63	6	13	10	25
Pembury	Tunbridge Wells	6128	46	65	1	5	13	26
Queenborough	Maidstone	3407	29	40	36	52	19	28
Ramsgate	Canterbury	40408	17	29	64	83	48	60

Parish Location (over 2500 population)	Closest Radiotherapy Centre (existing or proposed)	2011 census	Canterbury Radiotherapy Centre		Tunbridge Wells Hospital		Maidstone Hospital	
		Population	Journey Distance (Miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)
River	Canterbury	3876	14	26	60	73	43	46
Rochester	Maidstone	(Medway)	32	48	26	42	10	20
Robertsbridge	Tunbridge Wells	2641	40	75	**17**	**28**	25	50
Rye	Tunbridge Wells	9041	40	58	**28**	**45**	25	50
Rusthall	Tunbridge Wells	4976	51	79	4	16	17	41
Sandgate	Canterbury	4639	19	36	53	68	37	39
Sandwich	Canterbury	4985	12	29	66	84	50	57
Seal	Tunbridge Wells	2556	42	56	12	24	15	24
Sevenoaks	Tunbridge Wells	20409	45.8	65	11	20	17	27
Sheerness	Maidstone	16054	33	50	38	56	22	30
Sittingbourne	Maidstone	44523	17	36	30	48	14	25
Singleton	Maidstone	6801	26	40	28	48	27	32
Snodland	Maidstone	10211	36	47	17	32		
Southborough	Tunbridge Wells	12061	47	72	3	14	17	36
Speldhurst	Tunbridge Wells	4978	49	76	5	15	18	40
St. Cosmus and St. Damian in the Blean	Canterbury	5589	4	14	47	59	31	35
St Mary in the Marsh/ St Mary's Bay	Canterbury	2819	22	42	39	67	40	46
Sturry	Canterbury	6820	5	15	54	69	38	44
Staplehurst	Maidstone	5947	38	56	16	28	13	20
Stanhope	Maidstone	4068	23	37	29	52	25	30
Stone	Maidstone	10778	43	51	27	30	23	30
Swanley	Maidstone	16226	47	64	22	26	19	21
Swanscombe and Greenhithe	Maidstone	14128	41	49	28	33	20	28
Tenterden	Tunbridge Wells	7735	26	47	**21**	**39**	22	49
Teynham	Canterbury	3913	14	28	34	51	18	29
Ticehurst	Tunbridge Wells	3873	38	66	12	20	19	36
Tonbridge	Tunbridge Wells	34694	44	65	5	10	12	27
Tovil	Maidstone	3542	29	46	13	28	1	4
Tunbridge Wells	Tunbridge Wells	48324	49	73	3	10	19	32
Uckfield	Eq. Brighton/T Wells	14,493	65	92	18	37	33	60

Parish Location (over 2500 population)	Closest Radiotherapy Centre (existing or proposed)	2011 census	Canterbury Radiotherapy Centre		Tunbridge Wells Hospital		Maidstone Hospital	
		Population	Journey Distance (Miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)	Journey Distance (miles)	Journey Time (Minutes)
Wadhurst	Tunbridge Wells	4883	45	82	**12**	**19**	24	46
Walmer	Canterbury	8178	19	31	67	78	48	54
Westerham	Tunbridge Wells	4475	58	67	16	22	22	42
West Kingsdown	Maidstone	5484	40	51	18	28	13	17
West Malling	Maidstone	2590	34	52	13	24	4	11
Whitfeild	Canterbury	5142	13	20	60	69	43	45
Whitstable	Canterbury	(HerneBay)	7	19	46	64	29	42
Wilmington	Maidstone	7178	47	55	25	33	25	31
Total minimum* Population of areas identified								1695681
Total minimum* Population with Tunbridge Wells as closest radiotherapy service								244896 (14%)
Total minimum* Population with Tunbridge Wells as closest linac of which have had to travel longer than 45 minutes before proposal.								57830 (3.5%)
Urban area minimum* population equidistant between proposed or existing other site and/or less than 45 minute travel time								158095 (9.3%)
Total minimum* population within Kent and East Sussex to benefit from a linac at Tunbridge Wells with regard to travel times and patient choice.								402991 (23.8%)

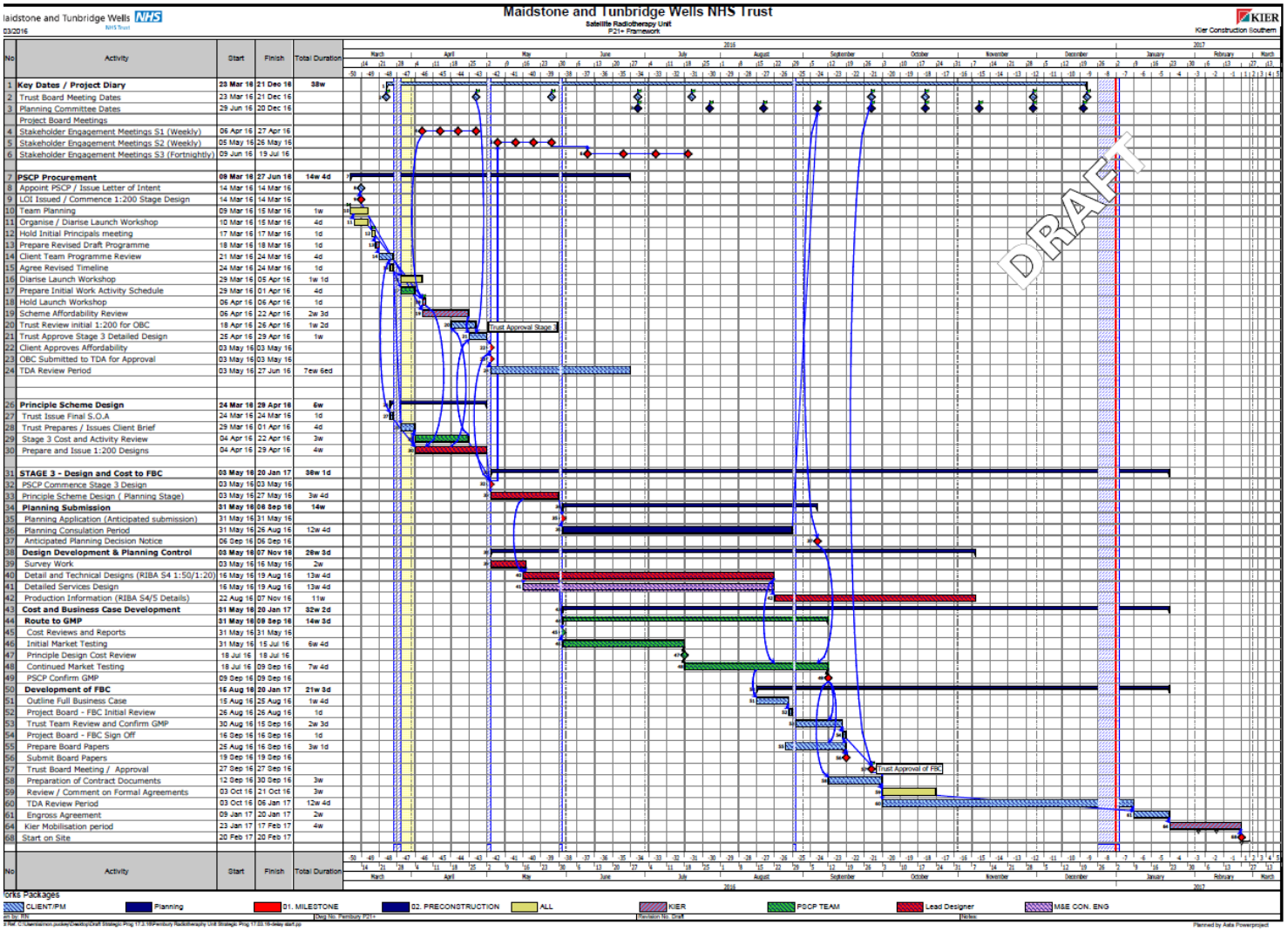
* Minimum - only parishes with a population of more than 2500 have been assessed within this analysis.

Appendix C Feasibility Report – see attachment.

Maidstone and Tunbridge Wells NHS Trust

Appendix D Project Plan Gantt Chart

Magnify to 250%



No	Activity	Start	Finish	Total Duration
1	**Key Dates / Project Diary**	**23 Mar 16**	**21 Dec 16**	**38w**
2	Trust Board Meeting Dates	23 Mar 16	21 Dec 16	
3	Planning Committee Dates	29 Jun 16	20 Dec 16	
	Project Board Meetings			
4	Stakeholder Engagement Meetings S1 (Weekly)	06 Apr 16	27 Apr 16	
5	Stakeholder Engagement Meetings S2 (Weekly)	05 May 16	26 May 16	
6	Stakeholder Engagement Meetings S3 (Fortnightly)	09 Jun 16	19 Jul 16	
7	**PSCP Procurement**	**09 Mar 16**	**27 Jun 16**	**14w 4d**
8	Appoint PSCP / Issue Letter of Intent	14 Mar 16	14 Mar 16	
9	LOI Issued / Commence 1:200 Stage Design	14 Mar 16	14 Mar 16	
10	Team Planning	09 Mar 16	15 Mar 16	1w
11	Organise / Diarise Launch Workshop	10 Mar 16	15 Mar 16	4d
12	Hold Initial Principals meeting	17 Mar 16	17 Mar 16	1d
13	Prepare Revised Draft Programme	18 Mar 16	18 Mar 16	1d
14	Client Team Programme Review	21 Mar 16	24 Mar 16	4d
15	Agree Revised Timeline	24 Mar 16	24 Mar 16	1d
16	Diarise Launch Workshop	29 Mar 16	05 Apr 16	1w 1d
17	Prepare Initial Work Activity Schedule	29 Mar 16	01 Apr 16	4d
18	Hold Launch Workshop	06 Apr 16	06 Apr 16	1d
19	Scheme Affordability Review	06 Apr 16	22 Apr 16	2w 3d
20	Trust Review initial 1:200 for OBC	18 Apr 16	26 Apr 16	1w 2d
21	Trust Approve Stage 3 Detailed Design	26 Apr 16	29 Apr 16	1w
22	Client Approves Affordability	03 May 16	03 May 16	
23	OBC Submitted to TDA for Approval	03 May 16	03 May 16	
24	TDA Review Period	03 May 16	27 Jun 16	7ew 6ed
26	**Principle Scheme Design**	**24 Mar 16**	**29 Apr 16**	**6w**
27	Trust Issue Final S.O.A	24 Mar 16	24 Mar 16	1d
28	Trust Prepares / Issues Client Brief	29 Mar 16	01 Apr 16	4d
29	Stage 3 Cost and Activity Review	04 Apr 16	22 Apr 16	3w
30	Prepare and Issue 1:200 Designs	04 Apr 16	29 Apr 16	4w
31	**STAGE 3 - Design and Cost to FBC**	**03 May 16**	**20 Jan 17**	**38w 1d**
32	PSCP Commence Stage 3 Design	03 May 16	03 May 16	
33	Principle Scheme Design (Planning Stage)	03 May 16	27 May 16	3w 4d
34	**Planning Submission**	**31 May 16**	**08 Sep 16**	**14w**
35	Planning Application (Anticipated submission)	31 May 16	31 May 16	
36	Planning Consulation Period	31 May 16	26 Aug 16	12w 4d
37	Anticipated Planning Decision Notice	06 Sep 16	06 Sep 16	
38	**Design Development & Planning Control**	**03 May 16**	**07 Nov 16**	**28w 3d**
39	Survey Work	03 May 16	16 May 16	2w
40	Detail and Technical Designs (RIBA S4 1:50/1:20)	16 May 16	19 Aug 16	13w 4d
41	Detailed Services Design	16 May 16	19 Aug 16	13w 4d
42	Production Information (RIBA S4/5 Details)	22 Aug 16	07 Nov 16	11w
43	**Cost and Business Case Development**	**31 May 16**	**20 Jan 17**	**32w 2d**
44	**Route to GMP**	**31 May 16**	**09 Sep 16**	**14w 3d**
45	Cost Reviews and Reports	31 May 16	31 May 16	
46	Initial Market Testing	31 May 16	15 Jul 16	6w 4d
47	Principle Design Cost Review	18 Jul 16	18 Jul 16	
48	Continued Market Testing	18 Jul 16	09 Sep 16	7w 4d
49	PSCP Confirm GMP	09 Sep 16	09 Sep 16	
50	**Development of FBC**	**16 Aug 16**	**20 Jan 17**	**21w 3d**
51	Outline Full Business Case	15 Aug 16	25 Aug 16	1w 4d
52	Project Board - FBC Initial Review	26 Aug 16	26 Aug 16	1d
53	Trust Team Review and Confirm GMP	30 Aug 16	15 Sep 16	2w 3d
54	Project Board - FBC Sign Off	16 Sep 16	16 Sep 16	1d
55	Prepare Board Papers	25 Aug 16	16 Sep 16	3w 1d
56	Submit Board Papers	19 Sep 16	19 Sep 16	
57	Trust Board Meeting / Approval	27 Sep 16	27 Sep 16	
58	Preparation of Contract Documents	12 Sep 16	30 Sep 16	3w
59	Review / Comment on Formal Agreements	03 Oct 16	21 Oct 16	3w
60	TDA Review Period	03 Oct 16	06 Jan 17	12w 4d
61	Engross Agreement	09 Jan 17	20 Jan 17	2w
64	Kier Mobilisation period	23 Jan 17	17 Feb 17	4w
68	Start on Site	20 Feb 17	20 Feb 17	

Appendix E Additional Staffing for Increased Activity and Satellite Requirements (Option 2)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Other	Total
Radiotherapy Staff				1.20	1.50	1.50	1.50		5.70
Admin	2.00		0.75						2.75
Clinical Physics				0.31	0.69	2.20	0.70		3.90
Computer Sciences					0.60				0.60
Nursing	0.48			1.20					1.68.40
Total	2.48		0.75	2.71	2.79	3.70	2.20		14.63

Maidstone and Tunbridge Wells NHS Trust

Appendix F Additional Staffing for Options 1a and 1b

Option 1a No further RT staff required due to shift changes:

