TRUST BOARD MEETING

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

NHS Maidstone and Tunbridge Wells NHS Trust

10.30am – c.1pm WEDNESDAY 19TH JULY 2017

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
7-1	To receive apologies for absence	Chair of the Trust Board	Verbal
7-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
7-3	Minutes of the Part 1 meeting of 28th June 2017	Chair of the Trust Board	1
7-4	To note progress with previous actions	Chair of the Trust Board	2
7-5	Safety moment	Chief Nurse	Verbal
7-6	Chairman's report	Chair of the Trust Board	Verbal
7-7	Chief Executive's report	Chief Executive	3
7-8	A patient's experiences of the Trust's services	Chief Nurse[1]	Verbal
7-9	Review of the Board Assurance Framework 2017/18	Trust Secretary	4
7-10	Integrated Performance Report for June 2017 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) ▪ Safe / Effectiveness (incl. mortality)	Chief Executive Chief Operating Officer Chief Nurse Chief Nurse Director of Finance Deputy Chief Executive Medical Director	5
	Quality items		
7-11	Staffing: 6-monthly review of Ward and non-Ward areas	Chief Nurse	6
7-12	Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)	Chief Nurse / Matron, Safeguarding Children	7
7-13	Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)	Chief Nurse / Matron, Safeguarding Adults	8
	Assurance and policy		
7-14	Estates and Facilities Annual Report 2016/17	Chief Operating Officer	9
7-15	Responsible Officer's Annual Report 2016/17	Medical Director	10
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
7-16	The Charitable Funds Committee, 26/06/17 (including approval of Annual Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund, 2016/17)	Committee Chair	11
7-17	The Quality Committee, 05/07/17	Committee Chair	12
7-18	The Trust Management Executive (TME), 12/07/17	Committee Chair	13
7-19	The Finance and Performance Committee, 17/07/17	Committee Chair	14 (to follow)
	Other matters		
7-20	Board members' hospital visits	Trust Secretary	15
7-21	**To consider any other business**		
7-22	**To receive any questions from members of the public**		
7-23	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chair of the Trust Board	Verbal
	Date of next meetings: ▪ 7th September 2017, 10am, Academic Centre, Maidstone Hospital ▪ 18th October 2017, 10am, Venue TBC ▪ 29th November 2017, 10am, Education Centre, Tunbridge Wells Hospital ▪ 20th December 2017, 10am, Education Centre, Tunbridge Wells Hospital		

David Highton,
Chair of the Trust Board

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

MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 28TH JUNE 2017, 10.30A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Hamudi Kisat	Clinical Director, Children's Services (for item 6-8)	(HK)
	Jim Lusby	Deputy Chief Executive	(JL)
	Fiona Martin	General Manager, Women's and Children's Services (for item 6-8)	(FM)
	Sara Mumford	Director of Infection Prevention & Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Paul Sigston	Deputy Medical Director (representing the Medical Director)	(PS)
	Jackie Tyler	Lead Matron, Children's Services (for item 6-8)	(JT)
Observing:	Claire Baigent	Communications Manager	(CB)
	Annemieke Koper	Staff Side representative	(AKo)
	Priscilla Kankam	Lead Pharmacist, West Kent Clinical Commissioning Group (CCG)	(PK)

6-1 To receive apologies for absence

Apologies were received from Tim Livett (TL), Non-Executive Director; Peter Maskell (PM), Medical Director; and Kevin Tallett (KT), Non-Executive Director. It was however noted that PS was attending in PM's place.

6-2 To declare interests relevant to agenda items

No interests were declared.

6-3 Minutes of the Part 1 meeting of 24th May 2017

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

6-4 To note progress with previous actions

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

- **4-8 ("Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval")**. KR reported the intention to submit a proposal to the July 2017 Trust Board meeting.
- **5-10 ("Ensure the Chair of the Trust Board received a detailed briefing on the implementation of the PAS+")**. JL agreed to purse the scheduling of a meeting with DH.

6-5 Safety moment

COB reported that the focus for the month was Safeguarding Adults, and conveyed the following points:

- The opportunity had been taken that week to focus on the 'Prevent' initiative, to ensure that staff were equipped with the knowledge and skills to support those who may be at risk of radicalisation. The Trust's Prevent lead was the Matron for Safeguarding Adults, but any child-related issues would be addressed via the Matron for Safeguarding Children

- There was generally good compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), but there were occasional lapses in such compliance. Staff needed to be reminded of the need to take best interest decisions seriously when liaising with the families of patients who lacked capacity. Lacking of capacity was also noted to be a feature in some patient falls. The Mental Capacity Act would be subject of a Quality Committee 'deep dive' meeting in August 2017
- Staff had also been reminded about the appropriate terminology, and on how to respond to, and report, any concerns they had

6-6 Chairman's report

DH reported the following points:

- DH had recently attended a number of events organised by NHS Improvement (NHSI) and NHS Providers, including a regional Chairs meeting, a Chairs' and Chief Executives' meeting, and a dinner (along with circa 16 others) with the Chief Executive of NHSI
- The events had been used to remind those attending of the importance of meeting the A&E 4-hour waiting time target, but DH had also heard some good practice from another NHS provider in relation to their liaison with Junior Doctors
- The events demonstrated that there was not yet a clear understanding between NHSI and NHS Providers about future role of Sustainability and Transformation Plans (STPs) i.e. whether STPs would form an intermediate tier of NHS structure, or be a collaborative of like-minded organisations. There also did not seem to be a clear post-election strategy for the NHS, so the situation needed to be closely monitored
- There would be leadership changes in NHSI, with the Chairman leaving soon, and the Chief Executive leaving in October 2017
- The Trust had appointed a new Non-Executive Director, TL. TL's term of office began on 26/06/17, but he was unable to attend the meetings taking place that week. TL was currently the Chief Financial Officer of the Wellcome Trust, and had previously been the Director of Finance at Virgin Atlantic. DH hoped to welcome TL properly at the July 2017 Board meeting

6-7 Chief Executive's report

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

- The Trust had been awarded funding to support its efforts in improving patient flow and streaming from the Emergency Department (ED). The imperative was to create more space, to give greater flexibility, and the key to success was making the required changes before winter
- The Chaucer Frailty Unit at Maidstone Hospital (MH) was now operational. Significant effort was required to achieve this, and GD was confident this would prove to be one of the best things the Trust had done in the recent past
- Recent staff meetings had been held, which reinforced the fact that Trust Board Members needed to increase their visibility among departments. It was also clear that staff wanted a structure to provide feedback, and the 'Listening into Action' (LiA) programme would be the vehicle for this. JL was the lead for LiA, and the Trust needed to fully commit and believe in the programme's merits
- The findings of national inpatient survey 2016 would be considered under item 6-14, but GD believed that most Trust Board Members would recognise the Trust from the findings
- International volunteers' week had been celebrated. GD had mixed feelings about such volunteers, as he recognised the fantastic role they played, but also appreciated that many of the duties carried out by volunteers should be undertaken by the Trust. GD was however eternally grateful for the volunteers' support
- One of the Trust's midwives, Áine Alam, had received a prestigious Fellowship from the Royal College of Midwives (RCM) for her contribution to midwifery

GD also noted that this was RH's last Board meeting, and on behalf of the Board, wished RH all the best for the future.

Presentation from a Clinical Directorate

6-8 Children's Services

DH welcomed HK, FM and JT to the meeting. HK then gave a presentation which included the following points:

- The Directorate had 15 Paediatric Consultants, a Paediatric ED Consultant presence (between 14:00 and 22:00); a Level 2 Neonatal Unit (NNU); 23 Paediatric inpatient beds; 4 escalation beds (including 2 un-funded High Dependency Unit (HDU) beds); and the Woodlands Unit (which was a 15 bedded Paediatric ambulatory unit and Day Case surgical beds, operating between 07:00 and 00:00 7 days a week)
- The Directorate also had the Riverbank Unit (which was a 13-bedded ambulatory and Day Case Unit at MH, operating between 07:00 and 19:30, Monday to Friday); Outpatient services (at Tunbridge Wells Hospital (TWH), MH, Sevenoaks Hospital, Edenbridge Medical Practice and Crowborough War Memorial Hospital); and Specialist services provided for Gastroenterology, Diabetes, Epilepsy, Allergy services and Cystic fibrosis
- Tertiary outreach clinics were also offered at TWH and MH for Cardiology, Surgery, Endocrinology, Neurology, Genetics; and Paediatrics offered a 7-day Consultant-led service

The Directorate's position statement on the required standards in relation to the provision of 7-day services was then outlined, and an explanation of the compliance with each of the relevant standards was given.

DH then asked how often children were required to be transferred from the ambulatory unit at MH to TWH. HK replied that there were 2 to 3 such transfers per day, whilst this was only likely to occur once per week at night. HK then continued, and highlighted the following points:

- At the end of May, the Directorate had an underspend of £30k (excluding SLA figures). Pay costs were underspent by £94k (£11k for Medical, £76k for Nursing), whilst non-pay costs were overspent by £58k (which primarily related to clinical supplies for Paediatric Diabetes)
- The Directorate's Cost Improvement Programme (CIP) target was £1.076 million, of which £187k had been allocated, with £890k unallocated
- Occupancy in the NNU had been 85% for the last few months

SO asked about the recent increase in follow-up Outpatient clinics for May. FM explained that there had been a backlog of follow-up patients and therefore additional clinics had been established, but in the light of the new Aligned Incentives Contract (AIC), the need for follow-up appointments was being challenged, and this was expected to improve. HK added that the mind-set regarding follow-up appointments was changing as a result of the AIC.

DH asked whether a change in Neonatal pricing was expected. SO confirmed that this was being investigated with Specialist Commissioning, and the Trust was aiming to achieve a more favourable price, which would improve the Directorate's income.

HK then continued, and highlighted the following points:

- A financial 'deep dive' review would be held soon
- The Directorate's risks and challenges included the Junior Doctors' rota, and the availability of Doctors allocated by the Deanery (i.e. Health Education Kent, Surrey and Sussex). Many of the Doctors allocated to the Trust were part-time or unable to work all the shifts required by the Trust due to medical reasons. There was therefore pressure to cover shifts, to safely manage the department. Only 1 Registrar was currently available at night, to cover the Ward and ED. This was not compliant with new Junior Doctors' contract, as 30 minutes rest was required after 5 hours of work, and this rest period could not be currently guaranteed, as no one else was available to hold the 'bleep' during that time. A Business Case was therefore being developed to mitigate this, and ensure that there were 2 Registrar-level Doctors/Advanced Nurse Practitioners (ANP) on site at night
- Medication pumps were another risk/challenge, in that the pumps used for Paediatric medication were adult pumps. However, the company providing the pumps had now provided competencies for training, to enable Paediatric pumps to be introduced into Paediatric areas

- A further challenge/risk involved mental health patients being located on the Ward. Some Serious Incidents (SIs) had been declared, and patient and staff safety had been at risk on occasion. The issue had been added to the Risk Register

GD referred to the latter point, noted that the contract for Child and Adolescent Mental Health services (CAMHS) had just been awarded to East London NHS Foundation Trust, and wondered whether this provided an opportunity to improve the situation. AG stated that she was due to meet with the new service provider, and acknowledged that a strategy was needed to manage the relevant patients.

JT then continued, and highlighted the following points:

- The Community Paediatrics service, which had been set up as one of the Princess Diana Children's Community Nursing Teams, had high costs. Therefore FM and JT met monthly with West Kent CCG, to review community pathways & the responsibilities of acute Paediatric staff
- Future improvements and opportunities included the aforementioned proposal to increase Medical Registrar numbers by the use of ANPs. There was also potential to expand the Paediatric allergy service, and be recognised as the only Paediatric allergy centre for excellence in Kent. A further increase in Paediatric Gastroenterology was also planned, to allow referrals from further afield in the South East of England, and the number of referrals was already increasing

SDu commended the presentation, and noted that she was aware, anecdotally, that the Paediatric service was well-received by patients. SDu also noted the challenge in addressing the level of unidentified CIP whilst trying to meet the service's staffing needs, and asked for a comment on the overriding requirement to maintain a quality service whilst simultaneously finding savings. HK replied that the Paediatrics service was facing similar issues to services elsewhere in Kent, and elaborated that the 8 Middle Grade Doctor posts had never been problematic, in that it had previously always been possible to recruit to the specialist posts, even if the Deanery-allocated posts were vacant. HK continued that the situation had however now changed, and it was no longer possible to recruit to the specialist posts. HK added that he was aware that many people wanted to enter the Deanery programme, but they could not do so because of the number of available places. HK stated that he therefore believed the number of Deanery-allocated posts should increase in the South of England, as the majority of vacancies for such posts were in the North. HK did however acknowledge that the introduction of ANPs was expected to be beneficial.

DH asked whether the shortage of Deanery-allocated posts was a budgetary issue, or an accreditation issue. HK replied that he believed it was the latter, but the Royal College of Paediatrics and Child Health would not accredit any more posts. FM added that the Deanery often allocated part-time Doctors to the Trust, without having a job-share arrangement for the proportion of the post not undertaken by the allocated individual. RH pointed out that similar issues were being faced across the country, and referenced a discussion he had on 27/06/17 with colleagues from Alder Hey Children's NHS Foundation Trust.

SO then referred to the Directorate's CIP, noted that there were only a small number of red-rated schemes, and emphasised that it would be beneficial for additional, new, ideas to be generated soon, in light of the Trust's forthcoming Financial Special Measures (FSM) meeting with NHSI. SO clarified the importance of generating ideas that were still embryonic, to demonstrate that progress was being made, even if these were not fully developed. The point was acknowledged.

PS then noted that one of the current 2 very busy Paediatric Gastroenterologists may retire in the near future, and asked whether plans were being developed for this eventuality. HK gave assurance that he was aware of the situation, and that plans were being considered.

RH and GD then echoed SDu's earlier comment, and noted their own awareness of the positive feedback provided by parents about the Paediatrics service. COB also commended the immense professionalism and courage that the team had demonstrated during recent challenges.

DH thanked HK, FM and JT team for their presentation.

6-9 Integrated Performance Report for May 2017

GD referred to the circulated report and noted there were 2 main issues: the continued challenge of meeting the A&E 4-hour waiting time target and 62-day Cancer waiting time target; and the continued increase in clinical activity, which GD now acknowledged represented a new level of demand. GD then invited colleagues to highlight key issues.

Effectiveness / Responsiveness (incl. DTOCs)

AG highlighted the following points:

- The A&E 4-hour waiting time target performance was still below the agreed trajectory, but the Trust was performing in the top 15 to 30 of the circa 140 Trusts
- The Trust was in week 6 of its 6-week intensive programme (to improve patient flow), and many of the long-list of suggested improvements had been implemented, including those made by Junior Doctors
- Ambulatory Care was working better than in the previous year
- Escalation at TWH had been reduced over the past few weeks. There was much more to be done, but there was a belief that the right actions were being taken
- The Trust was working with Western Sussex Hospitals NHS Foundation Trust, who had transformed their performance. Three levels of visits were planned, including staff from that Foundation Trust 'walking through' the Trust's pathway
- For the 62-day Cancer waiting time target, only 85 treatments were carried out in April, and a crisis/escalation meeting had been held in response. A daily huddle for patients with waits between day 40 and day 61 had therefore now been introduced
- Delayed Transfers of Care (DTOCs) were still an issue, and there had been increased escalation with East Sussex Social Services following issues with patients from that area
- The numbers of 'Medically Fit For Discharge' (MFFD) patients had been included in the report, as requested

DH noted the helpful inclusion of the MFFD patients, in terms of assessing the scale of the issue.

GD asked about the average non-elective Length of Stay (LOS), noting that as the numbers of patients with a LOS of 0 to 2 days had increased, he would have expected to the overall LOS to decrease, but this was not the case. GD suggested that it may be helpful to therefore consider reviewing other measures of the LOS, such as the median. The suggestion was acknowledged.

DH asked what happened after the 6-week intensive improvement programme had ended. AG clarified that the programme was actually being extended up to, and including, the winter period.

DH asked whether there was likely to be pressure on the availability of senior staff during the summer school holidays. AG gave assurance that this had been foreseen and planned for, and therefore no particular problems were anticipated.

JL noted that he had met with some of the Trust's Junior Doctors, who confirmed they had been satisfied with changes made during the 6-week intensive improvement programme, and that they did not want these removed after the 6-week period had ended.