TWH Satelite Business Case costing										Factor for		Band	Salary	On-cost	
					Travel cost/mile:	£0.583				Annual & Sick		wte B3	£17,618	£21,073	
										Leave		wte B5	£24,072	£29,101	
Option 1 - Five Linac Model Summary			urn distance Canterbury to Maidstone:			64	miles	x	1.23			wte B6	£29,464	£35,809	
												wte B7	£35,191	£42,933	
				Cost of Weekend Varian PPM:		£13,000						wte B8a	£42,674	£52,338	
Assumes maintenance & QC of TWO linacs done out of hours						Other Costs			Costing details				Annual Cost		
						Unsocial (O/T) Hours	Travel Miles	No of Varian Wknd PPMS							
				Additional Radiotherapy Services costs:											
				- additional cost of treating 9 hr shifts on 2 linacs		126			costed @ x	1.5	B3 on-cost		£2,042.42		
				2 Sats per year for breakdowns		126			costed @ x	1.5	B6 on-cost		£3,470.72		
				5 Sats per year for lack of capacity		126			costed @ x	1.5	B7 on-cost		£4,161.24		
						126			costed @ x	1	B8a Bank cost		£3,381.86		
- travel ex's Cant to Maids for	3	Rads on	24	days/year			4608		costed @ x	£0.583	per mile		£2,686.46		
				Additional Reception Costs:											
				- overtime cost to cover 3 additional hours per day 10 weeks per year		225			costed @ x	1.5	B3 on-cost		£3,647.18		
				Additional Annual Physics costs:											
				- unsocial hours enhancements for Saturday Linac QC:		576.00			enhcd @ x	0.3	B7 on-cost		£3,804.57		
				- unsocial hours enhancements for Sunday Linac QC:		48.00			enhcd @ x	0.6	B7 on-cost		£634.09		
				- unsocial hours enhancements to cover 7 x 9 hour Saturday treatments:		63			enhcd @ x	0.3	B7 on-cost		£416.12		
- travel expenses for	2	staff/month Canterbury to Maidstone:					1536		costed @	£0.583	per mile		£895.49		
				Additional Annual Engineering staff cost:											
				- unsocial hours enhancements for Saturday Linac PPM:		176.00			enhcd @ x	0.3	B8a on-cost		£1,417.16		
				- unsocial hours enhancements for Sunday PPM:		56.00			enhcd @ x	0.6	B8a on-cost		£901.83		
				- overtime cost to cover 2 additional hours per day 2 days per week		208			costed @ x	1.5	B7 on-cost		£6,869.35		
				- Bank cost to cover 2 additional hrs per day 3 days per week		312			costed @ x	1	B8a Bank cost		£8,374.14		
				Additional payment to Varian to provide weekend PPM:				2	visits per year each @		£13,000		£26,000		
								TOTAL ANNUAL COST ASSOCIATED WITH OPTION 1:					**£68,702.66**		

Maidstone and Tunbridge Wells NHS Trust

Option 1b Further Staffing required to work weekends: Magnify 150%

Seven day light weekend working model						
Reason for choosing weekend-lite model	Comment					
Lite model at weekend chosen to enable:						
- working with a reduced team on Sat & Sun	i.e. on Sat & Sun none of the following staff required: Consultant Clinical Oncologist, Phlebotomist, Chemotherapy Nurses, Dietician, Counsellors; only one Site Specialist required; no new pts would mean additional CCO Planning sessions)					
- no need to increase CCO PAs for Planning	because starting new patients on Sat or Sun would require additional CCO Planning sessions					
Assumptions	Comment					
1) Model sustainable on 8 linacs	i.e. will not be always running with a Business Continuity risk					
2) Same activity as now	i.e. same number of Fractions treated per week					
3) Same hours treated per week	i.e. no change to complexity of treatments so same time slot per fraction					
4) Same Servicing & QC patterns as now	i.e. all done Monday to Friday within normal hours					
5) No transport patients on Sat & Sun	because impossible to arrange contract					
6) On Sat & Sun:						
- treat 9am to 5pm on 6 linacs						
- treat Prostate, Breast & Palliatives only						
- no new patients started						
7) On Mon to Fri:						
- 2 linacs would operate an extended day to cover Chemo-RT Patients and hyper-fractionation						
- All non treatment unit activity, apart from imaging and patient clinical reviews, will take place						
8) The WTEs will need to be increased by the x1.23 factor to allow for Annual Leave etc.						
				PA = 3.75 hrs		
Increase required to Establishment to cover Treatment for 4 PAs (2 PAs on Sat & 2 PAs on Sun)		Owner	Band	No of PAs	Hours/wk	WTE
Clinicians						
- Registrar	Already contracted to provide clinical cover on Maidstone site at weekend	MC/JA		0	0	0
Radiotherapy Services						
- Manager	To facilitate managerial cover for 7 day working on Maidstone site	KR	8C	5	18.75	0.5
- Clinical Specialist	To facilitate expert treatment support for 7 day working on Maidstone site	KR	8A	5	18.75	0.5
- Site Specialist	To support patients whilst running AM and PM review clinics on Sat & Sun.	KR	7	4	15	0.4
- Advanced Practitoner	To supervise 6 linacs & imaging on Maidstone site on Sat & Sun	KR	7	24	90	2.4
- Senior Practitioner	To operate 6 linacs on Maidstone site on Sat & Sun	KR	6	24	90	2.4
- Practitioner	To operate 6 linacs on Maidstone site on Sat & Sun	KR	5	24	90	2.4
Nursing						
- Staff Nurse	To provide nursng cover on Maidstone site at weekend	CW	5	4	15	0.4
- Nurse	To provide nursng cover on Maidstone site at weekend	CW	4	4	15	0.4
Clerical / Admin						
- Receptionist / Scheduler	To facilitate 7 day Scheduling and provide a Receoptionist on Sat & Sun	CR	4	10	37.5	1.0
- Clerical cover 1 wte Band 3 (JA)	To facilitate Clerical cover finding Notes etc on Sat & Sun	JA	3	4	15	0.4
Medical Physics						
- Engineer	To faciltate technical cover for 7 day rota working on Maidstone site	GP	8A	10	37.5	1.0
- Engineer	To faciltate technical cover for 7 day rota working on Maidstone site	GP	7	10	37.5	1.0
- Computer Science	To faciltate IT cover for 7 day rota working on Maidstone site	MP	6	10	37.5	1.0
- Computer Science	To faciltate IT cover for 7 day rota working on Maidstone site	MP	5	10	37.5	1.0
- Physicist	To faciltate Radiotherapy Physics cover for 7 day rota working on Maidstone site	NJ	8A	10	37.5	1.0
- Physicist	To faciltate Radiotherapy Physics cover for 7 day rota working on Maidstone site	NJ	7	10	37.5	1.0
- Planning Radiographer	To provide Pre-treatment cover & operate CT on Maidstone site at weekend	NJ	7	10	37.5	1.0
- Planning Radiographer	To provide Pre-treatment cover & operate CT on Maidstone site at weekend	NJ	6	10	37.5	1.0
Other increased costs						
- out of hours portering		JA				
- out of hours cleaning		JA				
- use of estate at weekends (e.g. increase in electricity consumption)		JA / KV				
- provision of Café service at weekends		JA/PD				
- provision of gowns at weekends		JA				

Maidstone and Tunbridge Wells NHS Trust

Appendix G Breakdown of Cost for Option 2 - Preferred Option

OUTLINE COST ESTIMATE **COST FORM 1**

TRUST/ORGANISATION	**Maidstone & Tunbridge Wells NHS Trus**	ORGANISATIONAL	
SCHEME	**Proposed Satelitte Linac Unit**	Project Contact	
Option	**Pembury Site Option 2**		
PROJECT DIRECTOR	**Kevin Vaughan**		

CAPITAL COSTS SUMMARY

		Cost Excl. VAT £	VAT £	Cost Incl. VAT £
1	Departmental Costs (from Form 2)	2,963,276	592,655	3,555,931
2	On Costs (from Form 3) (31.69% of Build Cost)	939,000	187,800	1,126,800
3	Works Cost Total (1+2) at Q4 2014 195	3,902,276	780,455	4,682,731
4	Provisional location adjustment (if applicabl 1.12	468,273	93,655	561,928
5	Sub Total (3+4)	4,370,549	874,110	5,244,659
6	Fees (23.79% of sub-total 5)	1,039,715		1,039,715
7	Non-Works Costs (Planning + Building Regs) LAND OTHER	60,000	12,000	72,000
8	Equipment Costs (1.01% of Departmental Cost)	30,000	6,000	36,000
9	Planning Contingency 5.0%	273,513	44,305	317,819
10	Sub Total (5+6+7+8+9)	5,773,778	936,415	6,710,193
11	Inflation adjustments (f) PUBSEC 2017 Q1 223 Factor 14.4%	627,566	125,513	753,079
12	**TOTAL (for approval purposes) (10+11)**	**6,401,344**	**1,061,929**	**7,463,272**
13	Optimism Bias (referred to separatelty in BC)			

OUTLINE COST ESTIMATE - NEW BUILD OPTION 2 | **COST FORM 2**

TRUST/ORGANISATION	**Maidstone & Tunbridge Wells NHS Trust**
SCHEME	**Proposed Satellite Linac Unit**
OPTION	**Pembury Site Option 2**
PROJECT DIRECTOR	Kevin Vaughan, Jeanette Rooke

CAPITAL COSTS : DEPARTMENTAL COSTS (EXCLUDES EQUIPMENT COSTS)

Functional Content	Functional Units/Space Requirements (1)	Area (m^2)	N/A/C (2)	Cost Allowance
Reception / Foyer				
Lobby	Lobby	15	N	40,200
Reception	Reception	12	N	32,160
Wheelchair parking bay	Bay	1	N	2,680
Waiting				
Private waiting	Waiting area	16	N	42,880
NHS Waiting	Waiting area	48	N	128,640
Beverage Point	Beverage	2	N	5,360
Consulting Rooms				
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Treatment Room	Treat Room	16	N	42,880
Resus trolley bay	Bay	2	N	5,360
Administration				
10 person office	Office	40	N	107,200
2 person office	Office	12	N	32,160
2 person office	Office	12	N	32,160
Interview/Quiet Room	Office	9	N	24,120
Breakout/VC room	Office	10	N	26,800
Stores				
Clinical Store	Store	8		21,440
Radio Physics store	Store	12	N	32,160
Cleaner	Store	8	N	21,440
Gown Store	Store	2	N	5,360

Gown Store	Store	2	N	5,360
Disposal	Disposal Hold	12	N	32,160
Utility Areas				
Dirty Utility	Dirty Utility	12	N	32,160
Rest Room	Rest Room	16	N	42,880
Toilets/Changing				
WC Semi Ambulant	WC	3	N	6,700
WC Semi Ambulant	WC	3	N	6,700
WC Disabled	WC	5	N	12,060
WC Semi Ambulant	WC	3	N	6,700
WC Semi Ambulant	WC	3	N	6,700
WC Disabled	WC	5	N	12,060
Changing	Changing	2	N	5,360
Changing Wheelchair	Changing	5	N	12,060
Changing	Changing	2	N	5,360
Changing Wheelchair	Changing	5	N	12,060
Staff				
WC		3	N	6,968
WC		3	N	6,968
Staff Changing		10	N	26,800
Staff Changing		10	N	26,800
Linacs				
Linac Room 1		110	N	294,800
Control Room		20	N	53,600
Linac Room 2		110	N	294,800
Control Room		20	N	53,600
Sub waiting		3	N	8,040
Circulation				
Corridors		231	N	619,080
Plant				
Plant Room		214	N	572,180
ICT Hub	Comms	10	N	26,800
Departmental Costs excluding Equipment Costs Carried to Summary £		1,106		2,963,276
Equipment				
As identified				30,000

OUTLINE COST ESTIMATE **COST FORM 3**

TRUST/ORGANISATION Maidstone & Tunbridge Wells NHS Trust
SCHEME Proposed Satelitte Linac Unit
Option Pembury Site Option 2

CAPITAL COSTS: ON COSTS

			Estimated Cost (exc. VAT)	Percentage of Departmental Cost
1	Communications	£	£	%
	a. Space			
	b. Lifts	65,000	65,000	2.19
2	"External" Building Works (1)			
	a. Drainage	40,000 }		
	b. Roads, paths, parking	20,000 }		
	c. Site layout, walls, fencing, gates	15,000 }		
	d. Builders work for engineering	25,000 }		
	services outside buildings	}	100,000	3.37
3	"External" Engineering Works (1)	}		
	a. Steam, condensate, heating, hot	}		
	water and gas supply mains	100,000 }		
	b. Cold water mains and storage	10,000 }		
	c. Electricity mains, sub-stations,	300,000 }		
	stand-by generating plant	}		
	d. Calorifiers and associated plant	50,000 }		
	e. Miscellaneous services	100,000 }	560,000	18.90
4	Auxiliary Buildings	}		
5	Other on-costs and abnormals (2)	}		
	a. Building	100,000 }		
	b. Engineering			
	c. IT (Trust costs)	114,000		
		}	214,000	7.22
Total On-Costs to Summary FB1			£ 939,000	31.69

Maidstone and Tunbridge Wells NHS Trust

OUTLINE COST ESTIMATE **COST FORM 4**

TRUST/ORGANISATIC Maidstone & Tonbridge Hospitals NHS Trust
SCHEME Proposed Linac Satelitte Facility
Option Pembury Site Option 2

CAPITAL COSTS: FEES AND NON-WORKS COSTS

			£	Percentage of Works Cost %	Pre construction costs
1	Fees (including "in-house" resource costs)				
	a. Architects	6.15%	268,789	6.15	151,411
	b. Structural Engineers	1.45%	63,373	1.45	35,329
	c. Mechanical Engineers	1.55%	67,744	1.55	37,853
	d. Electrical Engineers	1.55%	67,744	1.55	37,853
	e. Quantity Surveyors (P21+ Cost Advisor)	1.80%	78,670	1.80	30,000
	f. Project Management (P21+PM)	1.80%	78,670	1.80	20,000
	g. Project Sponsorship				
	h. Legal fees				
	i. Site Supervision (P21+ Supervisor)		20,000	0.46	
	j. Building Regulations and Planning Fees				
	k. Other M T W Project Management Costs		200,000	4.58	20,000
	M T W Oncology Project Management		92,000	2.10	
	KMHIS Project Manangment		20,000	0.46	
	Principal Designer/CDMC	0.52%	22,727	0.52	5,000
	M&E Consultant		15,000	0.34	
	BREEAM Assessor		20,000	0.46	10,000
	MTW Feasibility Costing works		25,000	0.57	
	Total Fees to Summary (OB1)	£	1,039,715	23.79	367,445

		£	
2	Non-Works Costs		
	a. Land purchase costs and associated legal fees		
	b. Statutory and Local Authority charges		
	c. Building Regulations and Planning Fees	35,000	Already approved
	d. Other (specify)		
	e.g. decanting costs	25,000	
	Trust Commissioning		
	PFI / legal costs for taking over new areas after build		Budget allowance.
	Non-Works Costs to Summary (OB1)	£ 60,000	

Notes:
* Delete as appropriate.

Completed			
e (capitals)	**Kevin Vaughan**	Authorised for issue	**Jeanette Rooke**
Position	**Head of Estates Strategy**		Project Director
Address	**Maidstone Hospital**		
	Hermitage Lane		
		Date	**21st April 2016**
Telephone	**01622 224520**		

mtw Cancer Services CHKS UKAS

Maidstone and Tunbridge Wells NHS Trust

Appendix H Breakdown of Cost for Option 3

OUTLINE COST ESTIMATE				COST FORM 1		
UST/ORGANISATION	Maidstone & Tunbridge Wells NHS Trust		ORGANISATIONAL	MTW		
SCHEME	Proposed Satelitte Linac Unit		Project Contact	Kevin Vaughan		
Option	Maidstone Hospital Site Option 3					
PROJECT DIRECTOR	Jeanette Rooke					
CAPITAL COSTS SUMMARY						
			Cost Excl. VAT £	VAT £	Cost Incl. VAT £	
1	Departmental Costs (from Form 2)		2,693,936	538,787	3,232,723	
2	On Costs (from Form 3)					
	(30.59% of Build Cost)		824,000	164,800	988,800	
	HV Substation		2,232,052	446,410	2,678,462	
	VAT Recovery on HV Substation			-13,700	-13,700	
3	Works Cost Total (1+2) at Q4 2014	**195**	5,749,988	1,136,298	6,886,286	
4	Provisional location adjustment (if applicable)	1.12	689,999	136,356	826,354	
5	Sub Total (3+4)		6,439,987	1,272,653	7,712,640	
6	Fees					
	(20.91% of sub-total 5)		1,346,406		1,346,406	
7	Non-Works Costs (Planning + Building Regs)					
		LAND				
		OTHER	60,000	12,000	72,000	
8	Equipment Costs					
	(1.11% of Departmental Cost)		30,000	6,000	36,000	
9	Planning Contingency	0.05	392,320	78,464	470,784	
10	Sub Total (5+6+7+8+9)		8,268,712	1,369,117	9,637,829	
11	Inflation adju PUBSEC 2017 Q1	223				
	Factor	14.4%	927,358	185,472	1,112,830	
12	**TOTAL (for approval purposes) (10+11)**		**9,196,070**	**1,554,589**	**10,750,659**	

OUTLINE COST ESTIMATE - NEW BUILD OPTION 3

COST FORM 2

TRUST/ORGANISATION	**Maidstone & Tunbridge Wells NHS Trust**
SCHEME	**Proposed Satelitte Linac Unit**
OPTION	**Maidstone Option 3**
PROJECT DIRECTOR	Kevin Vaughan

CAPITAL COSTS : DEPARTMENTAL COSTS (EXCLUDES EQUIPMENT COSTS)

Functional Content	Functional Units/Space Requirements (1)	Area (m^2)	N/A/C (2)	Cost Allowance
Reception / Foyer				
Reception	Reception	12	N	32,160
Wheelchair parking bay		1	N	2,680
Waiting				
Private waiting	Waiting area	16	N	42,880
NHS Waiting	Waiting area	33	N	88,440
Beverage Point	Beverage	2	N	5,360
Consulting Rooms				
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Treatment Room	Treat Room	16	N	42,880
Resus trolley bay	Bay	2	N	5,360
Administration				
10 person office	Office	40	N	107,200
2 person office	Office	12	N	32,160
2 person office	Office	12	N	32,160
Interview/Quiet Room	Office	9	N	24,120
Breakout/VC room	Office	10	N	26,800
Stores				
Clinical Store	Store	8	N	21,440
Radio Physics store	Store	12	N	32,160
Cleaner	Store	8	N	21,440

Gown Store	Store	2	N	5,360
Gown Store	Store	2	N	5,360
Disposal	Disposal Hold	12	N	32,160
Utility Areas				
Dirty Utility	Dirty Utility	12	N	32,160
Toilets/Changing				
WC Semi Ambulant	WC	3	N	6,700
WC Semi Ambulant	WC	3	N	6,700
WC Disabled	WC	5	N	12,060
WC Semi Ambulant	WC	3	N	6,700
WC Semi Ambulant	WC	3	N	6,700
WC Disabled	WC	5	N	12,060
Changing	Changing	2	N	5,360
Changing Wheelchair	Changing	5	N	12,060
Changing	Changing	2	N	5,360
Changing Wheelchair	Changing	5	N	12,060
Staff				
WC	WC	3	N	6,968
WC	WC	3	N	6,968
Staff Changing	Changing	10	N	26,800
Staff Changing	Changing	10	N	26,800
Linacs				
Linac Room 1		110	N	294,800
Control Room		20	N	53,600
Linac Room 2		110	N	294,800
Control Room		20	N	53,600
Sub waiting		3	N	8,040
Circulation				
Corridors		200	N	536,000
Plant				
Plant Room		200	N	536,000
Departmental Costs excluding Equipment Costs Carried to Summary £		1,005		2,693,936
Equipment				
As identified				30,000

OUTLINE COST ESTIMATE **COST FORM 3**

TRUST/ORGANISATION	Maidstone & Tunbridge Wells NHS Trust
SCHEME	Proposed Satelitte Linac Unit
Option	Maidstone Hospital Site Option 3

CAPITAL COSTS: ON COSTS

				Estimated Cost (exc. VAT)	Percentage of Departmental Cost
1	Communications	£		£	%
	a. Space				
	b. Lifts				
2	"External" Building Works (1)				
	a. Drainage	40,000	}		
	b. Roads, paths, parking	20,000	}		
	c. Site layout, walls, fencing, gates	15,000	}		
	d. Builders work for engineering	25,000	}		
	services outside buildings		}	100,000	3.71
3	"External" Engineering Works (1)		}		
	a. Steam, condensate, heating, hot		}		
	water and gas supply mains	100,000	}		
	b. Cold water mains and storage	10,000	}		
	c. Electricity mains, sub-stations,	300,000	}		
	stand-by generating plant		}		
	d. Calorifiers and associated plant	50,000	}		
	e. Miscellaneous services	100,000	}	560,000	20.79
4	Auxiliary Buildings		}		
5	Other on-costs and abnormals (2)		}		
	a. Building	50,000	}		
	b. Engineering				
	c. IT	114,000			
			}	164,000	6.09
Total On-Costs to Summary FB1			£	824,000	30.59

OUTLINE COST ESTIMATE **COST FORM 4**

TRUST/ORGANISATIO	Maidstone & Tonbridge Hospitals NHS Trust
SCHEME	Proposed Linac Satelitte Facility
Option	Maidstone Hospital Site Option 3

CAPITAL COSTS: FEES AND NON-WORKS COSTS

			£	Percentage of Works Cost %
1	Fees (including "in-house" resource costs)			
	a. Architects	6.15%	396,059	6.15
	b. Structural Engineers	1.45%	93,380	1.45
	c. Mechanical Engineers	1.55%	99,820	1.55
	d. Electrical Engineers	1.55%	99,820	1.55
	e. Quantity Surveyors	1.80%	115,920	1.80
	f. Project Management	1.80%	115,920	1.80
	g. Project Sponsorship			
	h. Legal fees			
	i. Site Supervision (Clerk of Works / CDMC)	0.52%	33,488	0.52
	j. Building Regulations and Planning Fees			
	k. Other MTW Project Management Costs		200,000	3.11
	KMHIS Project Manangment		20,000	0.31
	MTW P21+ Project Manager		92,000	2.32
	MTW Feasibility Costing works		25,000	0.63
	MTW P21+ Advisor		20,000	0.50
	MTW Commissioning Engineer		15,000	0.38
	BREEAM Assessor		20,000	0.50
	Total Fees to Summary (OB1)	£	1,346,406	20.91

		£	
2	Non-Works Costs		
	a. Land purchase costs and associated legal fees		
	b. Statutory and Local Authority charges		
	c. Building Regulations and Planning Fees		35,000
	d. Other (specify)		
	e.g. decanting costs		25,000
	Trust Commissioning		
	PFI / legal costs for taking over new areas after build		Budget allowance.
	Non-Works Costs to Summary (OB1)	£	60,000

Maidstone and Tunbridge Wells NHS Trust

Appendix I Breakdown of Cost for Option 4

OUTLINE COST ESTIMATE **COST FORM 1**

UST/ORGANISATION	**Maidstone & Tunbridge Wells NHS Trust**	ORGANISATIONAL	**MTW**
SCHEME	**Proposed Satelitte Linac Unit**	Project Contact	**Kevin Vaughan**
Option	**Maidstone Hospital Site Single Linac Option 4**		
PROJECT DIRECTOR	**Jeanette Rooke**		

CAPITAL COSTS SUMMARY

		Cost Excl. VAT £	VAT £	Cost Incl. VAT £
1	Departmental Costs (from Form 2)	1,921,580	384,316	2,305,896
2	On Costs (from Form 3) (42.88% of Build Cost)	824,000	164,800	988,800
	HV Substation	2,232,052	446,410	2,678,462
	VAT Recovery on HV Substation		-13,700	-13,700
3	Works Cost Total (1+2) at Q4 2014 **195**	4,977,632	981,826	5,959,458
4	Provisional location adjustment (if applicable) **1.12**	597,316	117,819	715,135
5	Sub Total (3+4)	5,574,948	1,099,646	6,674,593
6	Fees (20.95% of sub-total 5)	1,168,207		1,168,207
7	Non-Works Costs (Planning + Building Regs) LAND / OTHER	60,000	12,000	72,000
8	Equipment Costs (1.30% of Departmental Cost)	25,000	5,000	30,000
9	Planning Contingency 5.0%	340,158	55,582	395,740
10	Sub Total (5+6+7+8+9)	7,168,313	1,172,228	8,340,541
11	Inflation adjus PUBSEC 2017 Q1 **223** Factor 14.4%	800,505	160,101	960,606
12	**TOTAL (for approval purposes) (5+6+7+8+9)**	**7,968,818**	**1,332,329**	**9,301,147**

OUTLINE COST ESTIMATE - NEW BUILD OPTION 2

COST FORM 2

TRUST/ORGANISATION	**Maidstone & Tunbridge Wells NHS Trust**
SCHEME	**Proposed Satelitte Linac Unit**
OPTION	**Maidstone Site Single Bunker**
PROJECT DIRECTOR	Kevin Vaughan

CAPITAL COSTS : DEPARTMENTAL COSTS (EXCLUDES EQUIPMENT COSTS)

Functional Content	Functional Units/Space Requirements (1)	Area (m^2)	N/A/C (2)	Cost Allowance
Reception / Foyer				
Reception	Reception	16	N	42,880
Wheelchair Parking		1	N	2,680
Waiting				
Private waiting	Waiting area	16	N	42,880
NHS Waiting	Waiting area	33	N	88,440
Beverage Point		2	N	5,360
Consulting Rooms				
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Clinical Consulting/Examination Room	C/E Room	16	N	42,880
Treatroom Room	Treatment	16	N	42,896
Resus trolley	Bay	2	N	5,364
Administration				
10 person office	Office	40	N	107,200
Interview/Quiet	Office	9	N	24,120
Breakout Room	Office	10	N	26,800
2 person office	Office	12	N	32,160
2 person office	Office	12	N	32,160
Stores				
Clinical Store	Store	8	N	21,440

Radiotherapy store	Store	12	N	32,160
Gown Store	Store	4	N	10,720
Cleaner	Store	6	N	16,080
Disposal	Disposal Hold	10	N	26,800
Utility Areas				
Dirty Utility	Dirty Utility	8	N	21,440
Toilets/Changing				
WC	WC	3	N	8,040
WC Semi Ambulant	WC	3	N	8,040
WC Disabled	WC	5	N	13,400
WC	WC	3	N	8,040
WC Semi Ambulant	WC	3	N	8,040
WC Disabled	WC	5	N	13,400
Changing	Changing	3	N	8,040
Changing Wheelchair	Changing	5	N	13,400
Staff				
WC		3	N	8,040
WC		3	N	8,040
Staff Changing		10	N	26,800
Staff Changing		10	N	26,800
Linacs				
Linac Room 1		110	N	294,800
Control Room		20	N	53,600
Circulation				
Corridors	incl stairs	150	N	402,000
Plant				
Plant Room		100	N	268,000
Departmental Costs excluding Equipment Costs Carried to Summary £		717		1,921,580

OUTLINE COST ESTIMATE **COST FORM 3**

TRUST/ORGANISATION Maidstone & Tunbridge Wells NHS Trust
SCHEME Proposed Satelitte Linac Unit
Option Maidstone Hospital Site Single Linac Option 4

CAPITAL COSTS: ON COSTS

			Estimated Cost (exc. VAT)	Percentage of Departmental Cost
1	Communications	£	£	%
	a. Space			
	b. Lifts			
2	"External" Building Works (1)			
	a. Drainage	40,000		
	b. Roads, paths, parking	20,000		
	c. Site layout, walls, fencing, gates	15,000		
	d. Builders work for engineering services outside buildings	25,000	100,000	5.20
3	"External" Engineering Works (1)			
	a. Steam, condensate, heating, hot water and gas supply mains	100,000		
	b. Cold water mains and storage	10,000		
	c. Electricity mains, sub-stations, stand-by generating plant	300,000		
	d. Calorifiers and associated plant	50,000		
	e. Miscellaneous services	100,000	560,000	29.14
4	Auxiliary Buildings			
5	Other on-costs and abnormals (2)			
	a. Building	50,000		
	b. Engineering			
	c. IT	114,000	164,000	8.53
Total On-Costs to Summary FB1			£ 824,000	42.88

OUTLINE COST ESTIMATE **COST FORM 4**

TRUST/ORGANISATI(Maidstone & Tonbridge Hospitals NHS Trust
SCHEME Proposed Linac Satelitte Facility
Option Maidstone Hospital Site Single Linac Option 4

CAPITAL COSTS: FEES AND NON-WORKS COSTS

			£	Percentage of Works Cost %
1	Fees (including "in-house" resource costs)			
	a. Architects	6.15%	342,859	6.15
	b. Structural Engineers	1.45%	80,837	1.45
	c. Mechanical Engineers	1.55%	86,412	1.55
	d. Electrical Engineers	1.55%	86,412	1.55
	e. Quantity Surveyors	1.80%	100,349	1.80
	f. Project Management	1.80%	100,349	1.80
	g. Project Sponsorship			
	h. Legal fees			
	i. Site Supervision (Clerk of Works / CDMC)	0.52%	28,990	0.52
	j. Building Regulations and Planning Fees			
	k. Other MTW Project Management Costs		150,000	2.69
	KMHIS Project Manangment		20,000	0.36
	MTW P21+ Project Manager		92,000	2.32
	MTW Feasibility Costing works		25,000	0.63
	MTW P21+ Advisor		20,000	0.50
	MTW Commissioning Engineer		15,000	0.38
	BREEAM Assessor		20,000	0.50
	Total Fees to Summary (OB1)	£	1,168,207	20.95

		£	
2	Non-Works Costs		
	a. Land purchase costs and associated legal fees		
	b. Statutory and Local Authority charges		
	c. Building Regulations and Planning Fees		35,000
	d. Other (specify)		
	e.g. decanting costs		25,000
	Trust Commissioning		
	PFI / legal costs for taking over new areas after build		Budget allowance.
	Non-Works Costs to Summary (OB1)	£	60,000

Appendix J Extra capacity Income Calculations

Extra capacity for extended hours at Tunbridge Wells = 3500 Fractions (#)

Service	Tariff per service (£)	Number per capacity	Income (£)
Prostate Plan	949	74	70,226
Prostate Treatment	154	74 x 27# = 1998	307,692
Prostate Review	92	74 x 5 = 370	34,040
Breast Plan	571	75	42,825
Breast Treatment	119	75 x 20# = 1500	178,500
Breast Review	92	75 x 4 = 300	27,600
		Total Income (£)	660,883

The extra capacity of 3500 will allow for 74 extra prostate and 75 extra breast patients per annum for radiotherapy. This in turn will increase the number of patient reviews and planning required. This extra capacity is envisaged to come from the extended scope due to the site location which is in keeping with the population analysis with regards to travel times

A prostate patient will have on average (considering hypo-fractionation):
27 fractions
1 plan
5 reviews.

A breast patient will have on average:
20 fractions
1 plan
4 reviews

Appendix K Car Parking Requirements at TWH

Please see Risk Log 4.3 Pg 54 for mitigating actions.

Assumed Maximum Number of spaces required for Radiotherapy Patients at one point in time	4
Assumed Maximum Number of Spaces for Staff @ One Point in Time working all day. Additional staff are anticipated to take the trust connecting bus if visiting the site.	6

It is assumed that the current parking facilities at Tunbridge Wells will be used for the new site with a separate drop off area near to the site. The estates department have provisionally suggested allocated parking for radiotherapy patients to the rear of the site in keeping with arrangements at MH. The Trust are currently considering options to increase the number of parking spaces at Tunbridge Wells as part of their wider strategy.