Safe / Effectiveness / Caring

COB then reported the following points:

- The Trust remained 'green'-rated for hospital acquired pressure ulcers and falls
- There had been 5 falls-related SIs in the month, which was a slight rise from the previous month. So far, 3 falls-related SIs had been reported in June
- May saw a total of 17 SIs (including the aforementioned 5 falls-related), which was an increase on the same period in 2016/17. The SIs included a number of alleged assaults. The investigations into these allegations were being collated, to understand any key themes. An increase in challenging behaviour had been seen, but there were no major concerns at present in relation to how the relevant patients were being managed. The SIs also included unusual circumstances, such as missing prescription pads and a miscarriage in the ED

- The Complaints response rate had reduced, but the Central Complaints Team was awaiting a new team member from another Trust
- The Friends and Family Test (FFT) maternity response rate continued to struggle to achieve the 95% rate which was known to be achieved elsewhere
- The Trust's Hospital Standardised Mortality Ratio (HSMR) was reported in Attachment 4 as 108.7, but this was now 106.8

DH referred to the alleged assaults, and stated that the Trust Board would be interested in receiving the outcome of the investigations at the next Board meeting. This was agreed.

Action: Submit a report to the Trust Board, in July 2017, providing the outcome of the investigations into the recent alleged assaults at the Trust (Chief Nurse, July 2017)

Safe (infection control)

SM then highlighted the following points:

- Month 2 had seen 5 cases of Clostridium difficile, against a trajectory of 3. However, the cases seen in June had reduced, so the Trust was likely to return to its trajectory at the end of June
- Lord North Ward had seen 2 recent Clostridium difficile cases. The cases had not occurred closely enough, in terms of time, to be regarded as an outbreak, but the Infection Prevention and Control Team were concerned. There had been some issues identified with the use of fans in hot weather, and the situation was being monitored
- The level of MRSA screening continued to be very good. It was hoped that the MH Acute Medical Unit would achieve 100% compliance in June, and the Unit had only missed this by 2 patients in May
- The Trust had seen its first case of Carbapenemase-producing Enterobacteriaceae (CPE), at TWH. This was a significant event, but the Trust's screening had worked, which demonstrated that the Trust's processes were operating properly

SO referred to the CPE case, and asked whether the occurrence meant that things needed to be done differently. SM described the actions that had been taken in response, including the isolation of the patient, and confirmed that she did not intend to change the Trust's response to such cases.

Well-Led (finance)

SO then highlighted the following points:

- The finance narrative had been moved to be adjacent to the narratives for other aspects of performance, and thereby make the 'story of the month' easier to follow
- The Trust had seen a £1.6m deficit in month, and had a year-to-date deficit of £2.8m. A pessimistic view of the Sustainability and Transformation Fund (STF) monies had been taken, but guidance had now been issued regarding this, and the criteria for payment included an element on streaming, as well as a focus on performance in Quarter 4, for which the Trust was expected to improve. Therefore the impact of the STF may have been overly pessimistic
- The Trust was overspent on pay, but had performed well on Nurse Agency expenditure, continuing the trend seen over the last 8 months. Medical and Locum Agency expenditure had also reduced from that seen the previous year. The Trust's efforts therefore appeared to be reaping benefit, but further work was needed, as the issue was a priority for NHSI
- The Trust was slightly behind on its CIP plan, despite the overall financial plan being achieved, which was therefore suggestive of non-recurrent benefit not being fully recognised
- One singular non-recurrent item was planned for later in the year but it was intended to bring this forward

Well-led (workforce)

RH then reported the following points:

- There had been a marked improvement in sickness absence, as a result of hard work over the last 6 months, to review each case diligently and manage these effectively
- The next area of focus would be staff turnover. The LiA programme would help this this, but the leaver questionnaire had also been simplified, to enable a better understanding of the reasons staff left

SDu referred to the staff who were not employed substantively, but who worked via the Bank or as a Locum, noted they worked under challenging conditions, and asked whether appropriate support was provided to such staff. RH replied that such staff were managed by the area in which they were engaged, but noted that they had access to the Trust's employee support processes. AG added that many Bank staff operated within the Trust's terms and conditions, and local managers undertook local induction for such staff. AG also noted that areas with lots of vacancies tended to be covered by the same staff, and such staff therefore became immersed in those teams. PS added that Locum Medical staff needed to connect to a Responsible Officer, as part of their Medical Revalidation, and this took place either via the Trust or the staff member's Agency.

GD asked whether there was any evidence of higher turnover as a consequence of the current pay restraint. RH replied that this was a feature of the national situation, as currently, moving to another job was the only way of achieving a pay increase. RH added that the impact of European Union (EU) staff leaving because of 'Brexit' had also been an issue. GD pointed out that recent media coverage had reported that Nursing staff joining from the EU had reduced to almost zero. DH also suggested that the concurrent raising of the threshold for overseas staff language skills, to a score of 7.0 on the International English Language Testing System (IELTS), had also been a factor. COB agreed, and noted that there was pressure to reduce the threshold, as some overseas Nurses had struggled with the new requirement. AK opined that such issues were likely to lead to an early budget, to relax the current pay restraint. JL reported that there had been an offer from one of the Trust's local MPs to clarify the Government's position on 'Brexit', and stated that the offer was likely to be considered.

Safe / Effectiveness (incl. Mortality)

PS then noted the HSMR data reported earlier by COB and the mortality report to be considered under item 6-13, and invited questions. None were received.

6-10 Update on the Workforce Transformation Programme

In PM's absence, JL referred to the circulated report and highlighted the following points:

- The latest update report had been received at the Finance Committee on 26/07/17
- The momentum continued, and the second meeting of the Steering Group was scheduled for 29/06/17. There was evidence of progress from, for example, the Trauma & Orthopaedics work, and SDu had been involved in some of the detailed work
- Further updates would be provided to the next Finance Committee and Trust Board meetings

KR referred to the latter point, and asked for clarification as to whether the Trust Board wished to receive a report at its next meeting, given the monthly report that was already submitted to the Finance Committee. DH asked SDu for her opinion. SDu proposed that a less frequent report be submitted to the Board i.e. every 6 months. JL agreed, as did SM. This was therefore agreed

Action: Schedule an update on the Workforce Transformation Programme at the Trust Board every 6 months (Trust Secretary, June 2017 onwards)

Quality Items

6-11 Planned and actual Ward staffing for May 2017

COB referred to the circulated report and drew attention to the following points:

- The Care Hours Per Patient Day (CHPPD) position remained stable
- 4 Wards had requested enhanced staffing
- 2 Wards (2 and 22 at TWH) were rated as 'amber', which reflected vacancies in workforce and quality indicators. The 'amber' rating had not arisen from the application of a scientific process, but was just an indicator that these areas would be subject to increased monitoring

SO noted the financial information and triangulation with escalation areas, but asked why there had been increased expenditure within the Maternity services at TWH. AG confirmed that the Maternity department had been asked to provide more detail regarding this, as it had been noted that more staff had been used. DH asked whether the Trust adopted a specific ratio of births to

Midwives. COB confirmed this was the case, and gave assurance that the Trust's ratio was acceptable, despite not being at the full recommended level.

KR asked whether the Trust Board wanted any specific action to be agreed in relation to SO's query regarding the Maternity areas. AG proposed that the issue be addressed via the Executive Performance Review meeting with the Division. SO instead proposed that an explanation be provided to the Finance Committee. This was agreed.

Action: Arrange for an explanation to be provided, to the July 2017 Finance Committee meeting, of the adverse variance between "Budget" and "Actual" for the Ante-Natal, Delivery Suite and Post-Natal areas at Tunbridge Wells Hospital (as reported in the "Planned and actual Ward staffing for May 2017" report to the Trust Board on 28/06/17) (Chief Operating Officer, July 2017)

6-12 Approval of Quality Accounts 2016/17

COB referred to the circulated report and highlighted that the Quality Accounts were required to be published by the end of June 2017. COB also noted that the independent auditors' 'limited assurance' report was included. KR clarified that the 'limited assurance' aspect referred to the fact that the Audit only covers 'limited' aspects of the Quality Accounts, and did not therefore have any negative connotation, which was the case when "limited assurance" was used within the context of Internal Audit reviews. The point was acknowledged.

DH noted that page 1 of the report stated that "it is expected that the External Auditors will sign off their report w/c 26th June", and asked if the External Audit would be finalised before the Quality Accounts were published. KR confirmed this would be the case, and noted that the full report of the External Audit would be received at the July 2017 meeting of the 'main' Quality Committee.

The Trust Board approved the Quality Accounts for 2016/17 as circulated.

6-13 Quarterly mortality data

In PM's absence, COB referred to the circulated report and highlighted the following:

- The report should be treated with caution, particularly Appendix 1
- The Trust's HSMR had now reduced to 106.8
- The patients with no comorbidities being reported was high, which reflected issues relating to Clinical Coding
- Page 13 (Appendix 1) appeared to compare the Trust with external organisations, but these organisations were fictional at present, as the Trust needed to identify the organisations against which it should compare. The Trust's data was however reported correctly on that page
- The Trust's current process for reviewing deaths involved allocation into 4 categories, whilst the new process had 6 categories The Trust's process therefore needed to be refined

PS then reported that although attention to Clinical Coding was important, the most important aspect was the outcome, and this therefore needed to be the focus of efforts. PS also noted that page 8 of 13 showed comparative performance on HSMR.

SDu remarked that it was helpful that one of the new Deputy Medical Directors would lead on mortality-related matters, without releasing PM of his responsibilities. SDu also noted that mortality would be the subject of a further Quality Committee 'deep dive' meeting in October 2017.

SO pointed out that 'Coding' was often used as shorthand for the end product of a long process relating to the recording of clinical information in the healthcare records. PS acknowledged that the issues being considered as part of the work were more likely to reflect the lack of recording of appropriate information in the healthcare records than any reflection on the Clinical Coders' ability to record information correctly.

6-14 Findings of the national inpatient survey 2016

COB referred to the circulated report and drew attention to the following points:

- The Trust's response rate was exceptional when compared to the national rate

- The Trust's results were satisfactory, but there were some particularly positive findings, which were highlighted in the flyer on page 4 of 25
- It was difficult to translate the findings into identifiable areas for improvement ahead of the next survey, which was being undertaken soon. However a number of actions were taken after the 2015 survey
- The performance on 13 questions had reduced from the 2015 survey. These had been examined to assess whether any differences related to the hospital site, and it was noted that MH had adversely affected the performance on "Did you ever use the same bathroom or shower area as patients of the opposite sex?". There was obviously limited opportunity to affect the layout at MH, but signage could be improved
- The performance at TWH was better for "Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?
- The specific actions to be taken in response were yet to be identified, but these would be developed and submitted to the Patient Experience Committee. COB's preference was to focus on a small number of key actions
- The report contained a summary of the comparative performance with other local Trusts, and this showed that the Trust had maintained its position locally
- Therefore although there had not been a significant improvement, there had also not been a major reduction. However, the Trust would aim to take the opportunity to improve

SM opined that more work was required regarding patient expectations, noting that one of the negative comments listed on the flyer on page 4 was that "All tv's [sic] need to be working". GD noted that missing or broken remote controls was a commonly-raised theme.

Planning and strategy

6-15 The 2017/18 Winter and Operational Resilience Plan

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

- The 'new normal' levels of activity had been reflected in the Plan, which was not just focused on numbers of beds, but included managing pathway changes
- The aforementioned streaming in the ED would assist. Workforce changes were also very pertinent, including replacements for Middle Grade Doctors in the ED that were unable to be recruited. The intention was to therefore provide cover via ANPs
- The Trust was also working with Kent Community Health NHS Foundation Trust and others to help move patients from hospital beds into community beds. It was intended to build resilience into the system, and further opportunities to better use bed stock would be taken
- The Rapid Improvement Weeks would continue, every 6 weeks, but the aforementioned 6-week intensive programme would now become 'business as usual'

SO asked whether any additional costs were expected from the Plan. AG confirmed there would be costs, particularly in relation to staffing during winter surges in activity, but added that such costs were being finalised. DH noted that the Trust had an unused contingency, and asked for confirmation that this would be used for that purpose. SO confirmed this would be the case.

DH stated that it would be beneficial to schedule an update on the Plan at the October 2017 Trust Board meeting. This was agreed.

Action: Schedule an update on the 2017/18 Winter and Operational Resilience Plan at the Trust Board in October 2017 (Trust Secretary, June 2017 onwards)

6-16 Kent and Medway Sustainability and Transformation Plan (STP) – Consideration of service models and hurdle criteria

GD referred to the report that had been circulated and drew attention the following points:

- It was considered important for the Board to see the detailed work that had been undertaken, which explained why the very lengthy report had been issued. The most important aspects of the report were however contained on page 15 of 319 i.e. the hurdle criteria
- The importance of the hurdle criteria was related to the 2 areas that would be subject to public consultation: services in East Kent, and Stroke services. Both were important to the Trust

GD emphasised the importance of the hurdle criteria, but gave assurance that he was content with the criteria listed in the report. PS added that he attended the STP Clinical Board each week, and that forum believed the hurdle criteria were important, but it was vital to understand that the application of the criteria may not deliver the outcome that each individual organisation wanted. PS did however note that this was how the STP was intended to function. DH acknowledged the need for Boards of individual organisations to possibly have to agree to issues that were disadvantageous to their own organisation, but beneficial to the wider STP, but also acknowledged the tension that existed as a result of there being no current legal basis for STPs. DH elaborated that there was a current governance issue relating to individual Trusts potentially being unwilling to take this approach. GD agreed, but noted that he believed this would be addressed by the establishment of STP-wide financial control totals, as individual organisations were likely to be influenced by the adverse financial implications of such behaviour.

AK remarked that he had struggled to read Attachment 11, and stated that he believed the report needed a much clearer summary. AK elaborated that Helen Whateley MP had recently raised the issue of Kent and Canterbury hospital at the House of Commons, and had referred to “STP” on more occasions than she had referred to that hospital. AK continued that there was a risk that “STP” became an umbrella term, and therefore this should be borne in mind when the Trust communicated with the Kent MPs in particular. GD acknowledged the point, and noted that he had now scheduled a meeting with the Kent MPs. GD did however clarify that the STP was unconnected with the recent closures at Kent and Canterbury hospital.

AK then asked whether it would be helpful to submit a concise version of Attachment 11 to the next round of Trust Board sub-Committee meetings, to enable a further discussion to occur before the July 2017 Trust Board meeting. GD expressed his support for the suggestion.

SDu then referred to the hurdle criteria and queried the inclusion of “Is the maximum travel time (by car) an average of one hour or less”, given that many patients accessed services via public transport. SDu also referred to the “Can the population access services within a window of 120 minutes from call to needle?”, & stated that she understood the required standard was a 60 minute call to needle time. PS explained there were 2 standards, for “call to door”, & for “door to needle”, with a 60 minute requirement for each, which therefore equated to 120 minutes for “call to needle”.

GD then referred to the SDu’s query regarding public transport, & noted that this aspect had been raised in many of the public STP meetings held, but was expected to be addressed during the next phase of development, in that additional public transport provision may need to be introduced.

GD then referred to the hurdle criteria for Stroke services, and noted that some aspects had been concluded to be desirable, but not be considered as hurdle criteria. GD elaborated that one such aspect was the co-location of a Hyper Acute Stroke Unit (HASU) with a Trauma Unit. GD continued that such desirable aspects would be applied when the various options were assessed. DH asked for clarification that the hurdle criteria therefore defined the de minimus requirements, and that evaluation criteria would then follow. GD confirmed this was the case.

GD then emphasised the importance of ensuring the process was correct, and noted the involvement of the local (i.e. South East Coast) Clinical Senate, as well as Public Health.

DH referred to the Local Care model, and stated that he would speculate that any 10-year forward view would still see the Trust’s 2 main sites in operation, and if it was therefore considered that these would be fixed point assumptions, the ability to shift care into the community was fundamental. DH continued that although this had been an aspiration for some time, there had only been marginal success. GD agreed, but noted that many of the changes that had been made in the past had improved patients’ access to services, and therefore improved services per se. DH commented that having a wider choice of solutions than just admitting patients or discharging them home would be very important. GD agreed.

GD then referred back to AK’s suggestion that the report be reviewed in detail in Trust Board sub-committees, and proposed this be scheduled. KR pointed out that the only Trust Board sub-committee meeting that was scheduled before the July Board was the ‘main’ Quality Committee,

which already had a full agenda. It was therefore agreed instead to schedule a review at a sub-Committee before the September 2017 Trust Board meeting. KR asked what sub-Committee/s should be asked to consider the report. GD suggested that the Quality Committee in particular consider the matter. DH proposed that this be discussed outside of the meeting. This was agreed.

Action: Liaise to confirm which Trust Board sub-committees should consider a more concise version of the "Kent and Medway Sustainability and Transformation Plan (STP) – Consideration of service models and hurdle criteria" report before the Trust Board reconsidered the matter again, at its meeting in September 2017 (Chair of the Trust Board / Trust Secretary, June 2017 onwards)

DH then asked when the impact assessments of the various options would be ready for review. GD confirmed this was likely to be in January 2018.