Appendix L GenesisCare Statement

http://www.genesiscare.co.uk/news/genesiscare-acquires-cancer-partners-uk - Accessed 10.01.2016

GenesisCare Acquires Cancer Partners UK – Cancer Patients to Benefit from Increased Access and New Services

GenesisCare, Australia's largest provider of radiotherapy services (GenesisCare), today announced the acquisition of the United Kingdom's leading provider of private cancer services, Cancer Partners UK (CPUK).

Adding to an existing network of eight cancer treatment centres, GenesisCare has also committed to develop three new treatment centres in areas of need across the UK. A suite of the latest cancer treatment technologies and techniques will also be introduced across all eleven facilities over the next 12 months.

Cancer patients are expected to benefit from continued investment in new personalised treatment techniques such as SABR*, SRS2# and brachytherapy. GenesisCare, with significant experience in providing high quality services in a public hospital tertiary teaching environment across Australia, is also planning to introduce and lead a number of new clinical trials.

Steve Bird, CPUK's CEO, said "Since our inception, we have been committed to providing precise and sophisticated radiotherapy treatment for cancer patients in the UK and to delivering the best patient care possible. Combining with GenesisCare enables our staff and referring consultants the ability to move forward rapidly to the cutting edge of treatment techniques and provide our patients with even greater choice, opportunity and access to global best practice."

More than one third of the United Kingdom's cancer patients who would benefit from radiotherapy are currently not accessing the essential treatment modality at the right time. With CPUK already providing overflow support to National Health Service (NHS) hospitals, it is expected that the GenesisCare linkages will provide even greater support for the NHS as it attempts to meet the rising tide of patient demand.

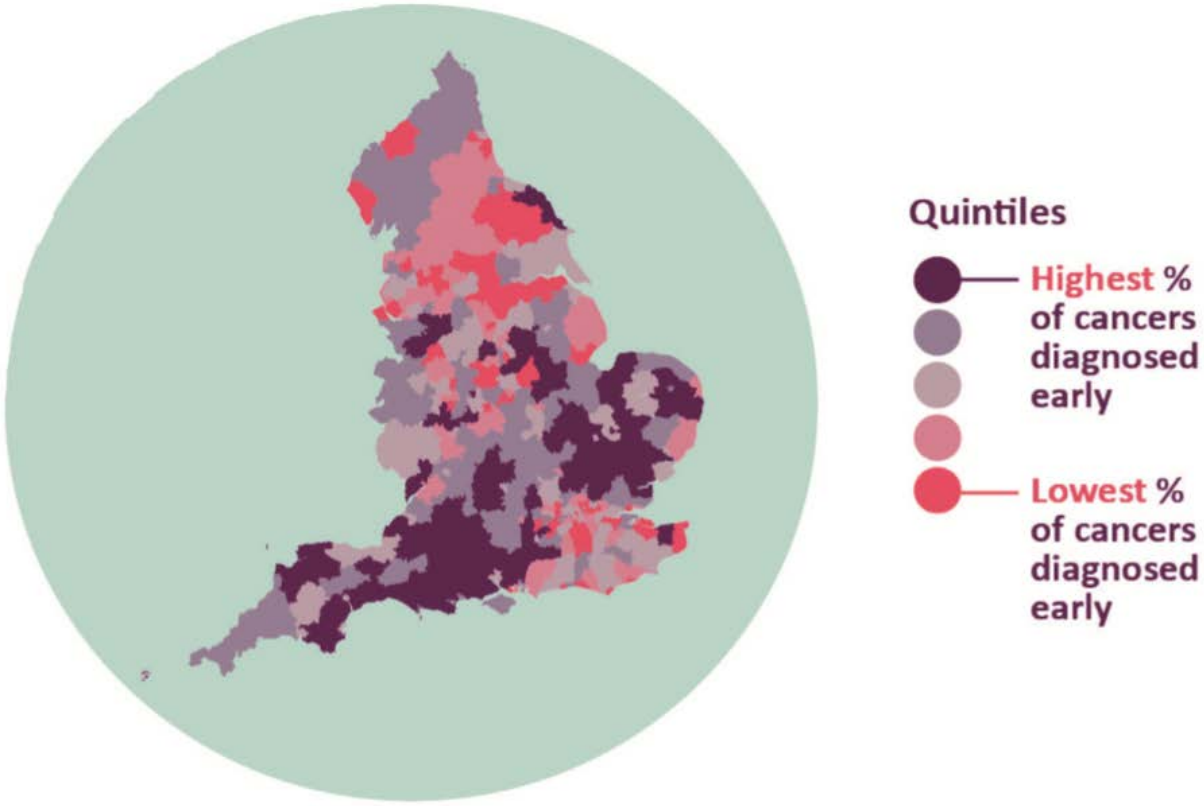
GenesisCare Managing Director, Dan Collins said "We want all cancer patients to receive the best possible care at the right time. Together with CPUK, GenesisCare is taking on the challenge to provide better outcomes for cancer patients, and to ease the burden across the community. We can achieve a better result for patients across the UK with a focus on innovation, sharing global best practice and investment in the latest technology and treatment techniques. We're excited at the prospect of making a positive difference."

Dr Michael Guiney, GenesisCare Radiation Oncologist and Director on the GenesisCare Board said "This is a very exciting time for GenesisCare but also for the practice of radiotherapy and cancer care globally. To be in a position to share best practice across borders and cultures and transcend the silos of healthcare that naturally exist in regulated environments is truly unique. As a practising Oncologist, it is a fantastic journey to be on and I look forward to what this partnership will deliver for patients."

GenesisCare recently announced a partnership with Ramsay Health Care for the development of two new sites at the Rivers Hospital in Sawbridgeworth and the Springfield Hospital in Chelmsford. With these two comprehensive cancer services opening in early 2016 and CPUK's ninth site commencing in Kent in December 2015, the combined GenesisCare UK network will be eleven sites. In Australia, GenesisCare operates more than twenty five cancer treatment centres.

* Stereotactic Ablative Radiotherapy (SABR), # Stereotactic Radio Surgery

Appendix M Early Diagnosis of Cancer per Location



'Across England, there is around a twofold variation in the proportion of cancers diagnosed at an early stage, suggesting significant scope for improvement'. Achieving World-Class Cancer Outcomes a Strategy for England 2015-2020 (p27)

There are a significant number of areas in Kent and East Sussex that unfortunately have some of the lowest percentages of cancers diagnosed early enough to benefit from curative radiotherapy/surgery/chemotherapy. This demonstrates the potential increase of radiotherapy demand if the strategy for earlier diagnosis is achieved.

Appendix N NPV Calculations

See attachment

NPV Calculations

[N.B. This has been reproduced at the end of the document, after Appendix T]

Appendix O Interest on Borrowing Calculations

See attachment

Interest Repayments

[N.B. This has been reproduced at the end of the document, after Appendix T]

Appendix P Identifying options

Critical Success Factors

The following critical success factors that each option is accessed against have been agreed by the project group.

Ease of transfer between inpatient services and radiotherapy facilities
Adjacency to required clinical and support facilities
Quality – patient safety
Quality – patient experience
Quality – patient outcomes
Flexibility in use
Patient accessibility
Sustainable
Achievable within timescale
Minimal disruption to other clinical service
Proven design

Draft generation of long list options

Options around scope of investment
No change – continue with current arrangements
Change provision of radiotherapy
Change provision of radiotherapy and treatment planning
Change whole cancer pathways e.g. including surgery, brachytherapy, and chemotherapy

Options around service solution
No change – continue with current arrangements
Reduce demand by changing patient pathways (less fractions, less complex e.g. IMRT, less imaging)
Provide more capacity through productivity/ efficiency changes (longer days / weekends)
Build more capacity- one bunker and one linac
Build more capacity -two more bunkers with one linac
Build more capacity -two more bunkers and two more linacs

Options around service delivery
No change –continue with current arrangements
Build additional bunker/s at Maidstone hub
Build additional bunker/s at Canterbury hub
Satellite adjacent to clinical facilities at Margate

Satellite adjacent to clinical facilities at Dartford
Satellite adjacent to clinical facilities at Ashford
Satellite adjacent to clinical facilities at Tunbridge Wells
Satellite at other stand-alone location

Options around implementation

Maintain current linac replacement programme
Expedite current linac replacement programme
Slow current programme down by a year

Options around funding

NHS
Private
Charitable funding

Long list option appraisal

Options concerning the scope of the investment

Option	Option 1a	Option 1b	Option 1c	Option 1d
Description	No change – continue with current arrangements	Change provision of radiotherapy	Change provision of radiotherapy and treatment planning	Change whole cancer pathways e.g. including surgery, brachytherapy, chemotherapy
Meets objective				
To provide continuity for the radiotherapy service, maintaining standards for patients living in Kent, Medway and parts of East Sussex	××	✓	✓	×
To provide the services at a location which is as close to home for as many patients as possible	×	✓	✓	×
To improve efficiency, cost effectiveness and maximise income from the radiotherapy service and in order to maximise resources available to meet needs.	×	✓	✓	×
Satisfies critical success factors				
Ease of transfer between inpatient services and the radiotherapy facility	✓	✓	✓	×
Patient safety	✓	✓	✓	?
Patient experience	✓	✓	✓	×
Patient outcomes	✓	✓	✓	×
Positive impact on efficiency and financial performance	×	✓	✓	×

Flexibility in use	×	✓	✓	×
Patient accessibility	×	✓	✓	?
Sustainable	×	✓	✓	×
Achievable within timescale	✓	✓	✓	×?
Minimal disruption to other clinical service	✓	?	✓	×
Proven design	✓	?	✓	×
Summary *discount / carry forward / preferred)*	*Carry forward*	*Carry forward*	*Carry forward*	*Discount*

Notes for SWOT regarding long list options of scope (options 1 a to d)

'No change' did not meet any of the investment objectives

Changing pathways for patients, for example pushing patients to other forms of treatment for example, surgery, and seed brachytherapy did not meet any of the objectives either. The option may provide continuity in numbers but a drop of standards would be involved. There were questions around the safety, effect on patient outcomes of changing pathways. Other concerns were lack of choice for patients, impact on other clinical services and a lack of sustainability.

Options concerning the service solution

Option	Option 2a	Option 2b	Option 2c	Option 2d	Option 2e	Option 2f
Description	No change – continue with current arrangements	Less fractions, less complex e.g. IMRT, less imaging	More productivity and efficiency	*Build 1 bunker With 1 replacement linac*	*Build 2 bunker With 1 replacement linac*	*Build 2 bunker With 2 linacs (1 replace & 1 new)*
Meets objective						
Continuity for the radiotherapy service, maintaining standards	××	××	×	✓	✓✓	✓✓
To provide the services at a location which is as close to home	×	×	×	✓	✓	✓✓
To improve efficiency, cost effectiveness and maximise income	×	×	✓	✓	-	✓
Satisfies critical success factors						
Ease of transfer	✓	✓	✓	✓	✓	✓
Patient safety	✓	✓	✓	✓	✓	✓
Patient experience	✓	×	✓	✓	✓	✓
Patient outcomes	✓	×	-	✓	✓	✓
Flexibility in use	×	×	×	✓	✓	✓
Patient accessibility	×	×	-	✓	✓	✓
Sustainable	×		×	✓	✓	✓
Achievable within timescale	✓	✓	✓	✓	✓	✓
Minimal disruption to other clinical service	✓	✓	×?	✓	✓	✓
Proven design	✓	×	×	? dependent on loc	✓	✓
Summary *discount / carry forward / preferred)*	Carry forward	Discount	Carry forward	Carry forward	Preferred	Carry forward

Notes for SWOT regarding long list options of service solution (options 2 a to 2f)

Option 2 b of providing less complex treatments, less IMRT, less imaging or reducing fractions was considered incompatible with maintaining standards and quality patient outcomes. There is a risk this option would lead to a loss of income and ultimately a loss of activity as patients choose to be treated at centres offering the higher quality service.

Option 2c More productivity and efficiency: Will be part of any solution. However, there are risks around achievability and therefore around providing continuity around staff recruitment and retention with extended hours during the week and at weekends. A further risk identified would concern unplanned machine downtime having a proportionately greater effect on capacity. A weakness of the option would be a knock on to other services that would need to match the extended hours during the week and weekend of the radiotherapy service.

Option 2d Build 1 bunker with 1 replacement linac. This would have to be at Maidstone, or it would not be a proven design, so would not improve objective 2.

Option 2e Build 2 bunkers with 1 replacement linac: Such an option could be in the form of a satellite unite and hence contribute to objective 2.

Option 2f Build 2 bunker s with 2 linacs (1 replacement & 1 new) There was a question around achievability within timescale

Long list options continued

Options concerning the delivery solution

Option	Option 3a	Option 3b		Option 3c		Option 3d		Option 3e	
Description	No change – continue with current arrangements	Build additional bunker/s at Maidstone hub		Build additional bunker/s at Canterbury hub		Satellite adjacent to clinical facilities at Margate		Satellite adjacent to clinical facilities at Dartford	
Meets objective		*EK*	*WK*	*EK*	*WK*	*EK*	*WK*	*EK*	*WK*
Continuity for the radiotherapy service, maintaining standards	××	✓	✓	×	×	✓	×	×	✓
To provide the services at a location which is as close to home	×	×	×	×	×	✓	×	×	✓
To improve efficiency, cost effectiveness and maximise income	×	✓	✓	×	×	?	×	×	?
Ease of transfer	✓	✓	✓			✓	×	×	✓
Patient safety	✓	✓	✓			✓	✓	✓	✓
Patient experience	✓	✓	✓			✓	✓	✓	✓
Patient outcomes	✓	✓	✓			✓	✓	✓	✓
Flexibility in use	×	?	?			✓	?	?	✓
Patient accessibility	×	×	✓			✓	×	×	✓
Sustainable	×	×	✓			✓	?	?	✓
Achievable within timescale	✓	✓	✓	××	××	?	?	?	?
Minimal disruption to other clinical service	✓	✓	✓			✓	×	×	✓
Proven design	✓	✓	✓			✓	×	×	✓
Summary *discount / carry forward / preferred)*	Carry forward	Carry forward		Discount		Carry forward		Carry forward	

Long list options continued

Options concerning the delivery solution continued

Option	Option 3f		Option 3g		Option 3h
Description	Satellite adjacent to clinical facilities at Ashford		Satellite adjacent to clinical facilities at Tunbridge Wells		Satellite at other stand-alone location
Meets objective	*EK*	*WK*	*EK*	*WK*	
Continuity for the radiotherapy service, maintaining standards	✓	✓	✓	✓	✓?
To provide the services at a location which is as close to home	?	?	✓	✓	✓
To improve efficiency, cost effectiveness and maximise income	?	?	✓	✓	✓
Satisfies critical success factors					
Ease of transfer	✓	✓	✓	✓	×
Patient safety	✓	✓	✓	✓	××
Patient experience	✓	✓	✓	✓	-
Patient outcomes	✓	✓	✓	✓	-
Flexibility in use	✓	✓	✓	✓	×
Patient accessibility	✓	✓	✓	✓	?
Sustainable	✓	✓	✓	✓	✓
Achievable within timescale	?	?	✓	✓	×
Minimal disruption to other clinical service	✓	✓	✓	✓	✓
Proven design	✓	✓	✓	✓	×
Summary *discount / carry forward / preferred)*	Carry forward		Carry forward-preferred		Discount

Notes for SWOT regarding long list options of service delivery

Option 3b: Building at the Maidstone hub met the criteria except for improving access, reducing travel times and improving income

Option 3c Building at the Canterbury hub was not considered achievable from an estates point of view.

Options 3d and f (A satellite at Margate or Ashford) improved access for East Kent patients while options 3 e and g (A satellite at Dartford or Tunbridge Wells improved access for West Kent patients)

Option 3g was preferred on the grounds of better achievability and improved income potential through extending current population

Long list options continued

Options concerning the implementation

Option	Option 4a	Option 4b	Option 4c
Description	Maintain current linac replacement programme	Expedite current linac replacement programme	Slow current programme down by a year
Meets objective			
Continuity for the radiotherapy service, maintaining standards	✓	✓	×
To provide the services at a location which is as close to home	-	-	-
To improve efficiency, cost effectiveness and maximise income	✓	✓	×
Satisfies critical success factors			
Ease of transfer	-	-	-
Patient safety	✓	✓	×
Patient experience	✓	✓✓	×
Patient outcomes	✓	✓✓	×
Flexibility in use	✓	✓	×
Patient accessibility	✓	✓	×
Sustainable	✓	✓	×
Achievable within timescale	✓	✓	-
Minimal disruption to other clinical service	✓	✓	-
Proven design	✓	✓	×
Summary *discount / carry forward / preferred)*	*Carry forward*	Carry forward. Preferred	*discount*

Long list options continued

Options concerning the funding

Option	Option 5a	Option 5b	Option 5c	
Description	*NHS*	*Private*	*Charitable*	
Meets objective				
Continuity for the radiotherapy service, maintaining standards	✓	✓		
To provide the services at a location which is as close to home				
To improve efficiency, cost effectiveness and maximise income		×		
Satisfies critical success factors				
Ease of transfer				
Patient safety				
Patient experience				
Patient outcomes				
Flexibility in use		×		
Patient accessibility				
Sustainable				
Achievable within timescale			×	
Minimal disruption to other clinical service				
Proven design			×	
Summary *discount / carry forward / preferred)*	Preferred	Carry forward	Discount	

Maidstone and Tunbridge Wells NHS Trust

Notes for SWOT regarding long list options of funding

The charitable funding option, although preferred in the SOC in 2012, was now in 2015 considered too high risk in terms of deliverability within timescale

The private funding option was considered to reduce flexibility and reduce potential income and efficiency potential

Summary matrix of long list options

scope options	No change – continue with current arrangements	Change provision of radiotherapy	Change provision of radiotherapy and treatment planning	Change cancer pathways e.g. surgery, brachy. chemotherapy			
	Carry forward	*Carry forward*	*Carry forward*	*Discount*			
Service solution options	No change – continue with current arrangements	Less fractions, less complex e.g. IMRT, less imaging	More productivity and efficiency	*Build 1 bunker With 1 replacement linac*	*Build 2 bunker With 1 replacement linac*	*Build 2 bunker With 2 linacs (1 replace. & 1 new)*	
	Carry forward	Discount	Carry forward	Carry forward	Preferred	Carry forward	
Service delivery options	No change – continue with current arrangements	Build additional bunker/s at Maidstone hub	Build additional bunker/s at Canterbury hub	Satellite adjacent to clinical facilities at Margate	Satellite adjacent to clinical facilities at Dartford	Satellite adjacent to clinical facilities at Ashford	Satellite adjacent to clinical facilities at Tunbridge Wells
	Carry forward	Carry forward	Discount	Carry forward	Carry forward	Carry forward	Preferred
Service delivery options cont.	Satellite at other stand-alone location						
	Discount						
Implementation options	Maintain current linac replacement programme	Expedite current linac replacement programme	Slow current programme down by a year				
	Carry forward	Preferred	Discount				
Funding options	*NHS*	*Private*	*Charitable*				
	Preferred	Carry forward	Discount				

Short list options

1 No Change

2 TWH satellite facility, 2 bunkers, one replacement linac

Scope	Change provision of radiotherapy
Service solution	Build 2 bunkers with 1 replacement linac
Service delivery	Satellite adjacent to clinical facilities at Tunbridge Wells
Implementation	Maintain current linac replacement programme
Funding	*NHS*

3 A Maidstone Hub option. Maidstone Hub facility, 2 new bunker, one replacement linac, maintain linac replacement programme

Scope	Change provision of radiotherapy
Service solution	Build 1 bunkers with 1 replacement linac
Service delivery	Build additional bunker at Maidstone hub
Implementation	Maintain current linac replacement programme
Funding	*NHS*

4 A less ambitious option at Maidstone Hub. Maidstone Hub facility, 1 new bunker, one replacement linac, maintain linac replacement programme

Scope	Change provision of radiotherapy
Service solution	Build 1 bunkers with 1 replacement linac
Service delivery	Build additional bunker at Maidstone hub
Implementation	Maintain current linac replacement programme
Funding	*NHS*

Maidstone and Tunbridge Wells NHS Trust

Appendix Q HV Substation Summary

Capital Cost Main Summary		Cost	VAT	Gross Total	% VAT reclaim	Recovered VAT	Nett Total
Construction Costs			20.0%				
Enabling Works							
Asbestos Removal							
The Works		1484763	296953	1781715	0		1781715
Contingencies	5.0	74238	14848	89086			89086
Specialist installers							
PUBSEC Indexing 2011Q1 (170) 2016Q3(224) 31.8%		495762	99152	594914			594914
To Project Total		2054763	410953	2465715			2465715
Associated Costs							
Specialist Fees					100		
Structural Engineer		5000	1000	6000	100	1000	5000
Ecological Surveys		5000	1000	6000	100	1000	5000
Utility and Geotech Surveys		5000	1000	6000	100	1000	5000
CDM		2500	500	3000	100	500	2500
Local Authority Building Control					100		
Local Authority Planning		1000	200	1200	100	200	1000
Other					100		
Architect -		50000	10000	60000	100	10000	50000
					100		
Contractors Performance Bond							
Signage & Wayfinding							
Trust supplied items for build (locks)							
Clinical Cleaning							
IT (Relocating IT cabinets, switches, etc)							
Medical Gases Purity Testing							
Telephones (Virgin Media) & Handsets							
Blinds (if not included in builders works)							
Post Contract Modifications		2500	500	3000			3000
Trust Supplied							
To Total		71000	14200	85200		13700	71500
Design Team Fees							
On Construction and Associated Costs	5	106289		106289			106289
To Total		106289		106289			106289
Equipment							
Furniture							
Beds							
Specialist Equipment							
Sack Holders							
Monitors etc							
Other Equipment							
To Total							
Budget Total Cost		**2232052**	**425153**	**2657204**		**13700**	**2643504**

Maidstone and Tunbridge Wells NHS Trust

Detail Sheet	Quantity	Unit	Rate	Cost	VAT	Total
Building Works					20.0%	
Banyards budget March 2011)	1	Item	1000100.00	1000100.00	200020.00	1200120.00
			Subtotal	1000100.00	200020.00	1200120.00
Main Contractors Preliminaries on Works	7.5	%		75007.50	15001.50	90009.00
Main Contractors oh/p on Main Works	7.5	%		75007.50	15001.50	90009.00
			To Total	1150115.00	230023.00	1380138.00
Mechanical Services						
H&V services	1	Item	25000.00	25000.00	5000.00	30000.00
			Subtotal	25000.00	5000.00	30000.00
Main Contractor oh&p on Subcontrator	7.5	%		1875.00	375.00	2250.00
BWIC Mechanical Services	0.0	%				
			To Total	26875.00	5375.00	32250.00
Electrical Works						
Electrical Works	1	Item	286300.00	286300.00	57260.00	343560.00
			Subtotal	286300.00	42945.00	329245.00
Main Contractor oh&p on Subcontrator	7.5	%		21472.50	4294.50	25767.00
BWIC Electrical Services	0.0	%				
			To Total	307772.50	47239.50	355012.00
			Total	**£1,484,762.50**	**£282,637.50**	**£1,767,400.00**

Appendix R High Level Information Pack for Procure 21+ Process

High Level Information Pack
Satellite Radiotherapy Unit
at Tunbridge Wells Hospital

Tunbridge Wells Hospital Satellite Radiotherapy Unit P21+

1. Executive summary

The Maidstone and Tunbridge Wells NHS Trust are proposing to develop a satellite radiotherapy unit located on the Tunbridge Wells Hospital at Pembury site. The satellite will consist of 2 bunkers, with head room for a supplemental bunker downstream, and will initially house one replacement linear accelerator (linac) – the procurement and installation of the linac is outside the scope of this scheme.

The planned construction completion date is 14th April 2017

The satellite facility would be opened to patients on the 23rd October 2017 following installation of the linac and acceptance and commissioning by the Trust's Medical Physics team,.

The OBC is to be appraised at the Trust Board in January 2016.

The scope of the scheme will include:

- Gross construction of the satellite unit radiotherapy unit, including the linac bunkers, surrounding building/landscaping, ground works, utilities and built in accordance with HTM and HBN regulations.
- Installation of optical fibre, with appropriate redundancy and approved by the Trust, necessary to connect the radiotherapy satellite IT into the Trust's networking infrastructure within the main TWH building.
- Whilst the procurement of the replacement linac is outside the scope of this scheme, the selected PSCP will need to work in partnership with the linac supplier to ensure that the satellite facility meets their requirements and that beneficial access is provided to ensure that the linac is delivered into the bunker late March 2017. This delivery date is required to meet the Trust's capital planning requirements.

The Trust does not guarantee that all components of this scheme will be delivered by the selected P21+ PSCP.

2. Purpose of this document

The purpose of this HLIP is to provide the prospective Principal Supply Chain Partner (PSCP) with the following:

- Information about Maidstone and Tunbridge Wells NHS Trust
- Information about the proposed scheme including current status, budgets, time drivers and dependencies
- An invitation to participate in the scheme as the Trust's PSCP and to enter into the selection process
- Details of the Trust's adopted selection process and assessment criteria.

3. Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (MTW) is a Kent based Trust comprising of two main hospitals based at both Maidstone and Pembury, Tunbridge Wells. The Kent Oncology Centre is based at the Maidstone Hospital with an extending centre at Kent and Canterbury Hospital, and is the fourth largest Cancer Centre in the UK; providing Oncology Services to the 1.8m population of Kent and surrounding counties.

The Trust employs over 4,700 staff and each year treats 119,000 people in the Emergency Department, has 387,500 out-patient attendances and 84,000 inpatients per annum. Our new hospital in Tunbridge Wells is the first NHS hospital in England to be built with 100% single rooms for inpatients.

The Trust's Clinical Strategy is being developed to support the delivery of satellite radiotherapy services.

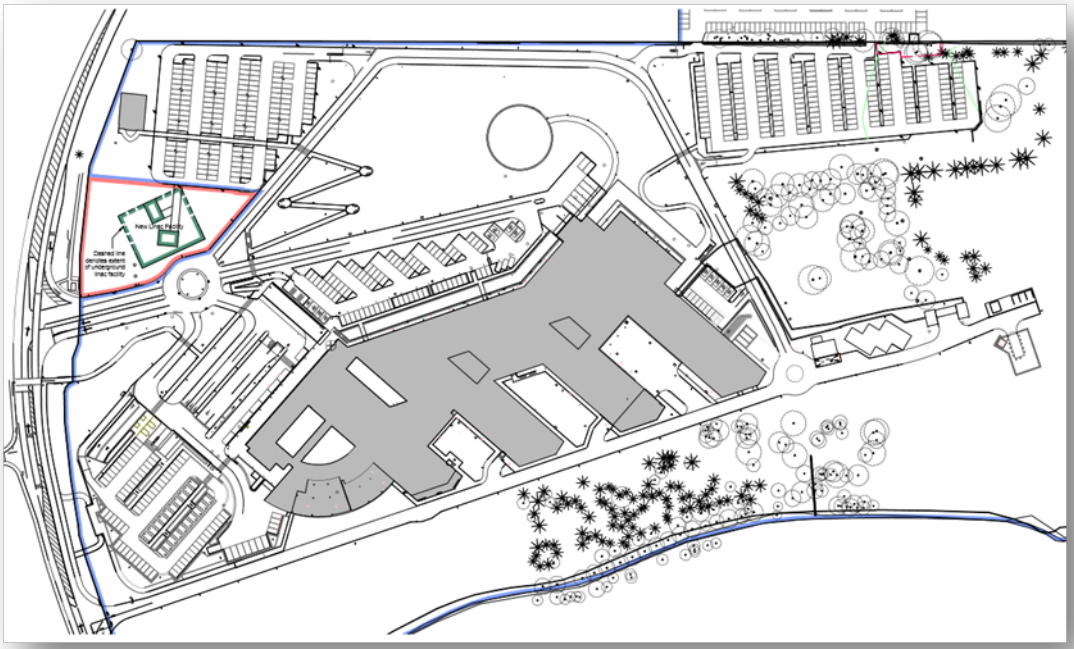
4. Project Budgets

Project budgets as quoted in this HLIP include all project costs including all PSCP costs and client side costs including fees, decanting, client risk, VAT etc. However the budget excludes radiotherapy equipment.

The scheme will require a loan to be approved from the Trust Development Authority.

4.1. Radiotherapy Linac Bunker Site

This project is a new build on the MTW Tunbridge Wells Hospital site, located near the main road entrance to the site, with good transport links to the A21 and A228.



4.2. Radiotherapy Linac Bunker Description

- Construction of a new stand-alone building set into the existing landscaping.

  Alternative construction materials may be required to ensure that two bunkers, with headroom for a third, fit within the allocated footprint and the facility meets the appropriate statutory and legislative requirements.

- Fit out of the new core building. The new core building will have the following requirements:

  Level 1 (ground): Linac bunkers, patient waiting rooms, outpatient clinics, offices, ancillary areas and other areas identified during the building design (approximately 900 m^2).

  Designed and constructed to meet the radiation protection requirements of IRR99 (along with the associated approved codes of practices) and the Trust's appointed Radiation Protection Adviser (RPA).

  The facility meets the linac supplier's design requirements.

  Allows for future expansion and that power, utilities and ancillary facilities provided are sufficient to support up to 3 linacs.

  Level 2 (first): Main Entrance into the centre from the rear car park with lift and stairs to the ground floor (approximately 30 m^2)

  Plant room (approximately 90 m^2) – able to support the satellite facility and up to 3 linacs.

4.3. Key Information:

Project Budget: £6.35m

Timescale

- Affordable GMP to be provided within 3 weeks of letter of appointment.
- Construction works – Commencement on site July 2016
- Construction works - Completion April 2017

Current status:

- SOC approved by Trust Finance Committee
- OBC submitted to the Trust Investment Appraisal Group Dec 2015.

Professional Advisors to date:

- AHP Architects
- DHA Planning and Development Consultants

The Trust does not require these to be retained and we would expect the PSCPs to select who they believe to be the optimum team to deliver this project.

Dependencies:

Delivery of the Linac equipment into the bunker will occur during March 2017.

Planning status:

Initial proposal supported by the Local planning office. Finances have been released to seek planning permission. Application for planning permission is current underway and is due for submission during January 2016.

4.4. Site constraints and risks

Whilst the Trust owns all land and accommodation required for these projects, the following site constraints should be noted:

- Restricted site with limited space available for supporting construction accommodation, welfare and parking.
- Site adjacent to hospital main road entrance with continuous surrounding traffic including public transport and emergency vehicles.
- Site of varying levels.
- All site services including ICT, medical gases, electricity etc. must remain operational at all times.
- The main hospital building is managed under a Private Finance Initiative (PFI).
- Site is located near to a Chapel, now deconsecrated but listed as a Grade II building.