The Trust Board indicated its support, in principle, for the service models, and the hurdle criteria, as circulated.

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

6-17 Audit and Governance Committee, 24/05/17

The circulated report was noted.

6-18 Workforce Committee, 01/06/17 (incl. quarterly report from the Guardian of Safe Working Hours)

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

- The LiA programme had been considered
- The impact of 'Brexit' on staffing had been discussed
- The quarterly report from the Guardian of Safe Working Hours had been received, and was submitted as part of Attachment 13, as this was required to be submitted to the Trust Board
- The new workforce dashboard was reviewed, and was well received

6-19 Patient Experience Committee, 13/06/17

AK referred to the circulated report and stated that it had been useful to have the Head of Quality from West Kent CCG attend. AK also noted that a useful update had been given on the opening of the new Frailty Unit at MH.

6-20 Quality Committee, 14/06/17

SDu referred to the circulated report and stated that excitement had been felt in relation to the establishment of the Frailty Unit at MH. SDu remarked that this was a good development that could unlock a great deal of opportunity for the Trust. SDu also noted that the End of Life Care team had delivered a presentation, and Attachment 15 did not do justice to the amount of work undertaken, and the valuable service provided, by the small team.

6-21 Trust Management Executive, 21/06/17

JL referred to the circulated report and noted that the meeting had been managed as 2 separate meetings, the first of which included a presentation on exiting Special Measures, and this had been very useful in relation to any forthcoming Care Quality Commission inspection. JL also noted that there were clear links between the issues covered in the presentation and the LiA programme. JL added that the Terms of Reference had also been adjusted to add the 3 new Deputy Medical Directors to the membership.

6-22 Finance Committee, 26/06/17 (incl. revised Terms of Reference; and Business Case to reconfigure Theatre capacity at Tunbridge. Wells Hospital, for approval)

SDu referred to the circulated report (Attachment 17) and highlighted that revised Terms of Reference had been agreed, which included a change of name to "The Finance and Performance Committee". SDu pointed out that the Terms of Reference had been submitted for approval.

The revised Terms of Reference were approved by the Trust Board, as circulated.

SDu then referred to Attachment 18, which contained the Business Case to reconfigure Theatre capacity at TWH, & noted that the Committee had recommended that the Trust Board approve the Case. SDu added the discussion had emphasised the importance of the need to ring-fence beds.

Questions were invited. None were received.

The Business Case to reconfigure Theatre capacity at Tunbridge Wells Hospital was approved as circulated.

6-23 Charitable Funds Committee, 26/06/17

SDu reported the following matters, noting that a written report would be submitted to the July 2017 Board meeting:

- The Charitable Fund Annual Report and Accounts 2016/17 was reviewed and recommended for approval by the Trust Board (at its meeting in July 2017)
- There was a marked difference (i.e. reduction) in the level of charitable income from 2015/16, which had reinforced the need for a Fundraising Manager post, which had been previously agreed to proceed. SDu appealed for the post to be approved as quickly as possible

JL referred to the latter point, and noted that there had already been some interest in the post.

6-24 To consider any other business

DH noted that a letter had been issued by NHSI regarding fire safety, and asked for an update. GD reported that a letter had been issued from NHSI's Chief Executive asking that all Trusts arrange for the Fire Service to risk-assess their buildings by the end of 25/06/17. GD continued that the Trust had not done this, and it later transpired that the Fire Service had not been consulted on the request. GD added that the situation had however developed, and a more stratified approach had been adopted. AG gave assurance that the Trust was not considered to be in the higher risk category.

6-25 To receive any questions from members of the public

AKo referred to the meeting being RH's last Trust Board, as the Chair of the Staff Side, and thanked RH on behalf of all Trust staff, for his contribution over the past 9 years. AKo added that all the staff she had spoken to had been sorry to see RH leave, and wished him well for the future.

6-26 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.

Trust Board Meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
4-8 (April 17)	Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval	Trust Secretary	May 2017	Liaison has occurred, and the following objective is proposed, for the Board's approval: "To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway"[2]
6-9 (June 17)	Submit a report to the Trust Board, in July 2017, providing the outcome of the investigations into the recent alleged assaults at the Trust	Chief Nurse	July 2017	The report has been deferred to September to allow the conclusion of police investigations and so that all allegations may be reviewed collectively

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
5-10 (May 17)	Ensure the Chair of the Trust Board received a detailed briefing on the implementation of the PAS+	Chief Operating Officer / Deputy Chief Executive	July 2017	A briefing took place on 03/07/17
6-10 (June 17)	Schedule an update on the Workforce Transformation Programme at the Trust Board every 6 months	Trust Secretary	June 2017	Updates have been scheduled for the Trust Board meetings in December 2017 and June 2018 (and every 6-months thereafter)
6-11 (June 17)	Arrange for an explanation to be provided, to the July 2017 Finance Committee meeting, of the adverse variance between "Budget" and "Actual" for the Ante-Natal, Delivery Suite and Post-Natal areas at Tunbridge Wells Hospital (as reported in the "Planned and actual Ward staffing for May 2017" report to the Trust Board on 28/06/17)	Chief Operating Officer	July 2017	An explanation was submitted to the Finance and Performance Committee in July 2017

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

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
6-15 (June 17)	Schedule an update on the 2017/18 Winter and Operational Resilience Plan at the Trust Board in October 2017	Trust Secretary	June 2017	An update has been scheduled for October 2017
6-16 (June 17)	Liaise to confirm which Trust Board sub-committees should consider a more concise version of the "Kent and Medway Sustainability and Transformation Plan (STP) – Consideration of service models and hurdle criteria" report before the Trust Board reconsidered the matter again, at its meeting in September 2017	Chair of the Trust Board / Trust Secretary	July 2017	Liaison occurred, and in the light of the pace of development with the various STP-related documents, it was not considered feasible for a Trust Board sub-committee to review the document before the September 2017 Trust Board (which will be asked to consider the short list of options following application of the hurdle criteria). It was therefore agreed that the "service models and hurdle criteria" document should be considered at the Trust Management Executive in July 2017 and this took place

Actions not yet due (and still 'open')

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

Trust Board meeting - July 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

7-7 Chief Executive's Report — Chief Executive

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

1. As you will see from our performance in June, A&E attendances and emergency admissions continue to increase at pace compared with this time last year. This remains a priority area for our Trust and an ongoing significant issue that also impacts on our planned care.

   We, as a Trust, delivered to the expected target of 92% for the A&E four hour standard in June, which given where we were for April and May is a huge achievement.

   I have thanked our staff for their efforts and cannot over-emphasise what a great team effort it has taken to achieve. The four hour standard is an indicator of patient care and our ability to get emergency patients through their time in the Emergency Department as quickly and safely as possible.

   It is so important to demonstrate to ourselves that we can do this. We must now continue the same effort into July taking it a day and week at a time. We are holding another Rapid Improvement Week this month to help further improve patient flow through our hospitals and create space in A&E at all times of the day. At the end of the week we hope to create space to decant wards for deep cleaning over the summer and provide areas for escalation in the winter.

2. We continue to place more of our staff at the forefront of our creative thinking to proactively improve our patient experience, wellbeing and overall safety, through Listening into Action (LiA).

   The aim of LiA is to engage our staff to make the changes they feel are important to patients and to the work of our Trust. We have held a launch event for 10 clinically-led schemes and will soon be holding `crowd fixing' events to give all of our staff the opportunity to bring more of their thoughts and ideas to bear.

3. In my last Board report, I gave examples of ways in which we have improved patient care following concerns raised by patients and relatives. It is equally important to ensure our organisation makes positive changes for our patients as a consequence of concerns raised by our staff and that we are transparent in the way we deal with these.

   I have shared with our staff the actions we have taken in response to concerns raised through our anonymous reporting system. The actions we have taken to improve our patient care include:

   - To address staffing concerns, we now have two trained paediatric nurses in paediatric A&E at peak times, supported by an adult nurse and include the area in our Nurse in Charge quality rounds.
   - Reminded all staff about patient perception, after a member of staff felt a colleague's comments to a patient could have been construed as discourteous and uncaring.
   - Reviewed staffing levels on AMU following concerns about support staff cover.

4. We have a new Cultural Diversity Network within the Trust and have marked its launch by hosting talks for our staff with NHS Employers, NHS Leadership Academy and NHS Digital.

5. A group of people with learning disabilities, from a day centre in Sevenoaks, along with their carers, came into TWH to see a demonstration in our simulation suite.

   The session was run by Matron Stella Davey and our guests were given the opportunity to try their own hands at being a nurse or doctor. The aim of this, and other sessions which have been run previously with the same group, was to make those with learning disabilities, who have to come into hospital, feel more comfortable with the environment and happier to come in should they need to.

6. Our patients have once again benefited from the generous support of Maidstone Hospital League of Friends, following a donation of a phlebotomy chair and ECG machine at a cost of over £5,000.

7. A number of our staff have taken part in clinical audits to help make improvements to patient care. Recent improvements in patient care that have stemmed from this work include:

   - Dr Alana Rochester raising the importance of follow-up chest x-ray post diagnosis of community acquired pneumonia
   - Dr Daniel Moult and Dr Aleks Baker improving the quality of care for, and reducing mortality of patients undergoing emergency laparotomy surgery
   - work by Dr Lewis Hendon-John on opiate conversion and improvements by Dr Sameena Mohammedally on diagnosis, management and follow-up of patients with pulmonary emboli

8. I have mentioned in many previous reports the wonderful support our staff provide people outside of our hospitals. Colleagues from the Kent Oncology Centre will shortly be holding another Health and Wellbeing day in the community, to help support people with their transition from treatment such as chemotherapy, radiotherapy or surgery to a `new, normal' life. The events, which are run in association with Macmillan and other volunteer organisations, are so important in helping patients move forward with their lives in a positive way, knowing they have support and advice.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-9 Board Assurance Framework (BAF) 2017/18 — Trust Secretary

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

The BAF is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, & to ensure adequate controls & 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 BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure it is updated through the year. The BAF differs from the Risk Register as the BAF only contains the risks posing a direct threat to the achievement of the Trust's objectives.

Additional aspects relating to the Risk Register

The last annual Internal Audit review of the Assurance Framework and Risk Register recommended that a summary of the status of the Risk Register be include in the BAF reports received at Board meetings. This summary is therefore enclosed in Appendix 1. In addition, it was agreed at the Audit and Governance C'ttee in Feb. 2017 that the substance of all 'red' rated risks in the Risk Register should be accounted for in the BAF, or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the current list of red risks (see Appendix 1), it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Board is obviously free to challenge this.

Key objectives for 2017/18, and summary of year-to-date position

The 5 key objectives in the 2017/18 BAF were approved at the Board on 26/04/17. The Board also asked that an additional activity-related key objective be set, & this has been submitted for approval in the 'actions log' report to the July Board meeting. The rating of the 5 objectives in terms of the Responsible Director's confidence that it will be achieved by the year-end is as follows:

Objective	Confidence[1]
1. To reduce mortality (HSMR) in line with the national average	Amber
2. To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target	Amber
3. To maintain a vacancy rate of no more than 8.5%	Amber
4. To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)	Amber
5. To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target	Green

Review by the Trust Board

This is the first time during 2017/18 that the Board has seen the populated BAF. Board members are asked to review and critique the content, by considering the following prompts:

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

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

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

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 12/07/17
- Finance Committee, 17/07/17 (objective 4 only)

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

Review and discussion

[1] This is the confidence of the Responsible Director that the objective will be achieved by the end of 2017/18

[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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective) [3] *Key objective*

1 To reduce mortality (HSMR) in line with the national average

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

What could prevent this objective being achieved? *Risks to key objective*

1. If the issue is not afforded appropriate priority
2. If there is insufficient analytical support to understand the data
3. If there is failure to follow best practice in response
4. If there is lack of ownership by Clinical Directorates

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

a. The issue has a high profile at the Trust Board and Quality Committee, and the response has been led by the Medical Director. One of the new Deputy Medical Directors will also be asked to take the lead on this (although responsibility will remain with the Medical Director) (1)
b. The Assistant Director of Business Intelligence is directly involved in the analysis to understand the situation, & there is close liaison with Dr Foster (2)
c. The Trust is following the investigation pathway recommended by Dr Foster (i.e. checking coding, casemix, structure, process, individuals & teams) (3)
d. The Trust is adapting its process of detailed Mortality Reviews to comply with the latest guidance/recommendations from the National Quality Board (as is expected by NHS Improvement) (3)
e. Of the 4 'red flags' identified by Dr Foster (Congestive Heart Failure, #NOF, Pneumonia and Non-Hodgkin's lymphoma), a 'deep dive' review has been undertaken into Orthopaedics, and the review of pneumonia is at its mid-point. The reviews of the other areas are in development (4)

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

1. Written reports to the 'main' Quality Committee (May 2017) and Quality Committee 'deep dive' meeting (Jan, Feb & June 2017)
2. Monthly verbal reports to the Trust Board (Feb 2017 onwards)
3. Monthly Performance Dashboard reports to Trust Board (which reports the latest HSMR)

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

If "No", what other data is needed?

1. N/A

Risk owner/s:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Trust Clinical Governance Committee / Quality Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18? [4]

July 2017	~~September 2017~~	~~November 2017~~	~~February 2018~~
☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- The current 12-month rolling average HSMR is 106.8 (the baseline/expected rate is 100)

[3] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. The key objectives for 2017/18 were approved at the Board on 26/04/17. This objective is intended to manage the broad risk that "The Trust fails to improve key aspects of clinical care and safety"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective) [5] *Key objective*

2 To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

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

What could prevent this objective being achieved? *Risks to key objective*

1. If the Trust's demand and capacity planning did not reflect the 'new norm' for non-elective activity
2. If A&E attendances continue to remain higher than plan
3. If the Trust failed to adopt and/or implement the latest best practice in relation to patient streaming and other aspects

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

a. Demand and capacity planning for 2017/18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning (1)
b. The Directorate management team and the Information Department have agreed a set of monthly targets to facilitate how the required performed is monitored (the Trust must achieve 90% or above for Q1, Q2 & Q3, and then 95% in March 2018). Monthly targets are also in place (2)
c. The Trust's bid for £645k national funding has been agreed, to provide dedicated co-located areas for GP-led care (which will enable up to 20% of A&E patients to be seen more appropriately by GPs) (3)
d. The Chaucer Acute Frailty Unit (CAFU) opened at Maidstone Hospital in June 2017 (3)
e. There has been intensive focus by the Urgent Care management team on resolving capacity and flow issues affecting the non-elective patient pathways (3)
f. The Trust is seeking clarification as to the allocation and spending plan of the new social care funding, which has been added to the Better Care Funding (2)

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

1. The monthly Trust Performance report (including the 'story of the month')

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18? [6]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- The latest performance (at month 2, is 87%) which compares to the target of 90.1%
- There remain a number of unpredictable factors that may affect performance

[5] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. The key objectives for 2017/18 were approved at the Board on 26/04/17. This objective is intended to manage the broad risk that "The Trust is unable to manage (either clinically or financially) during the winter period"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective) [7] *Key objective*

3 To maintain a vacancy rate of no more than 8.5%

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

What could prevent this objective being achieved? *Risks to key objective*

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

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

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Increased recruitment staffing resource (4)
d. Divisional New Ways of Working Task and Finish Groups (4, 5)
e. Establishments and workforce requirements have been reviewed as part of the Business Planning process for 2017/18 and 2018/19

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

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The Chief Nurse's report to the October 2016 Trust Board regarding Nursing staffing levels (N.B. the next detailed review is scheduled for submission to the Trust Board in July 2017)
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18? [8]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- The vacancy rate for the year to date (at month 2, 2017/18) is 9.3%. The actions already in place will continue, but no additional actions are considered to be required at this stage

[7] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. The key objectives for 2017/18 were approved at the Board on 26/04/17. This objective is intended to manage the broad risk that "The Trust does not have the correct level of substantive workforce for effective delivery"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

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

4 To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

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

What could prevent this objective being achieved? *Risks to key objective*

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the level of CIP has not been fully identified
5. If the CIP schemes were not rated 'green'
6. If the Trust's plans for 2017/18 had been developed without consideration of best practice elsewhere
7. If NHS Improvement (NHSI) did not accept the Trust's plans
8. If there was insufficient engagement with external stakeholders

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

a. The Executive has continued to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. The Trust has signed up to its control total, and submitted a plan to achieve this (1, 7)
c. Control targets have been set for each Directorate to reduce their cost run rate (2)
d. A number of 'Grip and Control' measures have been implemented to ensure delivery (2, 3)
e. The Performance Management Framework is now embedded (3)
f. The Plans were informed by the Phase 1 Financial Improvement Programme report from KPMG LLP and by guidance and advice from NHSI (including that from the Finance Improvement Director) (6, 7)
g. Action has been taken to engage with external stakeholders, including agreeing an aligned incentives contract with West Kent CCG for 2017/18 (8)
h. A series of fortnightly CIP progress meetings with each Division have been established (which will continue throughout 2017/18) (2, 4, 5)