4.5. Key members of Trust's project team

Project Role	Responsible Person
Trust Executive Project Sponsor	Steve Orpin, Director of Finance
P21+ Project Director, (Director of Estates & Facilities)	Jeanette Rooke
P21+ Project Liaison, (Head of Estates Strategy)	Kevin Vaughan
P21+ Project Manager	External (to be appointed)
P21+ Cost Advisor	External (to be appointed)
P21+ CDMC	External (to be appointed)
P21+ Supervisor	External (to be appointed)
Clinical Director	Dr Sharon Beesley
Director of Medical Physics and Oncology Project Director	Stephen Duck
General Manager	David Fitzgerald
Oncology Project Manager	Sarah Smith
Head of Radiotherapy Services	Christine Richards
Head of Radiotherapy Physics	Nick Jenkins
Radiation Protection Advisor (RPA)	Mark Knight
Head of Computer Science Operation	Mark Price

Project Role	Responsible Person
Lead Cancer Nurse	Gemma Craig
Head of Quality, Fire and Security	John Sinclair
Head of Costing and SLR	Patrick McGinley
Head of Category Management	Lesley Martin

5. PSCP selection procedure

The programme for the selection procedure, those involved including the Trust's project team and the assessment criteria are set out below

5.1. Anticipated selection panels

	EOI Assessor?	Interview Assessor?
Trust Executive Project Sponsor	No	No
P21+ Project Director, (Director of Estates and Facilities)	Yes	Yes
P21+ Project Liaison, (Head of Estates Strategy)	Yes	Yes
P21+ Project Manager	No	No
P21+ Cost Advisor	No	No
Head of Radiotherapy Services	Yes	Yes
Head of Radiotherapy Physics	Yes	Yes
RPA Advisor	Yes	Yes
Oncology Project Director	Yes	Yes
Oncology Project Manager	Yes	Yes
Head of Quality, Fire and Security	Yes	Yes
Head of Costing and SLR	Yes	Yes
Head of Category Management	Yes	Yes
P21+ Implementation Advisor	observer	observer

5.2. Selection timetable

Task	Date/time	Venue
Register scheme	22nd December 2015	N/A
Issue HLIP	24th December 2015	N/A
PSCP confirmation of intention to bid	6th January 2015	N/A
PSCP submit EOI	18th January 2016 @ midday	N/A
Trust assesses EOI's and shortlist	20nd January 2016	Estates Meeting Rm, Maidstone
PSCP Open Day	25th January 2016	TBA
PSCP Interview	4th February 2016	TBA

PSCP appointment	22nd February 2016	N/A

5.3. EOI Submission

- PSCPs are to return an electronic copy of their Expression of Interest.
- Note that the maximum incoming email accepted by the Trust is 10MB - excessive file sizes will not be accepted through Trust servers. PSCPs whose EOI files are larger than this size cap should split files prior to submission.
- Expressions of Interest must be restricted to 10 sides maximum of A4 at minimum font 10 in PDF format
- In line with the timetable above Expressions of Interest must be emailed to kevin.vaughan@nhs.net plus copied to the Implementation Advisor
- PSCPs who wish to decline the opportunity are requested to let the Trust and Implementation Advisor know, as soon as possible together with their reason.

5.4. Open Day and Interviews

Following receipt of Expressions of Interest, a short listing process will take place. Those PSCPs shortlisted will then be invited to attend an Open Day and thereafter an interview. Dates are noted above.

The Trust will expect a maximum of six PSCP attendees to the open day and interviews. The Trust would expect to see the following staff who will work on the project:

- Pre-construction manager
- Architect
- Commercial/Cost Manager

The open day will comprise a joint high level briefing of the shortlisted PSCP, and possible site walk and thereafter a half an hour private session between the client team and each shortlisted PSCP individually.

The interview format will be confirmed nearer the time, but at this early stage it is expected that five assessment criteria's will be brought forward to interview, and the interview format will be:

- 5 mins = set-up and introductions
- 25 mins = PSCP presentation against assessment criteria
- 25 mins = client questions of PSCP
- 5 mins = PSCP questions of client

Total 60 minute duration

Appendix A - High Level Information Pack

Radiotherapy Satellite Unit at Tunbridge Wells Hospital

The table below shows the Trust's assessment criteria together with the rank and weight that will be used in choosing the successful PSCP.

Rank	Assessment criteria	Weight
1	Relevant experience • Show the experience the PSCP and its supply chain have of this type of scheme/project and clinical model. • What lessons have been learned elsewhere which can be incorporated into this scheme? • Relevant experience and lessons learned of those directly involved in this project is of interest to the Trust. Demonstrable experience of: • Construction of a radiotherapy linac bunker including involvement with Ionising Radiations Regulations • Working in in partnership with radiotherapy linac suppliers • Construction within active hospital environment	100
2	Cost management • Show how the PSCP will manage costs on this scheme. • Demonstrate the ability to manage within a tight budget while delivering VFM. • Show how the PSCP will evidence open book accounting. • What is your anticipated commercial approach for this project? • Who will have ownership of delivering to the budget once established? • What commercial lessons have been learned from previous P21 / P21+ projects? • How will risk be quantified, priced and apportioned? • Demonstration of similar projects that have been delivered to budget.	90
3	Stakeholder engagement • Show how the PSCP will help the Client achieve a quality brief. • Show how the PSCP will engage stakeholders and manage their expectations to stay within project constraints. • Provide a statement on the process you might follow to ensure full liaison and co-ordination of activities. • What early warning mechanisms would be in place to avoid disruption to the many stakeholders? • What measures would be instigated to avoid reoccurrence should problems arise?	90

Rank	Assessment criteria	Weight
	• Examples of stakeholder satisfaction with regards to PSCP contact	
4	Design and Standardisation • Show how the supply chain will approach the design process and where previous/repeatable designs, components and other innovative solutions could be employed. • Consideration of alternative construction materials and system to address the site footprint and improve construction timetable. • Standardisation of design and materials to reflect the existing hospital environment. • Ensure relevant stakeholders are included within the design process.	90
5	Delivery confidence • Show how the PSCP will provide the Client with confidence that the programme and budget for this scheme are achievable and that client expectations are met. • Demonstrate previous NHS client satisfaction.	90
6	Working with us • Show how the PSCP proposes to integrate the supply chain with the Client and their suppliers to deliver high quality outputs? • What are the key activities to be undertaken and indicative time-table? • How does the PSCP see the delivery team interfacing with the Trust and their suppliers? • Communication will be key on so many facets of this scheme - demonstrate that you can communicate effectively by reference to reporting processes used on other P21+ projects.	80
7	Strength of team and leader • Demonstrate the capability of the team and leader to deliver this scheme. • Show how the PSCP will maintain continuity of the team and explain how the Client will be involved with any team changes. • What experience and attributes has the team leader that makes them suitable for the PSCP to put them forward for this project. • How will they be empowered? • Where are they located? • What makes them the right person for a scheme of this nature and this particular Trust?	60
8	Health and safety • Show how the PSCP will adhere to all statutory and occupational health and safety guidelines.	50

Rank	Assessment criteria	Weight
	• Show how patients and staff will be kept safe from construction activities. • From your experience of similar sites, what specific risks are foreseen during your works and how will they be performance managed? • What specific concerns have you on undertaking this project safely? • How will you ensure that your actions do not place the project team at risk? • Describe how you might arrange your site access and move plant, equipment, materials etc. to working area • Portrayal of previous significant incidents in a similar project including any involvement of members of the public. • Do you have any outstanding incidents/non-conformances with the HSE?	
9	Governance • Outline the PSCP governance structure for this scheme and detail how the PSCP team performance will be monitored and managed. • Name a PSCP SRO for this scheme. • Show how you will report progress, budget information, potential issues and forward look to the Client.	40
10	BREAM and sustainability • Demonstrate how the PSCP has developed and achieved value for money BREEAM ratings, and have considered viable carbon/energy savings. • Show how the PSCP will assist the Client with its corporate responsibilities.	40
	Total weighting	730

Appendix S Schedule of Accommodation

	version 2 post meeting 15 April			
Room name/function	**Unit area allowance**	**Quantity**	**Net internal area**	**Comments**
Public spaces				
Entrance, reception and visitors' facilities				
Lobby	15	0	15.0	From comms allowance
Reception and staff base - 2 places	12	1	12.0	1 receptionist to oversee the arrivals and one nurse place with IT to manage the Outpatients
Admin Office	12	1	12.0	2 people. To be adjacent to the reception/staff base
Waiting Room	1.2	40	48.0	Including Wheelchair space allowance as per KV email dated 19.04.16
Private Patients Waiting with beverage area	16	1	16.0	sized at the generic C/E size for future flexibility. To incorporate a beverage area. To comfortably seat 6/7 people
Beverage Point	2	1	2.0	adjacent to waiting area. Water cooler and beverage machine/vending machine+N3
WC - ambulant	2.5	4	10.0	unisex. 1 to have drop down baby change (tbc)
WC - disabled	4.5	1	4.5	unisex with drop down baby change (tbc)
Parking bay: wheelchair	1	1	1.0	assembled wheelchair or 2 folding. To be part of the circulation space near to the entrance. for NEAT patients
Clinical spaces for Outpatients				
Treatment room	16	1	16.0	Derogate from HBN as confirmed to be for dressings and line flushes rather than minor procedures. Planned at the generic C/E size. To house a patient A&E type trolley rather than C/E couch.

Room name/function	Unit area allowance	Quantity	Net internal area	Comments
Consulting/examination room: double sided couch access	16	4	64.0	
Dirty utility room	12	1	12.0	Increased in size as will house a macerator and a slop hopper and store the boxed macerator items (bowls, bottles etc) to have a single commode parked here (as with Maidstone - tbc). shared with linacs locate on the route from waiting area to external door, for privacy. Used for first discussions (back to waiting room) and bad news (straight to exit)
Interview room	9	1	9.0	Sized at 3mx3m based on exiting provision that is adequate. up to 4 people, usually 3. Will need an IT point in the room for first appointment discussions. Consider location of computer or use of a laptop at 1:50 stage
Store: equipment and consumables	8	1	8.0	for all storage plus to house a drug dispensing cupboard for Patient Group Directives (PGDs), dispensed for linac patients or C/E patients
Clinical spaces for radiotherapy treatment suite				
Radiotherapy treatment room (bunker) and maze	110	2	220.0	Based on the HliP size. Further work being done by design team to determine the size based on a maze or door. To be Varian Trubeam system to be located adjacent to each other in a location that allows radiotherapy staff to observe the changing area. A screen for patient ID is required at the maze/door end or a relayed screen on the maze wall
Control area serving radiotherapy treatment room	20	2	40.0	
Changing room: semi-ambulant	2	2	4.0	pass through, one per each bunker. Includes the waiting when gowned
Changing room: independent wheelchair	4.5	2	9.0	pass through, one per each bunker. Includes the waiting when gowned related to each set of changing rooms. Exchange linen trolley for patient gowns and trousers. Separated linen skip for disposal to be included, may be in the changing room.
Gown store	2	2	4.0	

Room name/function	Unit area allowance	Quantity	Net internal area	Comments
WC - disabled	4.5	1	4.5	Close to linac room for prostate patients post bladder scan, pre radiotherapy treatment.
Sub wait	3	1	3.0	Discreet subwait for gowned prostate patients, next to the WC. Usually 1 patient only. May be joined by their relative therefore 2 seats.
Staff spaces: shared support				
Cleaners' room	8	1	8.0	Centrally located
Parking bay: resuscitation trolley	2	1	2.0	alcove with power central to the clinical area. Also to include a small oxygen cyclinder on a trolley
Disposal hold: 3000 litres	12	1	12.0	based Trust's standard size
Staff spaces: administration and non patient areas				
Radio Physics store (adjacent to office area)	12	1	12.0	to include printer and portable water bath as well as strong racking for equipment and a work bench. May require engineering solution if to include soldering and other similar activities? Leaf and a half door needed
Office - 2 persons	12	1	12.0	Med Physics and radiographer - quiet office. May be occasionally joined by a 3rd person
Office area: shared use (hot desks)	4	10	40.0	planned as a single office area of hot desks and assigned. Space to include for local storage and a printer/scanner/copier to include Palliative and AOS, doctors, visiting management and admin and visiting IT. Desks not permanently assigned therefore no desk storage required. Room may include lockers/pigeon holes for minimal personal storage
Break out/VC Room	10	1	10.0	Telemedicne and IT links to Maidstone
Rest room with mini kitchen	16	1	16.0	sized at the standard generic department size. To have a beverage area. Capacity will be based on the size as not all staff

				take breaks at the same time.
WC: ambulant (staff)	2.6	2	5.2	
IT server room (based on Trust standard size)	10	1	10.0	Trust has a standard size and layout. For 1 rack
Changing area: staff	10	2	20.0	Based on one wall of half height unassigned lockers and up to 5 people changing simultaneously. To include coat hooks and a small bench. Gender segregation, assumed to be 50:50 as currently
Departmental Area (sub total) ***Best comparison line - at room level***			***661.2***	

Plant	213.5
Comms and circulation	231.4

Building total	***1106.1***

Appendix T Approval Signature Sheet

Maidstone and Tunbridge Wells NHS Trust

Outline Business Case

MTW Additional Radiotherapy Linac Bunker Capacity Project

Issue date	22/04/2016 Post Finance Committee re-submission with adjusted timeframe.
Department	Kent Oncology Centre
Directorate	Cancer & Haematology
Author	S Duck, N Baber, S Smith and P McGinley
Clinical lead	S Beesley
Executive Sponsor	S Orpin
ID reference	277

Approved by	Name	Signature	Date
Director of Medical Physics	S. Duck		21.4.16
Cancer and Haematology General Manager	D Fitzgerald		21/4/16
Head of Costing and SLR	P McGinley		
Cancer and Haematology Clinical Director	S Beesley		21/04/16
Executive sponsor	S Orpin		21/4/16
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	J Rooke		21/4/16
Director of Health Informatics	D Jarrett		
Director of Workforce	R Hayden		
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group	S Doyle		10.01.2016
Trust Management Executive			
Finance Committee	S Doyle		22.02.2016
Trust Board			

Option 2 - Preferred Option

£s.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Year 26	Year 27	Year 28	Year 29	Year 30
Capital cost	-1053719	-5347625																													
Demand extra fractions		0	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500
Revenue Cost	0	-63,807	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686	-765,686
Efficiency Income	0	0	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712	761,712
Benefit Income	0	0	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618	462,618
Total Income	0	0	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330	1,224,330
Total	-1,053,719	-5,411,432	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644	458,644
Discount factor	1	0.9962	0.9335	0.9019	0.8714	0.842	0.8135	0.786	0.7594	0.7337	0.7089	0.6849	0.6618	0.6394	0.6178	0.5969	0.5767	0.5572	0.5384	0.5202	0.5026	0.4856	0.4692	0.4533	0.438	0.4231	0.4082	0.3933	0.3784	0.3635	0.3486
NPV	-1,053,719	-5,390,869	428,144	413,651	399,662	386,178	373,107	360,494	348,294	336,507	325,133	314,125	303,531	293,257	283,350	273,765	264,500	255,556	246,934	238,587	230,514	222,718	215,196	207,903	200,886	194,052	187,218	180,385	173,551	166,717	159,883
Total NPV	1,539,212																														

Option 1a - Treat on extended days

£s.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Year 26	Year 27	Year 28	Year 29	Year 30
Capital cost	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	0	0	0
Demand extra fractions	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	0	0	0
Revenue Cost	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700	-88,700
Efficiency Income	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315
Benefit Income	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555
Total Income	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760
Total	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460	-249,460
Discount factor	1	0.9962	0.9335	0.9019	0.8714	0.842	0.8135	0.786	0.7594	0.7337	0.7089	0.6849	0.6618	0.6394	0.6178	0.5969	0.5767	0.5572	0.5384	0.5202	0.5026	0.4856	0.4692	0.4533	0.438	0.4231	0.4082	0.3933	0.3784	0.3635	0.3486
NPV	-249,460	-248,512	-232,871	-224,988	-217,379	-210,045	-202,936	-196,076	-189,440	-183,029	-176,842	-170,855	-165,093	-159,505	-154,116	-148,903	-143,864	-138,999	-134,309	-129,769	-125,379	-121,138	-117,047	-113,080	-109,263	-105,547	-101,830	-98,113	-94,396	-90,679	-86,962
Total NPV	-4,840,422																														

Option 1b - Treat on Weekends

£s.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Year 26	Year 27	Year 28	Year 29	Year 30
Capital cost	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	0	0	0
Demand extra fractions	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	0	0	0
Revenue Cost	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234	-595,234
Efficiency Income	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315	-459,315
Benefit Income	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555
Total Income	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760	-160,760
Total	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994	-755,994
Discount factor	1	0.9962	0.9335	0.9019	0.8714	0.842	0.8135	0.786	0.7594	0.7337	0.7089	0.6849	0.6618	0.6394	0.6178	0.5969	0.5767	0.5572	0.5384	0.5202	0.5026	0.4856	0.4692	0.4533	0.438	0.4231	0.4082	0.3933	0.3784	0.3635	0.3486
NPV	-755,994	-753,121	-705,720	-681,831	-658,773	-636,547	-615,001	-594,211	-574,102	-554,673	-535,924	-517,780	-500,317	-483,383	-467,053	-451,253	-435,982	-421,240	-407,027	-393,268	-379,963	-367,111	-354,712	-342,692	-331,125	-319,861	-308,597	-297,332	-286,068	-274,804	-263,540
Total NPV	-14,669,005																														

Option 3 - Maidstone Two Bunkers, One Replacement

£s.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Year 26	Year 27	Year 28	Year 29	Year 30
Capital cost	-926141	-2982149	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	0
Capital costs HV	-587616	-2982149																													
Demand extra fractions	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	0	0	0
Revenue Cost		-15,214	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566	-182,566
Efficiency Income		0	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397
Benefit Income		0	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555
Total Income	0	0	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952
Total	-1,513,757	-5,979,512	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386	418,386
Discount factor	1	0.9962	0.9335	0.9019	0.8714	0.842	0.8135	0.786	0.7594	0.7337	0.7089	0.6849	0.6618	0.6394	0.6178	0.5969	0.5767	0.5572	0.5384	0.5202	0.5026	0.4856	0.4692	0.4533	0.438	0.4231	0.4082	0.3933	0.3784	0.3635	0.3486
NPV	-1,513,757	-5,956,790	390,563	377,342	364,582	352,281	340,357	328,851	317,722	306,970	296,594	286,553	276,888	267,516	258,479	249,735	241,283	233,125	225,259	217,644	210,281	203,168	196,307	189,654	183,253	177,019	170,785	164,551	158,317	152,083	145,849
Total NPV	-187,534																														

Option 4 - Maidstone One Bunker and One replacement

£s.	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	Year 19	Year 20	Year 21	Year 22	Year 23	Year 24	Year 25	Year 26	Year 27	Year 28	Year 29	Year 30
Capital cost	-723534	-3675519	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	0
Capital costs HV	-587616	-2982149																													
Demand extra fractions	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	0	0	0
Revenue Cost		-12,293	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519	-147,519
Efficiency Income		0	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397	302,397
Benefit Income		0	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555	298,555
Total Income	0	0	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952	600,952
Total	-1,311,150	-6,669,961	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433	453,433
Discount factor	1	0.9962	0.9335	0.9019	0.8714	0.842	0.8135	0.786	0.7594	0.7337	0.7089	0.6849	0.6618	0.6394	0.6178	0.5969	0.5767	0.5572	0.5384	0.5202	0.5026	0.4856	0.4692	0.4533	0.438	0.4231	0.4082	0.3933	0.3784	0.3635	0.3486
NPV	-1,311,150	-6,644,615	423,280	408,951	395,122	381,791	368,868	356,398	344,337	332,684	321,439	310,556	300,082	289,925	280,131	270,654	261,495	252,653	244,128	235,876	227,895	220,187	212,751	205,541	198,604	191,848	185,091	178,335	171,579	164,823	158,067
Total NPV	-62,676																														

Option	Total NPV	Comment
1a	-4,840,422	Option 1a - Treat on extended days
1b	-14,669,005	Option 1b - Treat on Weekends
2	1,539,212	Option 2 - Preferred Option
3	-187,534	Option 3 - Maidstone Two Bunkers, One Replacement
4	-62,676	Option 4 - Maidstone One Bunker and One replacement

1 £0.97

Revised schedule from plan

Appendix O

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	**RWF**	
Trust Name	Maidstone & Tunbridge Wells	
DH Reference Number		
Loan Value	£7,463	
NLF Interest Rate	2.91%	Interest Rate at 21/04/16
Date of Loan	20-Feb-17	
Period - Years	25years	
First Repayment	15-Sep-17	

Date (where 15th is not a working day), repayment will actually be collected on next working day)	Advance Recovered £000	Interest £000	Total Recovered £000	Future Recovery £000	Days in Period
15-Sep-17	£149	£123	£272	£7,314	207
15-Mar-18	£149	£106	£255	£7,164	181
15-Sep-18	£149	£105	£254	£7,015	184
15-Mar-19	£149	£101	£250	£6,866	181
15-Sep-19	£149	£101	£250	£6,717	184
15-Mar-20	£149	£97	£247	£6,567	182
15-Sep-20	£149	£96	£246	£6,418	184
15-Mar-21	£149	£93	£242	£6,269	181
15-Sep-21	£149	£92	£241	£6,120	184
15-Mar-22	£149	£88	£238	£5,970	181
15-Sep-22	£149	£88	£237	£5,821	184
15-Mar-23	£149	£84	£233	£5,672	181
15-Sep-23	£149	£83	£232	£5,523	184
15-Mar-24	£149	£80	£229	£5,373	182
15-Sep-24	£149	£79	£228	£5,224	184
15-Mar-25	£149	£75	£225	£5,075	181
15-Sep-25	£149	£74	£224	£4,926	184
15-Mar-26	£149	£71	£220	£4,776	181
15-Sep-26	£149	£70	£219	£4,627	184
15-Mar-27	£149	£67	£216	£4,478	181
15-Sep-27	£149	£66	£215	£4,329	184
15-Mar-28	£149	£63	£212	£4,179	182
15-Sep-28	£149	£61	£211	£4,030	184
15-Mar-29	£149	£58	£207	£3,881	181
15-Sep-29	£149	£57	£206	£3,731	184
15-Mar-30	£149	£54	£203	£3,582	181
15-Sep-30	£149	£53	£202	£3,433	184
15-Mar-31	£149	£50	£199	£3,284	181
15-Sep-31	£149	£48	£197	£3,134	184
15-Mar-32	£149	£45	£195	£2,985	182
15-Sep-32	£149	£44	£193	£2,836	184
15-Mar-33	£149	£41	£190	£2,687	181
15-Sep-33	£149	£39	£189	£2,537	184
15-Mar-34	£149	£37	£186	£2,388	181
15-Sep-34	£149	£35	£184	£2,239	184
15-Mar-35	£149	£32	£182	£2,090	181
15-Sep-35	£149	£31	£180	£1,940	184
15-Mar-36	£149	£28	£177	£1,791	182
15-Sep-36	£149	£26	£176	£1,642	184
15-Mar-37	£149	£24	£173	£1,493	181
15-Sep-37	£149	£22	£171	£1,343	184
15-Mar-38	£149	£19	£169	£1,194	181
15-Sep-38	£149	£18	£167	£1,045	184
15-Mar-39	£149	£15	£164	£896	181
15-Sep-39	£149	£13	£162	£746	184
15-Mar-40	£149	£11	£160	£597	182
15-Sep-40	£149	£9	£158	£448	184
15-Mar-41	£149	£6	£156	£299	181
15-Sep-41	£149	£4	£154	£149	184
15-Mar-42	£149	£2	£151	-£0	181
Total	**£7,463**	**£2,785**	**£10,248**		

Revised schedule from plan

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	**RWF**	
Trust Name	Maidstone & Tunbridge Wells	
DH Reference Number		
Loan Value	£10,750	
NLF Interest Rate	2.91%	Interest Rate at 21.04.16
Date of Loan	20-Feb-17	
Period - Years	25years	
First Repayment	15-Sep-17	

Date (where 15th is not a working day), repayment will actually be collected on next working day)	**Advance Recovered £000**	**Interest £000**	**Total Recovered £000**	**Future Recovery £000**	**Days in Period**
15-Sep-17	£215	£177	£392	£10,535	207
15-Mar-18	£215	£152	£367	£10,320	181
15-Sep-18	£215	£151	£366	£10,105	184
15-Mar-19	£215	£146	£361	£9,890	181
15-Sep-19	£215	£145	£360	£9,675	184
15-Mar-20	£215	£140	£355	£9,460	182
15-Sep-20	£215	£139	£354	£9,245	184
15-Mar-21	£215	£133	£348	£9,030	181
15-Sep-21	£215	£132	£347	£8,815	184
15-Mar-22	£215	£127	£342	£8,600	181
15-Sep-22	£215	£126	£341	£8,385	184
15-Mar-23	£215	£121	£336	£8,170	181
15-Sep-23	£215	£120	£335	£7,955	184
15-Mar-24	£215	£115	£330	£7,740	182
15-Sep-24	£215	£114	£329	£7,525	184
15-Mar-25	£215	£109	£324	£7,310	181
15-Sep-25	£215	£107	£322	£7,095	184
15-Mar-26	£215	£102	£317	£6,880	181
15-Sep-26	£215	£101	£316	£6,665	184
15-Mar-27	£215	£96	£311	£6,450	181
15-Sep-27	£215	£95	£310	£6,235	184
15-Mar-28	£215	£90	£305	£6,020	182
15-Sep-28	£215	£88	£303	£5,805	184
15-Mar-29	£215	£84	£299	£5,590	181
15-Sep-29	£215	£82	£297	£5,375	184
15-Mar-30	£215	£78	£293	£5,160	181
15-Sep-30	£215	£76	£291	£4,945	184
15-Mar-31	£215	£71	£286	£4,730	181
15-Sep-31	£215	£69	£284	£4,515	184
15-Mar-32	£215	£66	£281	£4,300	182
15-Sep-32	£215	£63	£278	£4,085	184
15-Mar-33	£215	£59	£274	£3,870	181
15-Sep-33	£215	£57	£272	£3,655	184
15-Mar-34	£215	£53	£268	£3,440	181
15-Sep-34	£215	£50	£265	£3,225	184
15-Mar-35	£215	£47	£262	£3,010	181
15-Sep-35	£215	£44	£259	£2,795	184
15-Mar-36	£215	£41	£256	£2,580	182
15-Sep-36	£215	£38	£253	£2,365	184
15-Mar-37	£215	£34	£249	£2,150	181
15-Sep-37	£215	£32	£247	£1,935	184
15-Mar-38	£215	£28	£243	£1,720	181
15-Sep-38	£215	£25	£240	£1,505	184
15-Mar-39	£215	£22	£237	£1,290	181
15-Sep-39	£215	£19	£234	£1,075	184
15-Mar-40	£215	£16	£231	£860	182
15-Sep-40	£215	£13	£228	£645	184
15-Mar-41	£215	£9	£224	£430	181
15-Sep-41	£215	£6	£221	£215	184
15-Mar-42	£215	£3	£218	£0	181
Total	**£10,750**	**£4,011**	**£14,761**		

Revised schedule from plan

NHS TRUST CAPITAL INVESTMENT LOAN - REPAYMENT SCHEDULE (£000s)

Trust Code	**RWF**	
Trust Name	Maidstone & Tunbridge Wells	
DH Reference Number		
Loan Value	£9,301	
NLF Interest Rate	2.91%	Interest Rate at 05.08.15
Date of Loan	20-Feb-17	
Period - Years	25years	
First Repayment	15-Sep-17	

Date (where 15th is not a working day), repayment will actually be collected on next working day)	**Advance Recovered £000**	**Interest £000**	**Total Recovered £000**	**Future Recovery £000**	**Days in Period**
15-Sep-17	£186	£153	£340	£9,115	207
15-Mar-18	£186	£132	£318	£8,929	181
15-Sep-18	£186	£131	£317	£8,743	184
15-Mar-19	£186	£126	£312	£8,557	181
15-Sep-19	£186	£126	£312	£8,371	184
15-Mar-20	£186	£121	£307	£8,185	182
15-Sep-20	£186	£120	£306	£7,999	184
15-Mar-21	£186	£115	£301	£7,813	181
15-Sep-21	£186	£115	£301	£7,627	184
15-Mar-22	£186	£110	£296	£7,441	181
15-Sep-22	£186	£109	£295	£7,255	184
15-Mar-23	£186	£105	£291	£7,069	181
15-Sep-23	£186	£104	£290	£6,883	184
15-Mar-24	£186	£100	£286	£6,697	182
15-Sep-24	£186	£98	£284	£6,511	184
15-Mar-25	£186	£94	£280	£6,325	181
15-Sep-25	£186	£93	£279	£6,139	184
15-Mar-26	£186	£89	£275	£5,953	181
15-Sep-26	£186	£87	£273	£5,767	184
15-Mar-27	£186	£83	£269	£5,581	181
15-Sep-27	£186	£82	£268	£5,395	184
15-Mar-28	£186	£78	£264	£5,209	182
15-Sep-28	£186	£76	£262	£5,023	184
15-Mar-29	£186	£72	£258	£4,837	181
15-Sep-29	£186	£71	£257	£4,650	184
15-Mar-30	£186	£67	£253	£4,464	181
15-Sep-30	£186	£65	£252	£4,278	184
15-Mar-31	£186	£62	£248	£4,092	181
15-Sep-31	£186	£60	£246	£3,906	184
15-Mar-32	£186	£57	£243	£3,720	182
15-Sep-32	£186	£55	£241	£3,534	184
15-Mar-33	£186	£51	£237	£3,348	181
15-Sep-33	£186	£49	£235	£3,162	184
15-Mar-34	£186	£46	£232	£2,976	181
15-Sep-34	£186	£44	£230	£2,790	184
15-Mar-35	£186	£40	£226	£2,604	181
15-Sep-35	£186	£38	£224	£2,418	184
15-Mar-36	£186	£35	£221	£2,232	182
15-Sep-36	£186	£33	£219	£2,046	184
15-Mar-37	£186	£30	£216	£1,860	181
15-Sep-37	£186	£27	£213	£1,674	184
15-Mar-38	£186	£24	£210	£1,488	181
15-Sep-38	£186	£22	£208	£1,302	184
15-Mar-39	£186	£19	£205	£1,116	181
15-Sep-39	£186	£16	£202	£930	184
15-Mar-40	£186	£13	£200	£744	182
15-Sep-40	£186	£11	£197	£558	184
15-Mar-41	£186	£8	£194	£372	181
15-Sep-41	£186	£5	£191	£186	184
15-Mar-42	£186	£3	£189	-£0	181
Total	**£9,301**	**£3,471**	**£12,772**		

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-15 Staff Survey Action Plan **Director of Workforce**

Summary / Key points

Three key Trust priority areas have been identified as a result of the findings from the 2015 Staff Survey:

1) Improving employee health and well-being
2) Meaningful staff engagement
3) Addressing shortfalls in equality and diversity

These three key themes form part of the Trust Workforce Strategy for the next five years.