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

1. Monthly financial performance reports to TME, Finance and Performance Committee and Board
2. Monthly detailed CIP report to the Finance and Performance Committee

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18? [10]

July 2017	~~September 2017~~	~~November 2017~~	~~February 2018~~
☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- The year to deficit (at month 2) was £2.8m, against a planned deficit of £2.5m i.e. £0.3m adverse to plan. The CIP was £0.3m adverse in the month.
- The Trust is therefore broadly performing to plan at month 2, but there are risks to the long-term position

[9] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. The key objectives for 2017/18 were approved at the Board on 26/04/17. This objective is intended to manage the broad risk that "The Trust fails to demonstrate an ability to achieve future financial viability"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective) [11] *Key objective*

5 To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target[12]

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

What could prevent this objective being achieved? *Risks to key objective*

1. If there was insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. If pathways were not optimal in relation to achieving the required performance
3. If there was insufficient communication of the performance required outside of the Cancer and Haematology Directorate (only $^1/_3$ of the delivery is within that Directorate's control – the remainder is within Diagnostics, Surgery & Medicine)

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

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

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

1. The monthly Trust Performance report (including the 'story of the month')

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[13]

July 2017	September 2017	November 2017	February 2018
☒ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- At month 1, 2017/18, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date is 63.3%, but for MTW patients only is 69.6%. This compares to the target performance of 85%

[11] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators ('litmus test') for broader performance. The key objectives for 2017/18 were approved at the Board on 26/04/17. This objective is intended to manage the broad risk that "The Trust fails to maintain and improve its reputation as a Cancer provider"

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

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total	Q1	Q2	Q3	Q4
72.6	74.4	78.6	79.5	81.8	85.2	85.3	83.8	85.4	85.6	85.1	86.3	82	75.3	82.1	84.9	85.7

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

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

At 13/07/17, there are:
- 20 ‘red’ rated risks
- 45 ‘amber’ rated risks
- 21 ‘green’ rated risks
- 0 ‘blue’ rated risks

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

Each risk has a designated “Manager” and is allocated a review date. The management of the Risk Register is overseen by the Trust’s Risk and Compliance Manager, who instigates formal reviews every 2 months. The full Risk Register is submitted to the Trust Management Executive (TME) and Audit and Governance Committee. Clinical Directorate-based ‘red’ rated risks are discussed as part of the report that Directorates give to the ‘main’ Quality Committee. It is also intended that all ‘red’ rated risks will be subjected to regular review at Executive Team meetings.

The issues covered by the current 20 ‘red’ rated risks will be familiar to the Trust Board and its sub-committees, as these have been previously discussed (some very regularly) at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:
- High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- Patient flow/capacity in the Acute and Emergency Directorate
- Achieving the Cancer waiting time targets
- The gaps in relation to Medical devices training and a trainer/coordinator
- The delivery of the annual financial plan and long-term financial viability
- The cost pressures associated with the use of temporary staff
- The lack of appropriate Medical cover on night shifts for the Paediatric unit
- The shortage of Paediatric Specialty and Associate Specialist (SAS) (‘middle grade’) doctors on day shifts for paediatrics
- Medicines and Healthcare products Regulatory Agency (MHRA) compliance regarding the traceability of blood products
- Blood sciences staffing shortages
- The delivery of the Cost Improvement Programme (CIP) for the Urgent Care Division
- The management of outstanding open incidents in Specialist Medicine
- Nursing staffing levels on Ward 30 and 31
- The governance arrangements for Point of Care testing
- Delays in reporting of diagnostic tests at East Kent Hospitals University NHS Foundation Trust
- Lack of Consultant Oncologists specialising in Head & Neck, Lymphoma and Skin Cancers

In addition to the above list, 3 recent ‘red’ rated risks have been added to the Register by the relevant Directorate. These relate to dietetic staffing and non-compliance with NICE clinical guidelines relating to “Chest pain of recent onset: assessment and diagnosis”. Before adding a red-rated risk, Directorate Risk Leads are asked contact the Risk and Compliance Manager to discuss the risk (and to validate the assessment that the risk warrants a ‘red’ rating). These 3 risks have not however yet been subject to this first-stage review (and have not yet been featured within the Directorate reports given at the ‘main’ Quality Committee), so this process will be followed in the first instance.

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

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

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

Guidance on likelihood / probability

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

Risk grading matrix

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

Trust Board meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-10	**Integrated Performance Report, June 2017**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for June 2017 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Elective Activity / Referral to Treatment (RTT); and Cancer 62 day First Definitive Treatment)
- A financial commentary
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 12/07/17 (Trust performance dashboard)

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

The 'story of the month' for June 2017

The key areas of focus remain as previously reported, emergency 4 hour standard, RTT and Cancer 62 day target.

1. Emergency Performance (4 hour standard)

Performance for the Trust for June (calendar) rose substantially to 92.52% (including MIU), achieving the Trust recovery plan of 91.90%. 16/17 came in at 87.1%, which was in line with what was agreed as possible with NHSI. This year, we will be monitored against a new set of targets, where Q1, Q2 and Q3 must score 90% or above, then 95% in March 2018. The directorate management team and the Information Department have agreed a set of monthly targets to facilitate how we monitor and track this. The July target is set at 89.60%. Demand and capacity planning for 2017-18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning.

The key issues for June are:

- A&E Attendances remain higher than last year & higher than long term trends, conforming closely to the MTW activity model.
- Non-Elective Activity was 4,122 discharges in June (16.2% higher than plan & 12.0% higher than May last year). 7,997 discharges YTD (24.9% up on plan & 17.8% up on last year). NE activity over the past 4 months has been at an all-time high.
- There were 1,296 bed-days lost (6.13% of occupied bed-days) due to DTOCs.
- Average number of Medically Fit for Discharge (MFFD) patients in May was 117, whilst the average weekly total on the delays snapshot for the dame period was 43. So typically, 74 MFFD (around 2/3) are not counted as DToCs
- Non-elective LOS was 7.38 days for June discharges after spiking at 8.68 in January. Average occupied bed days rose to 715 in June, slightly down from May's 738

Focus remains on improving length of stay for all patients and establishing practice that is aimed at reducing the volume of patients that are admitted to inpatient beds and these are:

- Acute assessment facilities
- Ambulatory pathways across all specialties
- Frail elderly facilities & pathway

2. Delayed Transfers of Care

Count of Hospital ID	Column																											
Row Labels	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
A : Awaiting Assessment	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14	13	11
B : Awaiting Public Funding	2		1	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1	3	3
C : Awaiting Further Non-Acute NHS Care	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17	21	27
Di : Awaiting Residential Home	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21	8	16
Dii : Awaiting Nursing Home	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57	70	94
E : Awaiting Care Package	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35	39	43
F : Awaiting Community Adoptions	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6	8	7
G : Patient or Family Choice	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6	10	8
H : Disputes	2	1			1	3	1	1		1				3	1	1				1			1	1	1	1	2
I : Housing	3	4	3	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3	3	5
Grand Total	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228	161	176	216
Trust Percentage Delays	5.9%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.8%	5.9%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.3%	8.1%	6.7%	7.1%	6.2%	5.6%	6.0%	6.1%

For 2016/17, there were 17,781 bed days lost equating to a rate of 6.67 compared to 6.19 on 2015/16.

- Pathway 3 Home First for those patients requiring a care home facility is full at 10 beds. There has been a care manager in place to support flow through the beds
- There are 25+ patients being funded through the CCG commercial bed fund in private nursing homes, the vast majority of these are elderly patients with orthopaedic issues who are waiting healing in order to regain function. This has significantly decreased in month due to patients coming to the end of their stay
- Interviews for a Band 4 dedicated discharge resource for the MFFD wards interviews in July
- Enablement capacity has been good through month
- CHS (an external agency to locate and facilitate discharge to nursing homes and private POC within 5 days for privately funded patients) significantly exceeded target in June, placing 31 patients against a target of 20
- Senior staff (DH and JS) continue to lead the DTOC sign off meetings on Fridays with telephone attendance from the CCG, CHC and East Sussex leading to earlier identification of issues
- Meeting with East Sussex Social services to identify possible initiatives to assist with high DTOC for Kent

3. Elective Activity / Referral to Treatment (RTT)

Performance: June performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 87.0%

The Trust continues to be non-compliant at a speciality level for T&O, Gynae, ENT ,Neurology, General Surgery, Cardiology and Urology and the majority of the backlog is concentrated in these- all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs despite cancellations by moving lists to Maidstone and focusing capacity on booking patients within the backlog to all available lists. Extra Saturday sessions are being planned when current escalation reduces.

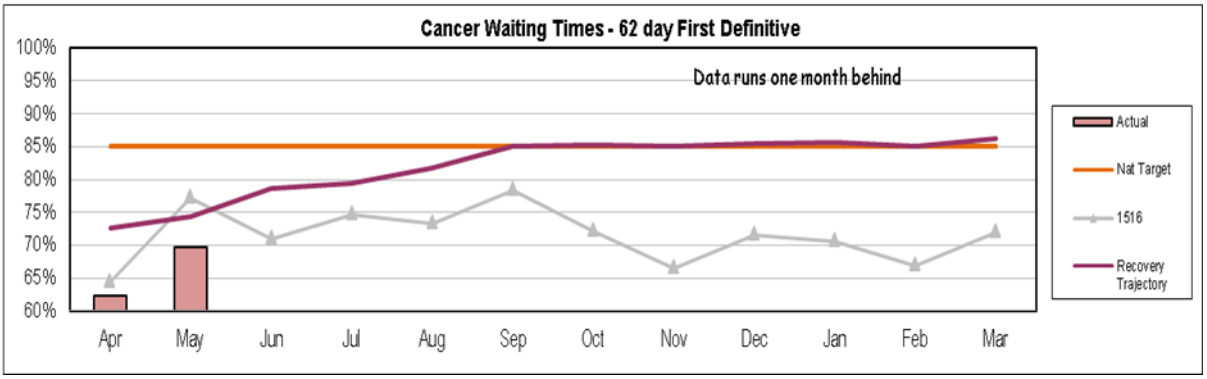
Operational teams are focused their recovery plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further. The Trust has now resubmitted the RTT trajectory for 17/18 which shows aggregate compliance by Nov 17.

	Jun-17	Jun-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3,260	2,220	-1048
RTT Waiting List	25,170	23,053	-2117
RTT Incomplete performance %	87.0%	90.46%	-3.46

4. Cancer 62 day First Definitive Treatment

Performance for 62 day First Definitive Treatment (data runs a month behind) - May-17: 69.7%, 1617 Q4: 69.7%, 1617 Full year 71.5% (70.1% using new breach allocation policy) which is below the national target of 85%.

62 FDT for May: 30 breaches (under current allocation policy), 23 of these were MTW only patients. 11 patients from Other Trusts to MTW and 3 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 3 patients from Medway, 1 patient from Darent Valley, 1 patient from East Sussex, 1 patient from QVH and 5 patients from East Kent (Patients shared across Trusts = 0.5 of a breach).



There are a number of remedial actions in place to achieve a sustainable improved performance.

- Straight to test triage clinics are now well established for colorectal referrals with increasing numbers of clinics per week and increasing numbers of patients being sent straight to test. This is reducing the length of pathways for these patients and will enable the number of breaches to be reduced. Performance is steadily improving.
- The weekly cancer PTL meeting has been revised to review all patients day 15 to 39 and an 11am daily “huddle” is taking place each day for the patients on days 40 and above to escalate actions more quickly to the relevant GM’s.
- An Oncology PTL is now taking place weekly to replicate the main PTL meeting
- The MDT co-ordinators have added a cover sheet to the MDT list each week detailing the number of patients on the PTL for that tumour site in sections of days 0 – 20, 21 – 39, 40 – 62, over 62 and over 62, highlighting the number diagnosed and those undiagnosed.
- Lung one stop clinic has started and appears to be having an immediate effect in that the number of patients on the PTL has reduced as have breaches.

Financial commentary

- The Trust had a favourable variance against plan in June 2017 of £0.1m including STF, this is due to £0.1m STF overperformance. New guidance was provided in June by NHS Improvement therefore a YTD STF adjustment for A&E GP streaming has been included.
- The Trust's net deficit (including technical adjustments) in June is £0.7m against a planned deficit of £0.8m, therefore £0.1m favourable to plan. The Trusts year to date net deficit (including technical adjustments) is £3.6m, £0.3m adverse to plan which is due to the non-achievement of the A&E trajectory.
- In June the Trust operated with an EBITDA surplus of £1.9m which was £0.1m favourable to plan and an improvement of £1m between months.
- The key variances in the month are as follows:
    - Total income was £0.1m favourable in the month, Clinical Income was £0.2m adverse which included an Aligned Incentive adjustment of a reduction of £0.8m (£0.8m positive YTD). STF was £0.1m favourable in June due to YTD catch-up of A&E GP streaming STF Income, HCD income £0.3m favourable to plan offsetting HCD overspend and other operating income was £0.1m adverse.
    - Pay was £0.2m favourable, Medical staff was the only pay group adverse in the month (£0.1m) the majority (£50k) related to the T&O directorate. Nursing underspent by £0.2m in the month which was due to the release of £150k 2016/17 agency accrual which was a non-recurrent in month benefit. Scientific and Technical staff continue to underspend against budget (£50k in month, £217k YTD), the main underspending directorates are Specialist Medicine (mainly Therapy staff) £357k YTD favourable and Cancer Directorate (£185k favourable)
    - Non Pay was overspent by £0.2m in June, £0.6m adverse relating to pass through costs for STP (£0.3m) and Drugs (£0.3m) which is offset by additional income. There was an in month benefit of £0.2m relating to a release of 16/17 accruals (£0.1m birthing unit and £0.1m Gas) and a £0.1m YTD ICT COIN subsidy benefit.
    - The CIP performance in June delivered efficiencies of £1.4m which was £0.4m adverse to plan, £0.8m adverse year to date.
- The Trust held £4.9m of cash at the end of June which is £2.5m lower than the plan value of £7.4m. The main reason for this is that the Trust is the host for the STP and has had to prioritise a number of these payments before being reimbursed by partner NHS organisations. Following the year end agreement of balances exercise the Trust is in contact with NHS organisations trying to collect all agreed values and escalating any items disputed for resolution.
- The trust is forecasting to deliver the planned pre STF deficit of £4.5m.

Workforce commentary

As at the end of June 2017, the Trust employed 5,058.4 whole time equivalent substantive staff, a 25.7 WTE reduction from the previous month. Overall temporary staffing is higher than planned, but continues to demonstrate a favourable shift from agency to bank.

Sickness absence in the month (May) remained consistent at 3.2% compared to the previous month and represented a 0.6% improvement on the same period last year. However, sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance has increased slightly to 87.8% from the previous month, and has remained consistently above the target percentage.

Turnover has remained higher than target in June at 11.7%, and a detailed analysis of trust Turnover was presented at the June Workforce Committee. Some areas have been identified for targeted investigation as a result of this analysis which will be progressed by the Business Partners in conjunction with the divisional operational management teams.

Appraisal compliance for June, following the end of the Trust's designated appraisal window, stands at 37.2%. Although there is a small backlog of appraisals being recorded on ESR (and hence the actual figure will be a little higher than stated), the expected figure remains below target. Business partners are currently working with divisional leads to promote return of completed appraisal paperwork.

The 'Recommended Place to Work' indicator from the last quarterly Friends and Family Test survey has risen slightly from the previous quarter, but remains substantially lower than the consistent response that the Trust has received over the past few years (circa 60%). This reduction was not mirrored in the recent published annual staff survey (February 2017) result of 63% for the Trust.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30 June 2017**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
1-01	*Rate C-Diff (Hospital only)	18.51	9.5	12.3	13.8	1.5	-	11.5	10.2	
1-02	Number of cases C.Difficile (Hospital)	4	2	8	9	1	-	27	27	
1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
1-04	Elective MRSA Screening	99.0%	98.0%	99.0%	98.0%	-1.0%	0.0%	98.0%	98.0%	
1-05	% Non-Elective MRSA Screening	99.0%	96.0%	99.0%	96.0%	-3.0%	1.0%	95.0%	96.0%	
1-06	**Rate of Hospital Pressure Ulcers	2.5	1.7	2.5	1.7	- 0.8	- 1.3	*3.0*	1.9	3.0
1-07	***Rate of Total Patient Falls	5.4	5.39	5.8	5.64	- 0.1	- 0.4	*6.00*	5.54	
1-08	***Rate of Total Patient Falls Maidstone	5.6	4.6	5.2	5.2	-			4.9	
1-09	***Rate of Total Patient Falls TWells	5.9	6.0	6.0	6.0	-			6.0	
1-10	Falls - SIs in month	2	3	3	9	6				
1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
1-12	Total No of SIs Open with MTW	28	41			13				
1-13	Number of New SIs in month	11	14	27	38	11	8			
1-14	***Serious Incidents rate	0.51	0.66	0.41	0.58	0.17	0.52	*0.0584 - 0.6978*	0.58	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.87	1.15	0.53	1.32	0.80	0.09	*0 - 1.23*	1.15	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.1%	96.4%	95.2%	96.4%	1.2%	1.4%	95.0%	96.4%	95.0%
1-18	Safety Thermometer % of Harm Free Care	97.2%	97.3%	96.7%	96.9%	0.2%	1.9%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	2.67%	2.46%	3.19%	2.89%	-0.30%	-0.1%	*3.00%*	2.89%	
1-20	C-Section Rate (non-elective)	12.9%	15.9%	12.4%	14.6%	2.12%	-0.4%	*15.0%*	14.6%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0260	1.0878	0.1	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		104.0	106.8	2.8	6.8	Lower confidence limit		100.0
2-03	Crude Mortality	1.0%	1.1%	1.3%	1.2%	-0.1%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.1%	11.3%	11.5%	11.8%	0.3%	-1.8%	*13.6%*	11.8%	14.1%
2-05	****Readmissions <30 days: All	10.3%	10.6%	10.8%	11.2%	0.5%	-3.4%	*14.7%*	11.2%	14.7%
2-06	Average LOS Elective	3.40	3.55	2.98	3.20	0.22	- 0.01	*3.20*	3.20	
2-07	Average LOS Non-Elective	7.71	7.38	7.20	7.53	0.33	0.73	*6.80*	6.80	
2-08	******FollowUp : New Ratio	1.62	1.34	1.63	1.47	- 0.16	- 0.05	*1.52*	1.47	
2-09	Day Case Rates	83.9%	86.3%	84.6%	87.0%	2.4%	7.0%	80.0%	87.0%	82.2%
2-10	Primary Referrals	10,230	8,875	30,811	27,136	-11.9%	-6.1%	119,266	119,266	
2-11	Cons to Cons Referrals	4,943	4,401	14,672	13,179	-10.2%	-13.0%	58,644	58,644	
2-12	First OP Activity	17,215	16,206	49,577	46,997	-5.2%	-6.6%	201,705	201,705	
2-13	Subsequent OP Activity	33,314	28,414	95,046	85,580	-10.0%	-8.3%	384,419	384,419	
2-14	Elective IP Activity	775	582	2,143	1,651	-23.0%	-27.2%	8,303	8,303	
2-15	Elective DC Activity	3,929	3,643	11,456	10,854	-5.3%	-7.0%	43,602	43,602	
2-16	Non-Elective Activity	4,090	4,707	12,657	13,937	10.1%	15.1%	46,435	46,435	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	14,113	14,579	41,694	42,767	2.6%	0.8%	168,161	164,934	
2-18	Oncology Fractions	6,486	6,284	18,606	17,182	-7.7%	-7.2%	75,273	75,273	
2-19	No of Births (Mothers Delivered)	477	528	1,461	1,476	1.0%	-1.2%	5,977	5,977	
2-20	% Mothers initiating breastfeeding	80.8%	80.0%	85.4%	81.0%	-4.4%	3.0%	78.0%	81.0%	
2-21	% Stillbirths Rate	0.4%	0.37%	0.83%	0.27%	*-0.6%*	*-0.2%*	*0.47%*	0.27%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.11	2.27	1.69	1.64	-0.1	0.32	*1.318-3.92*	1.61	
3-03	% complaints responded to within target	73.7%	57.6%	74.3%	69.7%	-4.6%	-5.3%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	87.2%	76.0%	87.2%	76.0%	-11.2%	-3.0%	79.0%	79.0%	
3-05	*****IP Friends & Family (FFT) % Positive	95.1%	95.9%	95.8%	95.6%	-0.2%	0.6%	95.0%	95.6%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	92.6%	92.3%	92.0%	91.7%	-0.3%	4.7%	87.0%	91.7%	85.5%
3-07	Maternity Combined FFT % Positive	99.0%	90.7%	94.5%	92.4%	-2.1%	-2.6%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	82.9%	84.5%	82.3%	84.2%	1.9%			84.2%	

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

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

****** IP Friends and Family includes Inpatients and Day Cases* *******SHMI is at Band 2 "As Expected"*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	91.0%	92.5%	91.0%	88.9%	-2.1%	-1.2%	90.1%	90.1%	77.6%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	321	New	1300					
4-04	Ambulance Handover Delays >60mins	New	19	New	112					
4-05	RTT Incomplete Admitted Backlog	1,431	2308	1,431	2308	877	843	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	718	952	718	952	234	217	631	631	
4-07	RTT Incomplete Pathway	91.4%	87.0%	91.4%	87.0%	-4.3%	-3.1%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	1	0	1	1	1	*0*	1	
4-09	RTT Incomplete Total Backlog	2,069	3260	2,069	3260	1,191	1,060	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.8%	99.7%	99.7%	99.7%	0.0%	0.7%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	3	3	3	-	- 6	9	9	
4-12	*Cancer two week wait	91.0%	93.1%	91.1%	92.1%	1.0%	-0.9%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	86.4%	90.4%	82.7%	87.9%	5.2%	-5.1%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.7%	93.2%	96.6%	92.6%	-4.0%	-3.4%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	77.1%	69.7%	70.5%	66.2%	-4.3%	-7.3%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	81.7%	73.3%	81.7%	73.3%	-8.5%		85.0%		
4-17	*Cancer 104 Day wait Accountable	8.5	6.0	22.5	15.0	-7.5	15.0	*0*	15.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	101	89	101	89	-12				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	69	62	69	62	-7				
4-20	Delayed Transfers of Care	6.2%	6.1%	5.6%	5.9%	0.3%	2.4%	3.5%	3.5%	
4-21	% TIA with high risk treated <24hrs	82.8%	77.8%	85.0%	72.7%	-12.3%	12.7%	60%	72.7%	
4-22	*******% spending 90% time on Stroke Ward	82.3%	84.4%	85.4%	88.8%	3.4%	8.8%	80%	88.8%	
4-23	*******Stroke:% to Stroke Unit <4hrs	43.2%	53.3%	50.0%	56.9%	6.9%	-3.1%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	56.0%	51.7%	59.0%	57.6%	-1.4%	9.6%	48.0%	57.6%	
4-25	*******Stroke:% assessed by Cons <24hrs	65.3%	75.0%	66.4%	73.5%	7.1%	-6.5%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	3	2	6	9	3	9	*0*	9	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

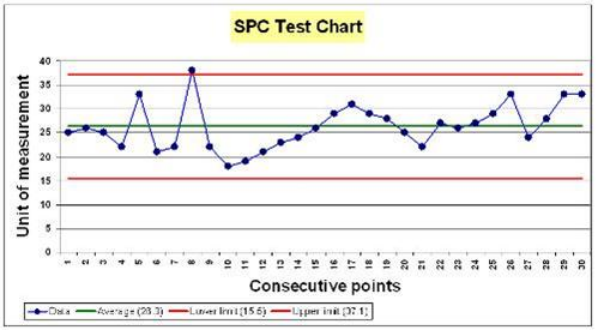
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	34,812	36,454	102,121	110,227	7.9%	1.8%	436,664	445,067	
5-02	EBITDA	(850)	1,862	(2,298)	4,084	-277.7%	-6.8%	38,055	37,704	
5-03	Surplus (Deficit) against B/E Duty	(3,569)	(693)	(10,475)	(3,524)			6,673	6,673	
5-04	CIP Savings	1,635	1,398	4,366	3,417	-21.7%	-9.2%	31,721	31,721	
5-05	Cash Balance	4,339	7,825	4,339	7,825	80.3%	-30%	1,000	1,000	
5-06	Capital Expenditure	202	143	384	180	-53.1%	-89.8%	*17,398*	17,398	
5-07	Establishment WTE	5,752.7	5,601.4	5,752.7	5,601.4	-2.6%	0.0%	5,601.4	5,601.4	
5-08	Contracted WTE	5,165.0	5,058.4	5,165.0	5,058.4	-2.1%	-1.0%	5,110.6	5,110.6	
5-09	Vacancies WTE	587.7	543.0	587.7	543.0	-7.6%	10.6%	490.8	490.8	
5-11	Vacancy Rate (%)	10.2%	9.7%	10.2%	9.7%	-0.5%	0.9%	8.8%	8.8%	
5-12	Substantive Staff Used	5,010.8	4,931.5	5,010.8	4,931.5	-1.6%	-3.5%	5,110.5	5,110.5	
5-13	Bank Staff Used	331.8	473.8	331.8	473.8	42.8%	41.3%	335	335.3	
5-14	Agency Staff Used	269.3	143.6	269.3	143.6	-46.7%	-7.7%	155.6	155.6	
5-15	Overtime Used	59.8	44.0	59.8	44.0	-26.5%				
5-16	Worked WTE	5,671.7	5,592.8	5,671.7	5,592.8		-0.2%	5,601.4	5,601.4	
5-17	Nurse Agency Spend	(867)	(547)	(2,520)	(1,806)	-28.3%				
5-18	Medical Locum & Agency Spend	(1,410)	(998)	(4,081)	(3,376)	-17.3%				
5-19	Temp costs & overtime as % of total pay bill	17.0%	13.7%	16.6%	14.2%	-2.4%				
5-20	Staff Turnover Rate	10.6%	11.7%		11.6%	1.1%	1.1%	*10.5%*	10.5%	11.05%
5-21	Sickness Absence	3.8%	3.2%		3.4%	-0.6%	0.1%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	89.1%	87.8%		87.3%	-1.3%	2.3%	85.0%	87.3%	
5-23	Appraisal Completeness	Data not reported for Quarter 1.								
5-24	Overall Safe staffing fill rate	99.6%	98.2%	101.5%	98.4%	-3.1%		93.5%	98.4%	
5-25	****Staff FFT % recommended work	64.2%	51%	64.2%	51%	-13.2%	-11.1%	62.0%	62%	
5-26	***Staff Friends & Family -Number Responses	664	701	664	701	37				
5-27	*****IP Resp Rate Recmd to Friends & Family	25.9%	23.8%	22.4%	23.6%	1.2%	-1.4%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.0%	20.2%	12.2%	19.1%	6.9%	4.1%	15.0%	19.1%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	7.6%	37.7%	20.8%	30.9%	10.1%	5.9%	25.0%	30.9%	24.0%

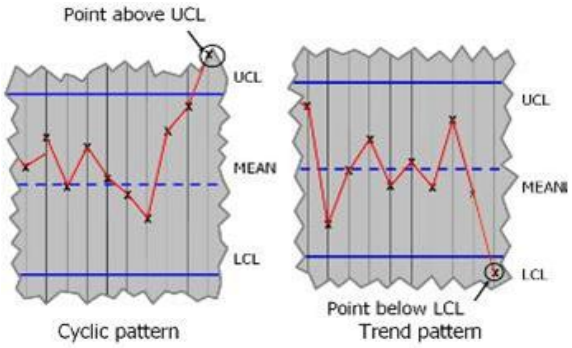
Explanation of Statistical Process Control (SPC) Charts

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

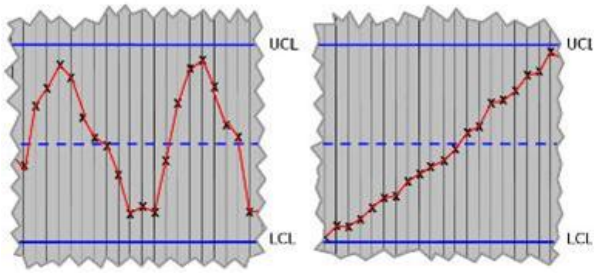


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

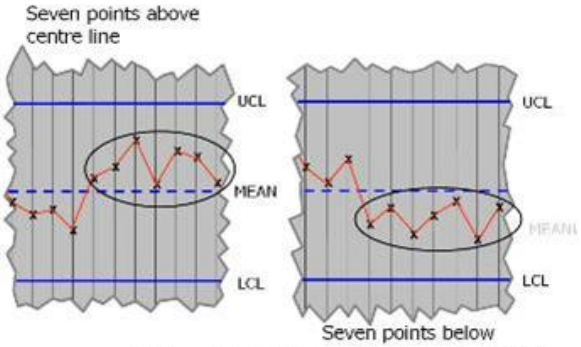


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

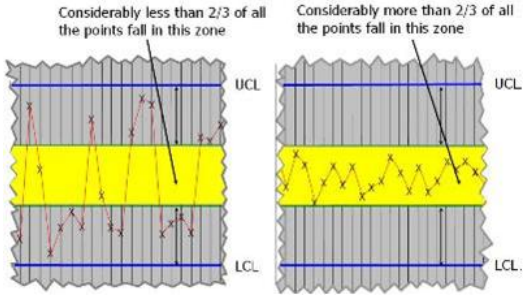


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

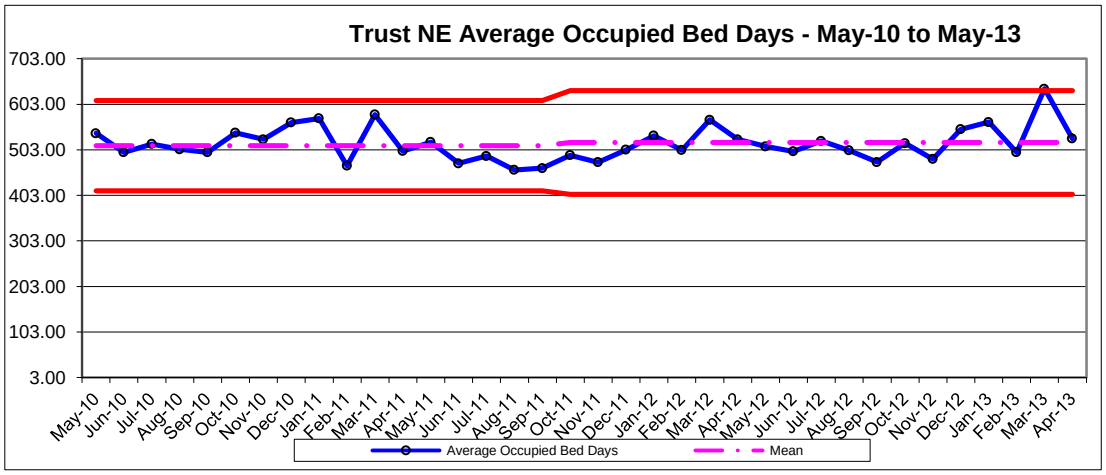


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

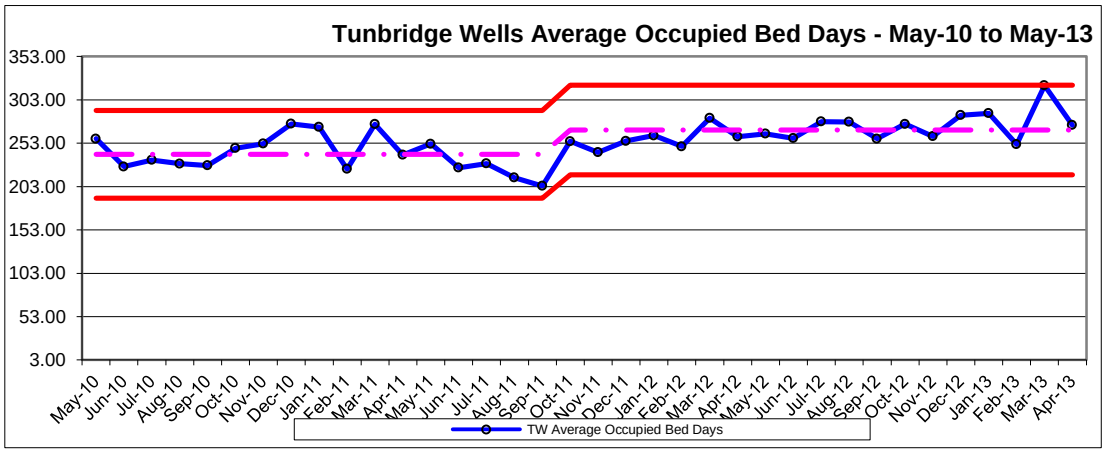


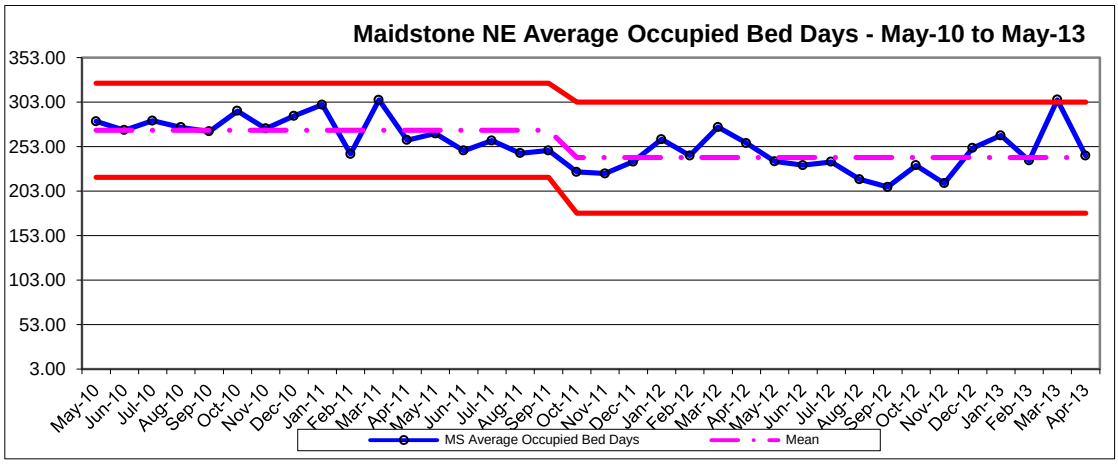
Changes to Control Lines

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



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

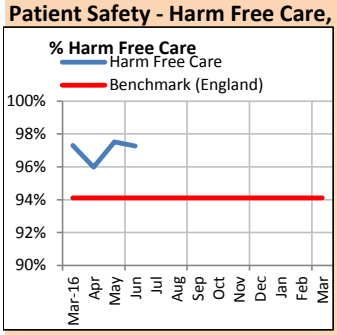


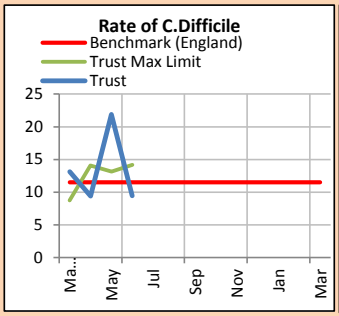


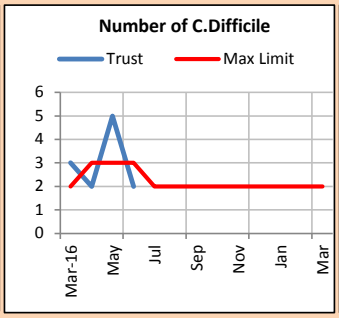
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

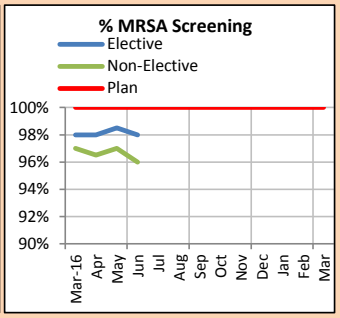
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

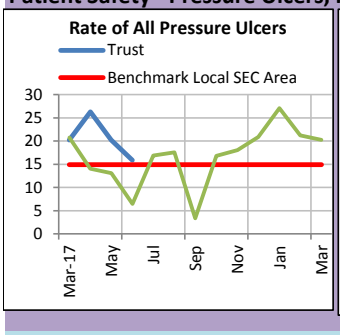


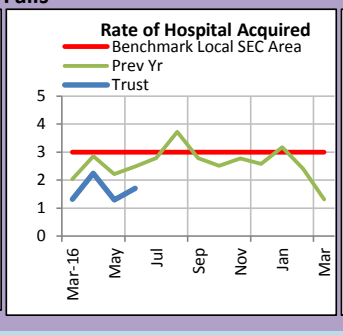


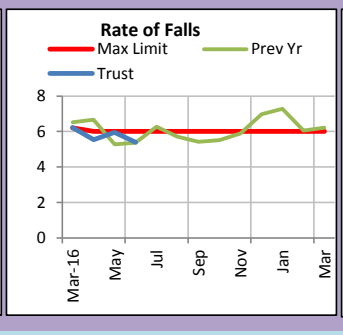


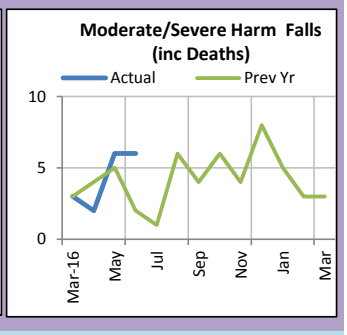


Patient Safety - Pressure Ulcers, Falls

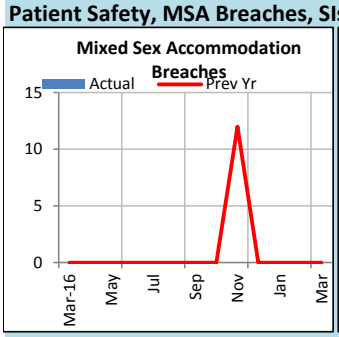


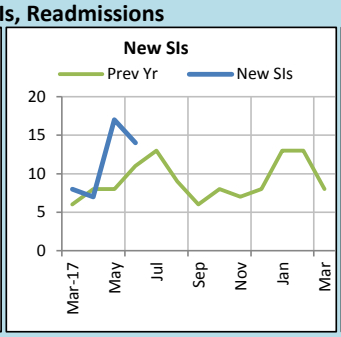


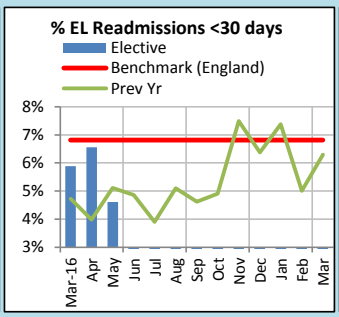


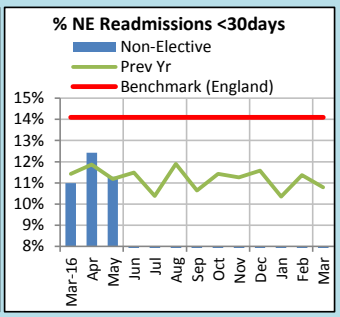


Patient Safety, MSA Breaches, SIs, Readmissions

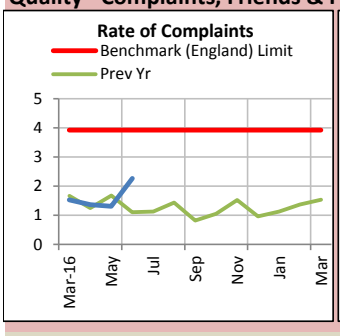


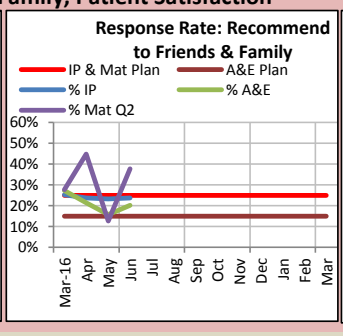


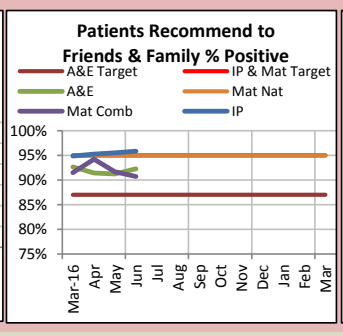


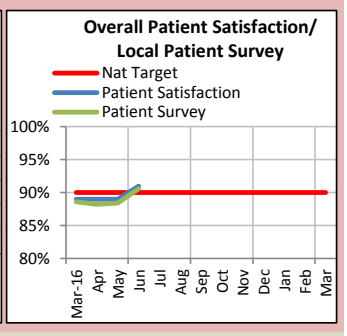


Quality - Complaints, Friends & Family, Patient Satisfaction

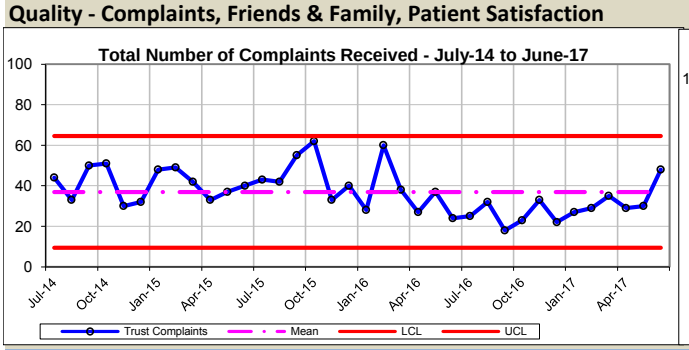


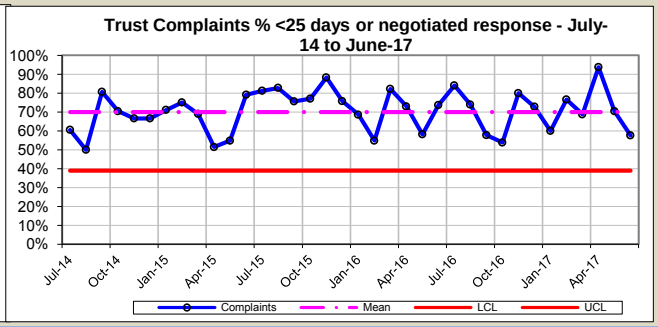




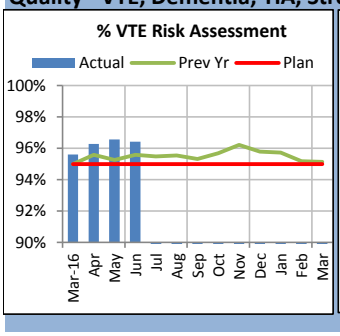


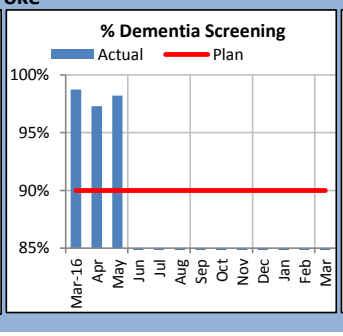
Quality - Complaints, Friends & Family, Patient Satisfaction

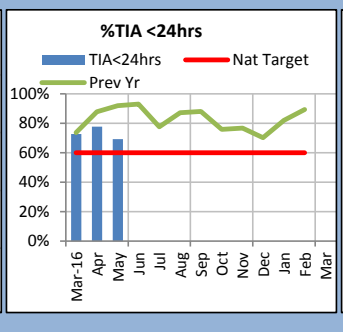


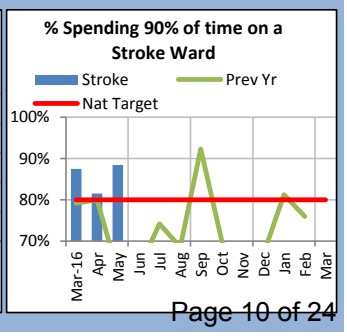


Quality - VTE, Dementia, TIA, Stroke



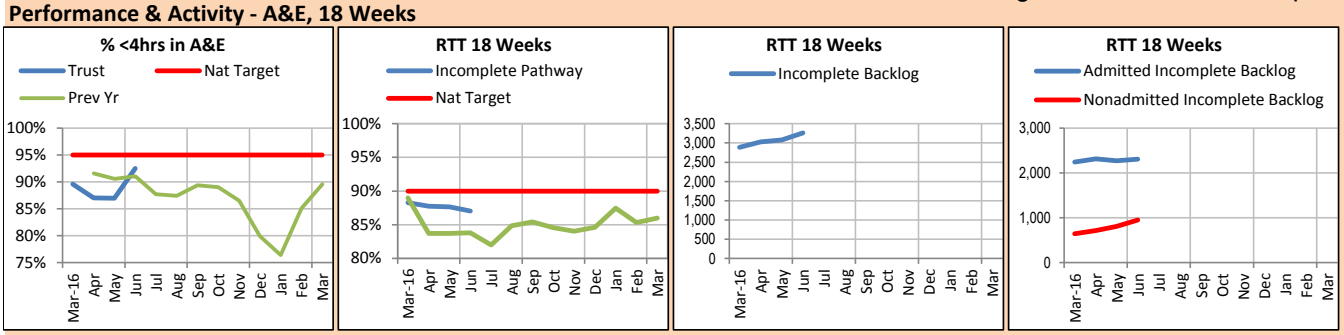




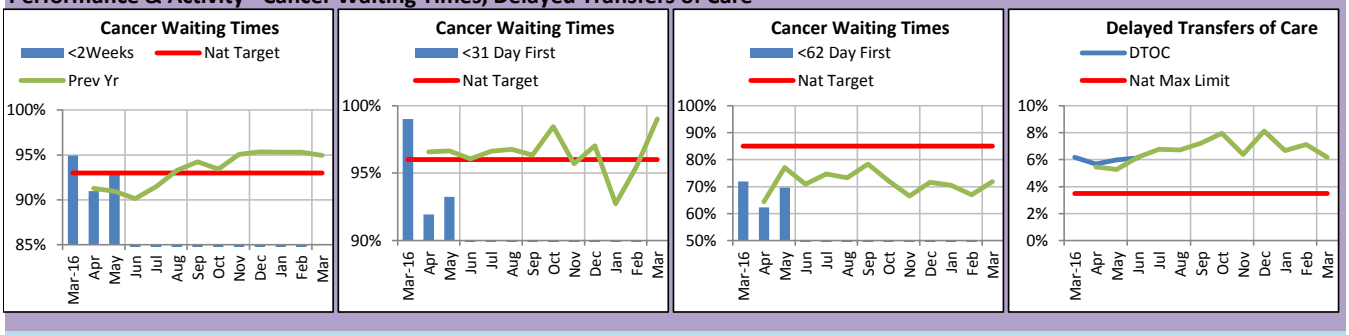


INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

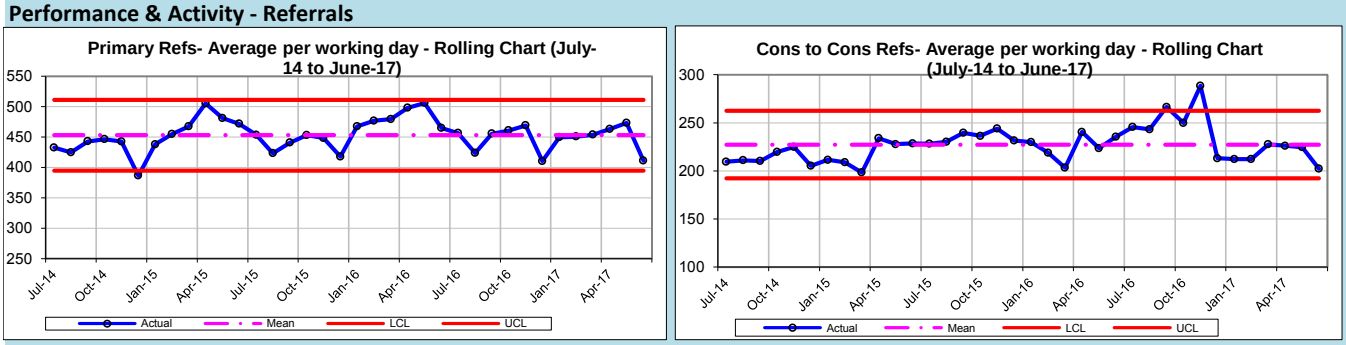
Performance & Activity - A&E, 18 Weeks



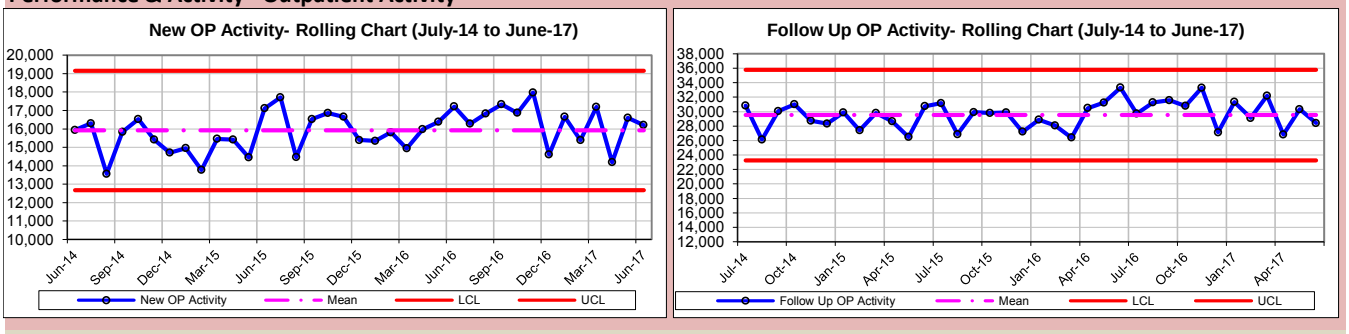
Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



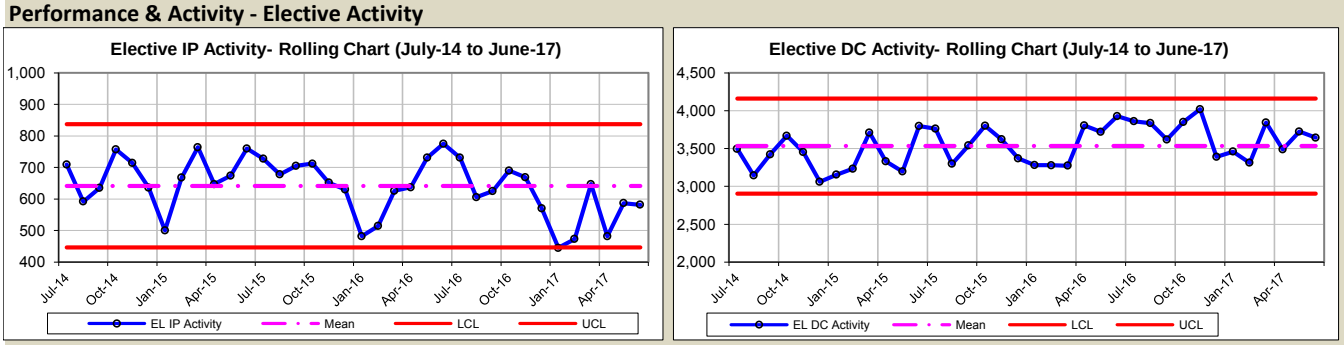
Performance & Activity - Referrals



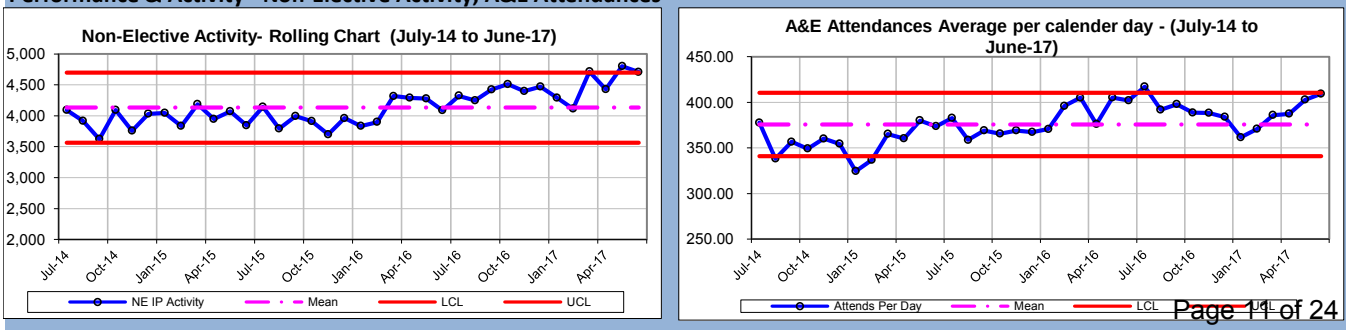
Performance & Activity - Outpatient Activity



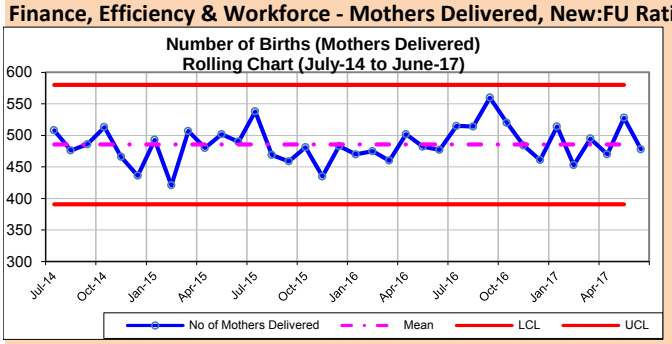
Performance & Activity - Elective Activity

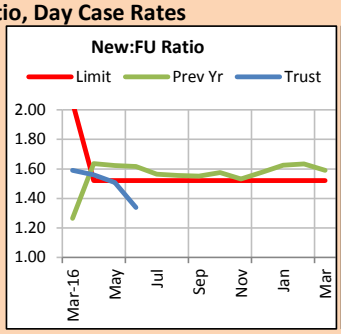


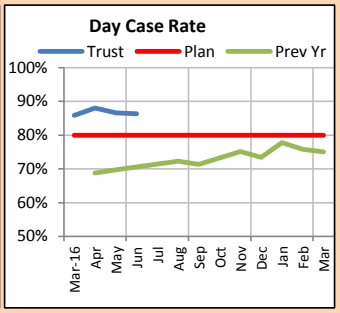
Performance & Activity - Non-Elective Activity, A&E Attendances



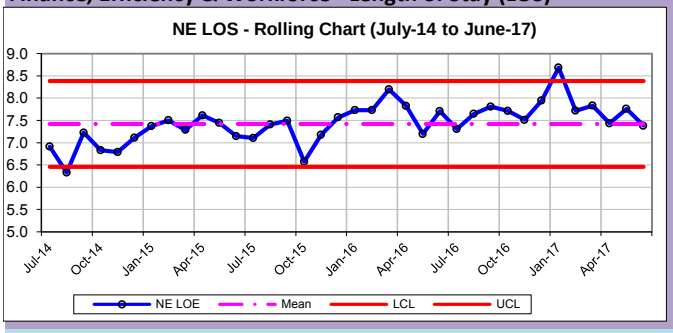
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

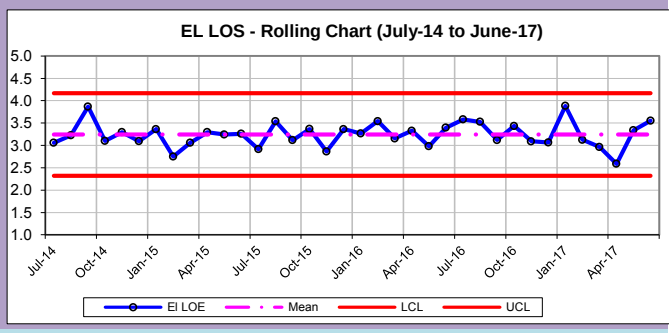




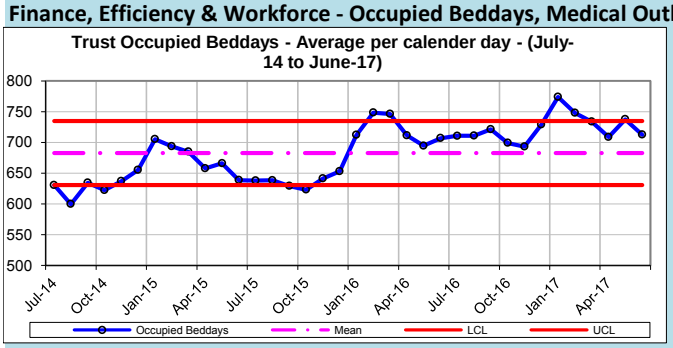


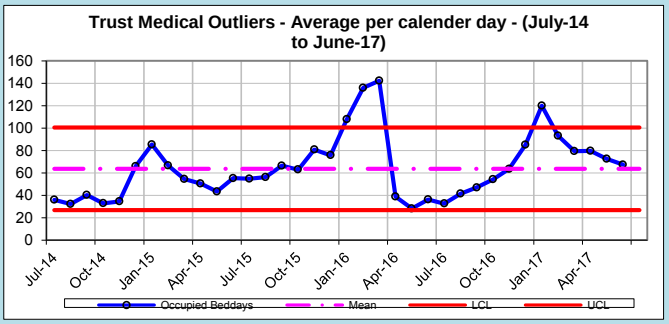
Finance, Efficiency & Workforce - Length of Stay (LOS)



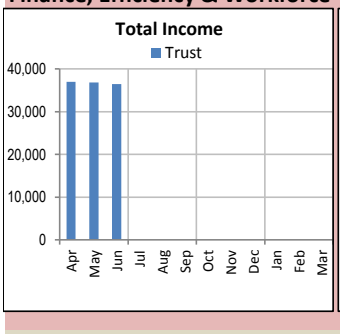


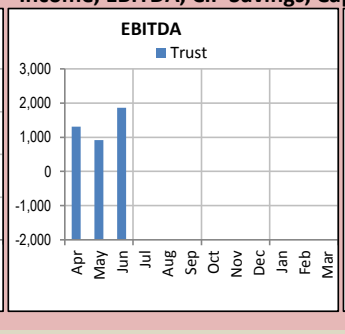
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

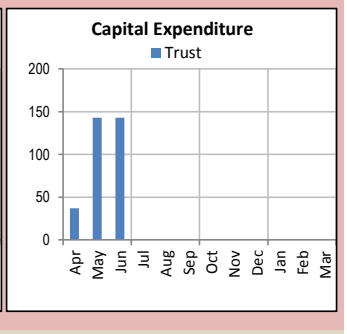




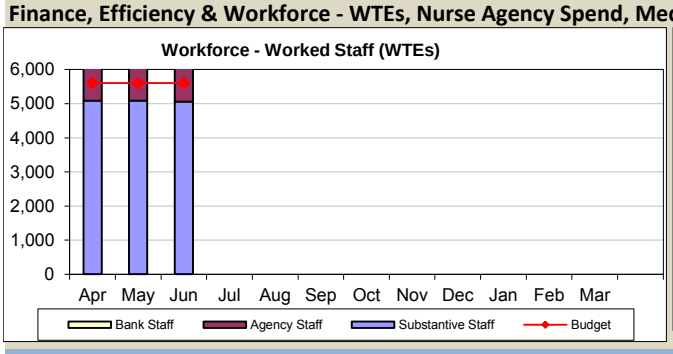
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

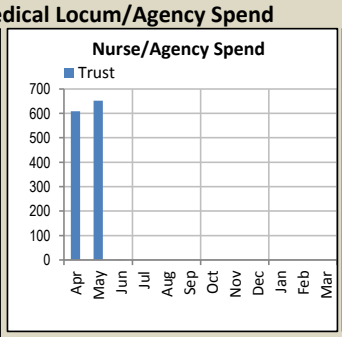


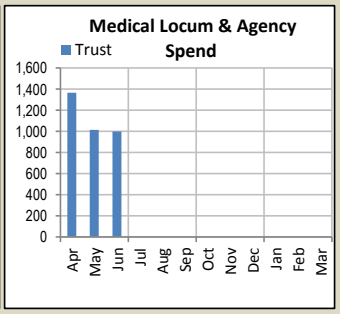




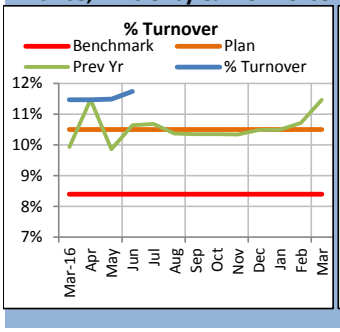
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

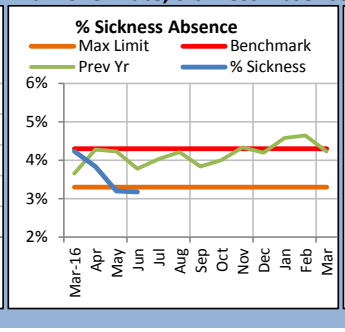


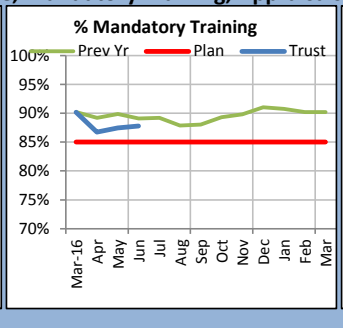


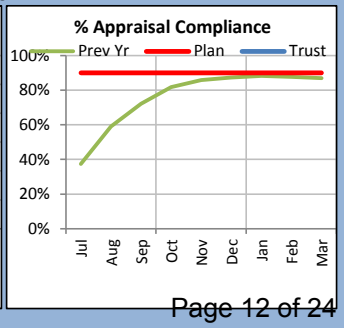


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 3
2017/18

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for June 2017

1.Executive Summary

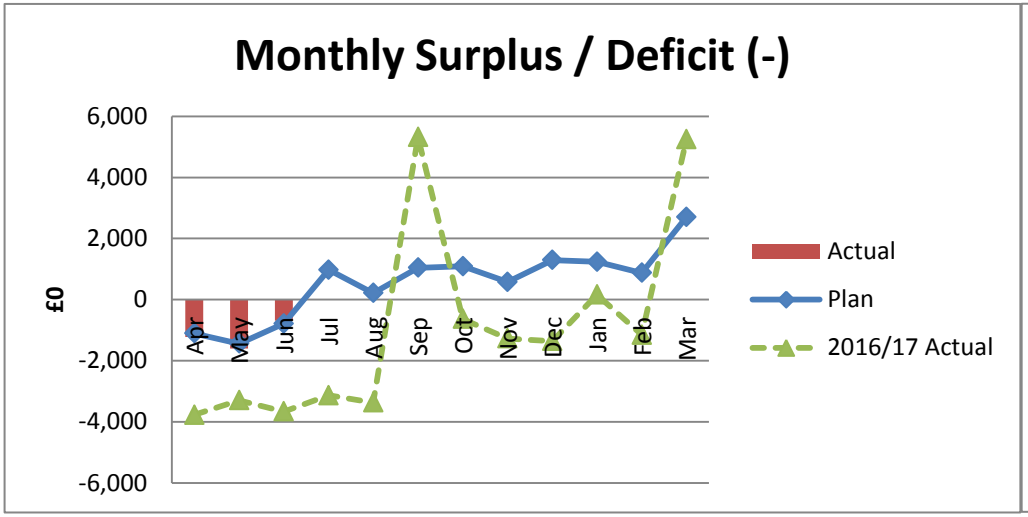
1a. Executive Summary June 2017

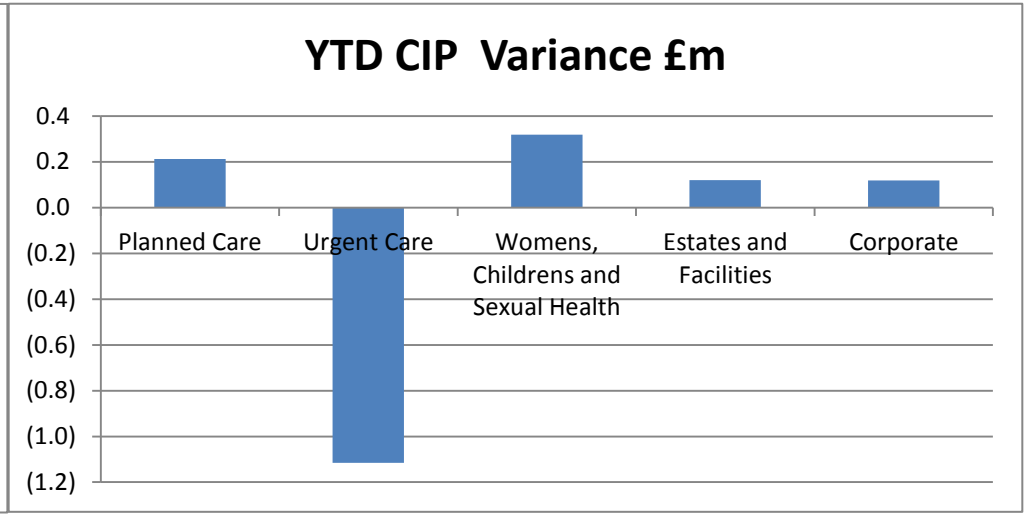
Key Variances £m

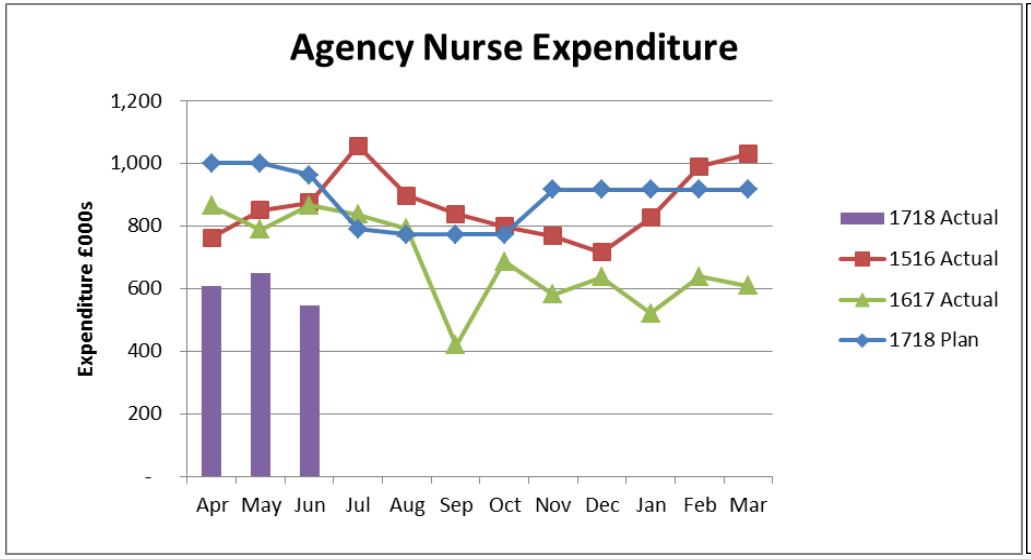
	June	YTD		Headlines
Total Surplus (+) / Deficit (-)	**0.1**	**(0.2)**	**Adverse**	The Trusts deficit including STF was £0.7m in June which was £0.1m favourable to plan. This was due to a YTD adjustment relating to STF income relating to A&E GP streaming. The Trust was breakeven to the pre STF plan. The Trust is £0.2m adverse YTD to plan, £0.3m relating to STF slippage (A&E 4 hour wait) partly offset by £0.1m surplus to the pre STF control target.
Clinical Income	**(0.2)**	**(0.8)**	**Favourable**	Clinical Income was £0.2m adverse in the month, which included a reduction adjustment of £0.8m for the impact of the aligned incentive contract, leaving a £0.8m positive adjustment year to date. The key adverse variances in May were Elective & Day Cases (£0.4m), Regular Attenders (£0.2m) offset by favourable variances within Non-Electives (£0.4m).
Other Operating Income	**(0.1)**	**1.8**	**Favourable**	Other Operating Income £0.1m favourable in the month, £0.3m favourable relating to STP costs (offset by additional costs), £0.2m adverse variance relating to private patient income and £0.1m adverse within Sexual Health due to a YTD adjustment to reflect the latest contract value for 1718.
Pay	**0.2**	**0.8**	**Favourable**	Pay was £0.2m favourable in the month, Medical staffing overspent by £0.1m mainly within T&O (£50k adverse), Nursing underspent by £0.2m in the month which was due to the release of £150k 2016/17 agency accrual which was a non recurrent benefit in month to the position. Scientific and Technical staff continue to underspend against budget (£50k in month, £217k YTD). The main directorates that are underspent are Specialist Medicine (mainly Therapy staff) £357k YTD favourable and the Cancer Directorate (£185k favourable)
Non Pay	**(0.2)**	**(3.1)**	**Adverse**	Non Pay was overspent by £0.2m in June, £0.6m adverse relating to pass through costs for STP (£0.3m) and Drugs (£0.3m) which is offset by additional income. There was an in month benefit of £0.2m linked to the release of 16/17 accruals (£0.1m birthing unit and £0.1m Gas) and a £0.1m YTD ICT COIN subsidy benefit.
Elective IP	**(0.2)**	**(1.1)**	**Adverse**	Elective Income was £0.4m adverse to plan in June, the Aligned Incentive contract adjustment relating to Elective activity was £0.4m therefore a zero net impact in the month. The continued pressure on Emergency Pathways together with the reduction in outsourced activity are key contributing factors towards this.
Sustainability and Transformation Fund	**0.1**	**(0.3)**	**Adverse**	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards A&E access targets, this is split 15% towards A&E 4 hour waiting times and 15% towards A&E front door streaming. The trust achieved the financial target in quarter 1 (£1,174k) but missed the A&E 4 hour wait for quarter 1 (although achieved June performance), income of £252k has been included relating to A&E streaming. This is on the basis that the Trust will receive sign off by the NHSI regional director (at the time of writing this has not yet been confirmed).
CIP / FRP	**0.0**	**(0.3)**	**Adverse**	The Trust achieved £1.4m savings in June which was £0.4m more than May and on plan. YTD the Trust is £0.3m adverse to plan and has delivered £3.4m savings YTD

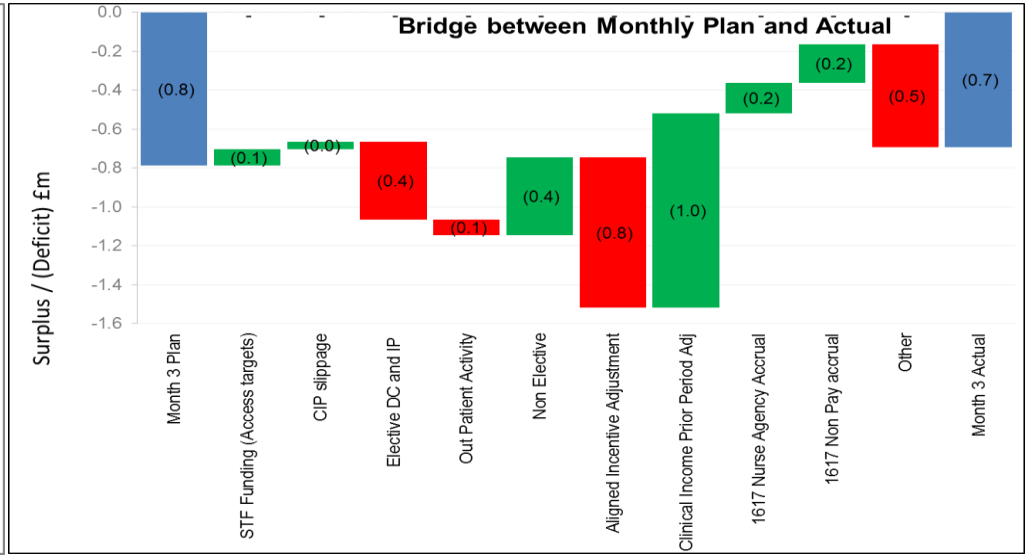
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's June 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

Income & Expenditure June 2017/18

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	28.8	29.0	(0.2)	85.2	86.0	(0.8)	337.9	339.9	(2.0)
	STF	0.6	0.6	0.1	1.4	1.7	(0.3)	11.2	11.2	(0.0)
	High Cost Drugs	3.5	3.2	0.3	10.8	9.7	1.2	43.3	42.0	1.3
	Other Operating Income	3.5	3.6	(0.1)	12.7	10.9	1.8	52.7	43.6	9.1
	Total Revenue	36.5	36.4	0.1	110.2	108.3	1.9	445.1	436.7	8.4
Expenditure										
	Substantive	(18.1)	(18.3)	0.2	(54.0)	(55.0)	1.0	(217.4)	(215.3)	(2.1)
	Bank	(0.9)	(0.6)	(0.3)	(2.7)	(1.8)	(0.9)	(10.2)	(6.1)	(4.1)
	Locum	(1.0)	(0.9)	(0.1)	(3.4)	(2.8)	(0.6)	(13.9)	(10.2)	(3.7)
	Agency	(0.8)	(1.2)	0.4	(2.5)	(3.8)	1.3	(9.8)	(13.4)	3.6
	Pay Reserves	(0.2)	(0.3)	0.0	(0.7)	(0.8)	0.0	7.9	(3.0)	10.9
	Total Pay	(21.1)	(21.3)	0.2	(63.3)	(64.2)	0.8	(243.5)	(248.1)	4.6
	Drugs & Medical Gases	(4.6)	(4.3)	(0.3)	(13.4)	(12.9)	(0.5)	(53.6)	(50.9)	(2.7)
	Blood	(0.2)	(0.2)	(0.0)	(0.7)	(0.6)	(0.0)	(2.6)	(2.5)	(0.2)
	Supplies & Services - Clinical	(2.7)	(2.3)	(0.4)	(8.0)	(6.9)	(1.1)	(31.2)	(23.7)	(7.5)
	Supplies & Services - General	(0.5)	(0.4)	(0.1)	(1.5)	(1.3)	(0.2)	(5.7)	(5.1)	(0.6)
	Services from Other NHS Bodies	(0.6)	(0.6)	(0.0)	(2.1)	(1.9)	(0.2)	(7.9)	(7.6)	(0.4)
	Purchase of Healthcare from Non-NHS	(0.2)	(0.9)	0.7	(1.2)	(2.7)	1.5	(4.3)	(7.9)	3.6
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(5.1)	(5.1)	(0.0)	(20.6)	(20.6)	(0.0)
	Establishment	(0.3)	(0.3)	(0.0)	(0.9)	(0.9)	0.1	(3.6)	(3.7)	0.1
	Premises	(1.6)	(1.9)	0.3	(6.0)	(5.6)	(0.4)	(22.9)	(21.5)	(1.3)
	Transport	(0.1)	(0.1)	(0.0)	(0.3)	(0.4)	0.0	(1.1)	(1.4)	0.3
	Other Non-Pay Costs	(0.7)	(0.4)	(0.3)	(3.3)	(1.2)	(2.1)	(14.6)	(4.9)	(9.7)
	Non-Pay Reserves	(0.1)	(0.1)	(0.0)	(0.3)	(0.1)	(0.2)	4.2	(0.8)	5.0
	Total Non Pay	(13.5)	(13.3)	(0.2)	(42.8)	(39.7)	(3.1)	(163.8)	(150.5)	(13.3)
	Total Expenditure	(34.6)	(34.6)	0.0	(106.1)	(103.9)	(2.2)	(407.4)	(398.6)	(8.8)
EBITDA	**EBITDA**	1.9	1.8	0.1	4.1	4.4	(0.3)	37.7	38.1	(0.4)
		0.0	*0.0*	*0.0*	*3.7%*	*4.0%*	*-15.3%*	*8.5%*	*8.7%*	*-4%*
Other Finance Costs										
	Depreciation	(1.2)	(1.2)	(0.0)	(3.6)	(3.6)	(0.0)	(14.7)	(14.8)	0.1
	Interest	(0.1)	(0.1)	(0.0)	(0.3)	(0.3)	0.0	(1.3)	(1.3)	(0.0)
	Dividend	(0.1)	(0.1)	0.0	(0.4)	(0.4)	0.0	(1.4)	(1.5)	0.1
	PFI and Impairments	(1.2)	(1.2)	0.0	(3.5)	(3.5)	0.0	(14.9)	(14.9)	0.0
	Total Finance Costs	(2.6)	(2.6)	(0.0)	(7.7)	(7.7)	(0.0)	(32.2)	(32.4)	0.2
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(0.7)	(0.8)	0.1	(3.6)	(3.3)	(0.3)	5.5	5.7	(0.1)
Technical Adjustments	**Technical Adjustments**	0.0	(0.0)	0.0	0.1	(0.0)	0.1	1.2	1.0	0.2
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(0.7)	(0.8)	0.1	(3.5)	(3.3)	(0.2)	6.7	6.7	0.0
	Surplus/ Deficit (-) to B/E Duty Excl STF	(1.3)	(1.3)	0.0	(4.9)	(5.0)	0.1	(4.5)	(4.5)	0.0

Commentary

The Trusts deficit including STF was £0.7m in June which was £0.1m favourable to plan due to £0.1m YTD adjustment for A&E GP streaming . The Trust was breakeven to the pre STF plan. The Trust is £0.2m adverse YTDto plan, £0.3m relating to STF slippage (A&E 4 hour wait) partly offset by £0.1m surplus to the pre STF control target.

Clinical Income was £0.2m adverse in the month, which included a reduction adjustment of £0.8m for the impact of the aligned incentive contract, leaving a £0.8m positive adjustment year to date. The key adverse variances in May were Elective & Day Cases (£0.4m), Regular Attenders (£0.2m) offset by favourable variances within Non-Electives (£0.4m).

STF £0.1m favourable in month due to a YTD adjustment relating to A&E streaming (£0.25m) and £0.3m adverse YTD due to non achievement in quarter 1 of A&E 4 hour waiting time, although the Trust did achieve the target for June the STF funding is based on quarterly performance. It should be noted at the time of writing the Trust has not received confirmation regarding the £251k relating to A&E streaming.

Other Operating Income £0.1m adverse in the month, £0.3m favourable relating to STP costs (offset by additional costs), £0.2m adverse variance relating to private patient income and £0.1m adverse within Sexual Health due to a YTD adjustment to reflect the latest contract value for 1718.

Pay was £0.2m favourable in the month, Medical staffing overspent by £0.1m mainly within T&O (£50k adverse), Nursing underspent by £0.2m in the month which was due to the release of £150k 2016/17 agency accrual which was a non recurrent benefit in month. Scientific and Technical staff continue to underspend against budget (£50k in month, £217k YTD), the main directorates are Specialist Medicine (mainly Therapy staff) £357k YTD favourable and Cancer Directorate (£185k favourable)

Non Pay was overspent by £0.2m in June, £0.6m adverse relating to pass through costs for STP (£0.3m) and Drugs (£0.3m) which is offset by additional income. There was an in month benefit of £0.2m relating to 16/17 accruals (£0.1m birthing unit and £0.1m Gas) and a £0.1m YTD ICT COIN subsidy benefit.

The trust is forecasting to deliver the planned pre STF deficit of £4.5m.

3. Expenditure Analysis

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Change between Months
Revenue	Clinical Income	27.8	27.2	27.2	31.4	27.9	28.0	27.5	26.9	26.4	28.7	28.5	28.0	28.8	0.8
	STF				2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	0.4	0.6	0.3
	High Cost Drugs	3.5	3.1	3.3	3.5	3.5	3.4	4.4	3.7	3.3	3.6	3.3	3.9	3.5	(0.3)
	Other Operating Income	3.6	4.0	3.6	1.0	4.0	3.9	3.9	4.5	3.9	8.4	4.7	4.6	3.5	(1.1)
	Total Revenue	**34.8**	**34.2**	**34.1**	**38.6**	**36.2**	**36.1**	**36.3**	**35.1**	**33.5**	**41.5**	**37.0**	**36.8**	**36.5**	**(0.4)**
Expenditure	Substantive	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(18.1)	(0.1)
	Bank	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	(0.9)	(0.0)
	Locum	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	(1.0)	(0.0)
	Agency	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	(0.8)	0.0
	Pay Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	(0.2)	0.0
	Total Pay	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	(21.1)	(0.1)
Non-Pay	Drugs & Medical Gases	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(4.6)	(0.1)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(2.7)	0.1
	Supplies & Services - General	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.5)	0.0
	Services from Other NHS Bodies	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	(0.6)	0.0
	Purchase of Healthcare from Non-NHS	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	0.3
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(1.7)	0.0
	Establishment	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.1)
	Premises	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(1.6)	0.7
	Transport	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	(0.7)	0.4
	Non-Pay Reserves	(0.4)	(0.4)	(0.4)	0.4	0.0	0.0	0.0	0.0	0.0	1.3	(0.1)	(0.1)	(0.1)	0.0
	Total Non Pay	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(13.5)	1.4
	Total Expenditure	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(34.6)	1.3
EBITDA	EBITDA	(0.8)	(0.4)	(0.5)	5.5	2.2	1.6	1.2	0.8	0.3	7.8	1.3	0.9	1.9	0.9
		-2%	*-1%*	*-1%*	*14%*	*6%*	*4%*	*3%*	*2%*	*1%*	*19%*	*4%*	*2%*	*5%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
		(2.8)	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.6)**	**(0.0)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(3.7)	(3.2)	(3.3)	2.6	(0.6)	(1.3)	(1.2)	0.1	(42.4)	5.4	(1.3)	(1.6)	(0.7)	0.9
Technical Adjustments	Technical Adjustments	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(3.6)	(3.1)	(3.3)	2.7	(0.5)	(1.2)	(1.3)	0.3	(2.0)	5.3	(1.2)	(1.6)	(0.7)	0.9
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(3.6)	(3.1)	(3.3)	(0.0)	(1.4)	(1.9)	(1.9)	0.3	(2.0)	4.5	(1.6)	(2.0)	(1.3)	0.7

Maidstone and Tunbridge Wells NHS Trust

4. Cost Improvement Programme

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.1	0.1	(0.0)
Critical Care	0.1	0.1	(0.0)
Diagnostics	0.1	0.1	(0.0)
Head and Neck	0.1	0.0	0.0
Surgery	0.1	0.1	0.0
Trauma and Orthopaedics	0.5	0.3	0.2
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**0.8**	**0.7**	**0.1**
Urgent Care	**0.1**	**0.5**	**(0.4)**
Womens, Childrens and Sexual Health	**0.2**	**0.1**	**0.2**
Estates and Facilities	**0.1**	**0.0**	**0.1**
Corporate	**0.1**	**0.1**	**0.1**
Total	**1.4**	**1.4**	**0.0**

Comment