Which Committees have reviewed the information prior to Board submission?
▪

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

1.0 INTRODUCTION

1.1 The purpose of the paper is:

- To outline the Trust 2015 staff survey outcome priorities and key actions
- To outline the timetable and plan for monitoring performance against the Trust overarching plan and directorate plans.

2.0 BACKGROUND

2.1 The Trust took part in the 13th annual National NHS Staff Survey between September and December 2015.

2.2 The results were previously shared and discussed by the Board. The results are an improved set of results year on year against a national benchmark and an improving position in a challenged local market.

2.3 The results have been shared Trust-wide and directorate management teams are in the process of developing plans to address any local issues.

2.4 The delivery of local priorities is important because it ensures ownership and a more localised and bespoke approach to issues raised.

3.0 TRUST PRIORITIES

3.1 Three key Trust priority areas have been identified as a result of the findings from the 2015 Staff Survey. Importantly these are the same three priority areas as last year.

1) Improving employee health and well-being

Nationally employee wellbeing has been identified as priority. NHS England published a new CQUIN for 2016/17 on NHS Staff health and wellbeing covering 3 indicators:

- Health and Wellbeing; physical activities, fast track access to physiotherapy, mental health support initiatives
- Healthy food for staff
- Improving the uptake of the flu vaccination for frontline clinical staff

Locally 1/3 of our staff report suffering work related stress in the last 12 months. A new key finding (KF19) was introduced in 2015 to measure 'organisation and management interest in and action on health and wellbeing'. We scored below the national average for acute Trusts for this new key finding in 2015.

Therefore to address this shortfall and the CQUIN we will:

a) Increase Occupational Health provision with recruitment of Trust employed Consultant Occupational Health Physician and an additional part time nurse specialist
b) Deliver an Employee Assistance Programme for all staff from existing resources
c) Promote employee fitness, Fast Track Access Policy and healthier lifestyle choices
d) Improved education and training for managers
e) Deliver the effective implementation of "The Workplace Wellbeing Charter" devised by Public Health England
f) Review catering options including the promotion and placement of food and drinks high in sugar, fat and salt in our restaurants.
g) Deploy more creative strategies to encourage staff to have their annual flu vaccination

2) Meaningful staff engagement

Although results from the National Staff Survey have shown an improving picture with relation to overall staff engagement, the Trust has not witnessed a significant step change in engagement. Successive staff survey action plans, both trust wide and within directorates, have assisted in improving the overall position but have been unsuccessful in making a significant step change in relation to staff engagement and satisfaction. It is clear that to move from average to good we need a vehicle to make this transition.

Therefore we will:

a) Identify a staff engagement approach/vehicle (e.g. Listening into Action)
b) Dedicate specific HR resource
c) Deploy employee champions throughout organisation
d) Work with staff side to improve engagement
e) Increase use of social media and other tools

3) Addressing shortfalls in equality and diversity

MTW is committed to creating a culture that promotes equality and embraces diversity in all its functions as both an employer and a service provider. The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued and are treated fairly. Despite the above commitment and progress to date, the staff survey findings and in particular Workforce Race Equality Standard (WRES) highlights that the Trust has a lot more that it needs to do in relation to achieving the above aim.

To ensure the equality and diversity agenda is moved forward, the Trust will:

a) Develop a new equality and diversity awareness programme for all staff
b) Identify an existing NHS centre of excellence and partner with them to ensure best practice and learning implemented in a timely fashion.
c) Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch.
d) Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities.
e) Work closely with Stonewall using the Workplace Equality Index to help us improve the experience of our LGBT community
f) Recognise discriminatory behaviour when it happens and empower all staff to challenge and act to eliminate it.
g) Implement the refreshed Equality Delivery System for the NHS (EDS2).
h) Work with key staff groups, patients, communities and forums to improve equality and diversity practice for both patients and service users.

3.2 These three key themes form part of the Trust Workforce Strategy for the next five years.

4.0 MONITORING PROGRESS

4.1 Progress against directorate action plans will be addressed during the quarterly performance meetings, held with each directorate. Directorate management teams will be expected to bring an updated action plan to the performance meeting, identify success and where it exists any shortcomings.

4.2 Progress against the overarching Trust Action Plan will be monitored through the Trust Management Executive and assurance provided to the Workforce Committee (June 2016 onwards) for onward transmission to the Board.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - April 2016

4-16	**Summary report from Quality Committee, 13/04/16**	**Committee Chair (Non-Executive Director)**

A Quality Committee 'deep dive' meeting was held on 13th April 2016.

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

- The actions agreed from previous meetings
- Review of Critical Care (for which several members of the Critical Care team attended). The Committee received a detailed presentation, focusing on the Team's response to the issues raised by the Care Quality Commission (CQC) during their inspection in Oct. 2014
- Potential issues for review at future 'deep dive' meetings

2. The Committee agreed that:

- The Trust Secretary should arrange for the Trust Board to receive a report on the conclusions and outcome of the recent external reviews that had been undertaken within Women's services
- The Deputy Chief Executive should be requested to incorporate the latest position on NHS England's review of Urological Cancer services in West Kent within the "To approve the Trust's Strategy" item scheduled for the Trust Board in May 2016
- The Medical Director, Chief Nurse, and Clinical Director for Critical Care should review the parameters used to 'RAG' rate the number of overnight discharges taking place from ICU (for Compliance Action 6 of the Quality Improvement Plan), and revise the parameters to reflect comparison with national average performance
- The Matron for Critical Care at Maidstone Hospital should arrange for the 2015/16 Annual Report of the Critical Care Outreach Team to include some objective measures of performance regarding the Team's effectiveness
- The 2015/16 Annual Report of the Critical Care Outreach Team should be submitted to the 'main' Quality Committee, for review
- The latest monthly South East Coast Critical Care Network (SECCCN) performance report should be circulated to members of Quality Committee 'deep dive' meeting
- The Trust Secretary should arrange for members of the Quality Committee 'deep dive' meeting to visit the new Paediatric A&E at Tunbridge Wells Hospital, when the area was fully functional
- "Review of End of Life Care" should be provisionally scheduled for the Quality Committee 'deep dive' meeting in August 2016
- "Review of Women's services" should be provisionally scheduled for the Quality Committee 'deep dive' meeting in October 2016

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

- The Committee received assurance that significant progress had been made since the inspection, but a number of challenges remained, particularly in relation to the recruitment of Consultant Intensivists.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2016

4-17 Summary of the Trust Management Executive (TME) meeting, 20/04	**Deputy Chief Executive**

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

- In the **safety moment**, the Chief Operating Officer highlighted the need for staff to be aware of, and comply with, the Trust's mortuary Policy, following a Serious Incident (SI) that occurred in January 2016
- The key issues highlighted via the **reports from the Clinical Directors (CD)** were as follows:
  - Two new CDs were welcomed to the meeting (Rowan Connell, Women's and Sexual Health Services; and Danny Lawes, Surgery)
  - Staffing issues were again were a theme for several Directorates, in relation to recruitment to specific posts and/or the continued usage of temporary staff. The importance of recruiting substantive staff was emphasised, particularly in light of the Trust's financial position, but it was agreed that the standard of the quality of staff appointed should not be lowered
  - The Histopathology contract for Medway had been awarded to the Trust
  - The report of the Breast Quality Assurance visit was awaited, but the key issues were related to staffing for the Breast Unit (which had been included in the Directorate's business plan)
  - An increase in Emergency Department attendances of 10% above plan in Quarter 4 had resulted in a sustained period of escalation, which impacted on quality and finances, particularly loss of elective income
  - A new Cancer Summit meeting was being scheduled, in response to the continuing non-compliance with the key Cancer-related access targets. It was noted that a 'tracker' of Cancer performance would be submitted to the TME each month from now onwards
  - Access to inpatient elective Orthopaedics beds remained a problem, although there were some small signs of a recent recovery in the position
  - The increasing number of deliveries meant that additional Obstretric lists were likely to be required, which would affect the Anaesthetic cover required
  - Problems were still occurring with the Cancer activity Service Level Agreements (SLAs), but it was noted that the level of debt from other local NHS providers had reduced recently
  - Delayed discharges from ICU could be the subject of a CQUIN target for 2016/17, although further discussions were required with Specialist Commissioning
  - The CD for Critical Care requested approval to appoint an additional Pain Consultant, given the regular turnover of such Consultants (there are currently 4 Consultant posts but turnover meant only 3 were in post for significant periods in recent years). The requested approval was given, subject to the data supporting the rationale purported by the CD at the meeting.
- The **performance for month 12**, 2015/16 was reported, which included the positive initial impact of the **new AMU at Tunbridge Wells Hospital** (TWH). It was noted that 5 weeks on, 20 escalation beds had been closed and elective activity had increased by $^{2}/_{3}$ of the level before the Unit opened
- The latest position regarding **infection prevention and control** was reported, which included notification that the Trust's rate of hospital-attributable Clostridium difficile (7.4 per 100,000 bed days) was lowest in the South of England, and was circa half of the rate for the whole of England
- The latest progress in implementing **the Quality Improvement Plan** developed in response to the findings from the Care Quality Commission's (CQC) inspection was reported
- The report of the recent meetings of the **Trust Clinical Governance Committee** (which is now a formal sub-committee of TME) was reported, which noted that the Trust was non-compliant with the recommendations in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report "Gastrointestinal Haemorrhage: Time to Get Control?". The Medical Director noted that there non-compliant status was unlikely to change.

- The Medical Director also submitted an explanation for, and response to, the **inability to obtain the clinical details of patients subject to alerts within the 'Dr Foster' IT system.** It was reported that the issue would now only be completely resolved if the Health and Social Care Information Centre (HSCIC) provided Dr Foster with 2014/15 final data of good quality (to enable Dr Foster to fill the gaps in the data for 2014/15)
- The Director of Finance gave an update on **the Trust's planning submissions for 2016/17**, which had been made in April, and also reported on the **key changes to the NHS standard contract, 2016/17**
- The Deputy Chief Executive gave an update on the **development of the Trust's strategy**, ahead of the intention to submit a Strategy to the Trust Board in May 2016, for approval
- An update on the **implementation of the SAcP (replacement PAS+)** was reported, and the Chief Operating Officer sought approval (which was granted) for a circa 3-month delay from the intended implementation date (which had been set for 10th and 11th June). The issues leading to the delay were related to the new PAS not currently demonstrating the required functionality in relation to the ordering of investigations. The TME heard that liaison was however continuing with the supplier to resolve the issue
- An update on **Chemotherapy e-prescribing** implementation was reported, and a **Project 'closure' report on the new ward at TWH** was received, for information
- The **Business Cases** that had been recently-approved by the Investment Appraisal Group and/or Executive Team were noted. The Director of Finance also noted that the Business Cases that had been submitted as part of the planning process would soon be subject to prioritisation as there were insufficient funds to support all of the Cases
- Five **replacement Consultant** posts were approved (a Consultant in Acute Medicine with Diabetes & Endocrinology (Maidstone Hospital); a Consultant in Cardiology with an interest in Electrophysiology (Maidstone Hospital); and 3 Consultant Histopathologists)
- The year-end **Board Assurance Framework** was reviewed, and the draft **Annual Governance Statement, 2015/16** was reviewed and endorsed. An update on **the Internal Audit reviews** within the 2015/16 plan was also received.
- Proposals regarding the **method and frequency of the reporting from the TME's 14 sub-committees** were approved; and updates were received on the work of those **sub-committees** (Capital meetings; Clinical Operations and Delivery Committee; Information Governance Committee; Informatics Steering Group; Clinical Directors Committee; Policy Ratification Committee; Procurement Strategy Committee; Patient Environment Committee; MTW Programme Committee; Health & Safety Committee; and Nursing, Midwifery & AHP Committee).
- The sub-committee reports included notification that the Trust's **Information Governance (IG) Toolkit** return for 2015/16 had been submitted, but this had needed to be accompanied by an action plan as the Trust did not achieve the required levels of IG training. It was also noted that **Nurse revalidation** came into force in April 2016, and although there were no risks at present, September would see the largest number of the Trust's Nurses due for revalidation
- The Committee discussed the **Safeguarding Adults Annual Report, 2015/16**, and received positive assurance regarding the state of the Trust's systems and processes
- Finally, the **preparations for the industrial action by Junior Doctors** on 26th and 27th April were discussed, and assurance was given that robust plans were in place in all areas

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2016

4-18	**Summary report from Finance Committee, 25/04/16**	**Committee Chairman (Non-Executive Director)**

The Finance Committee met on 25th April 2016.

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

- The "Safety Moment" commended the Trust's Infection Prevention and Control performance, and it was agreed to recommend that the Trust Board formally congratulate the Chief Executive and colleagues on that performance
- The latest position regarding the Trust's contracts for 2016/17 were discussed
- Month 12 financial performance was examined. As usual, the written reports were supplemented by a presentation, which included income & expenditure; income variances; details of outsourced activity; pay variances; workforce trends; Agency expenditure (which included a focus on Administrative & Clerical and Nursing staff); non-elective activity & A&E conversion; Delayed Transfers of Care, Length of Stay & Medical outliers; and non-elective occupied bed days. Cost Improvement Plan (CIP) performance was also noted
- An update on the Trust's 2016/17 planning submissions was given, which included the proposed deficit of £22.9m. It was agreed that details of progress against the opportunities in the Plan should be incorporated within the monthly information submitted to the Committee, from month 2 onwards
- A report describing the key changes to the NHS standard contract, 2016/17 was received
- To financial aspects of the Memorandum of Understanding for Kent Transforming Pathology Service (KTPS) were reviewed. Concerns were expressed, and it was noted that these would be discussed further at the Trust Board (Part 2) on 27/04/16
- A "Procurement transformation programme update" report was noted, along with an update on service tender submissions. It was agreed to continue to schedule the latter reports every 3 months.
- A report of the year-end position of the financial aspects of the Board Assurance Framework (BAF) was noted; along with reports on the Outstanding Oncology activity-related debt from local NHS providers; and the quarterly analysis of consultancy use
- The output from the work being undertaken by Meridian Productivity Ltd was reported, and it was agreed to ensure that the opportunities arising from that work were incorporated into the Trust's CIP for 2016/17
- The format and content of a proposed new "Finance Committee Pack" was reviewed, and comments made by Committee members.

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

- The Kent and Medway Sustainability and Transformation Plan should be discussed at the Trust Board 'Away Day' on 20/06/16
- The Director of Finance should arrange for the Trust's Solicitors to review the Memorandum of Understanding for the KTPS, and advise on the implications for the Trust; and also liaise with the Chairman of the Audit and Governance Committee to discuss their concerns regarding the Memorandum of Understanding
- All future "Procurement transformation programme update" items should be removed from the Committee forward programme, but a "Lord Carter efficiency review update and next steps" report should be submitted in May 2016, and every 3 months thereafter

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

- It was agreed to recommend that the Trust Board formally congratulate the Chief Executive and colleagues on the Trust's Infection Prevention and Control performance

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance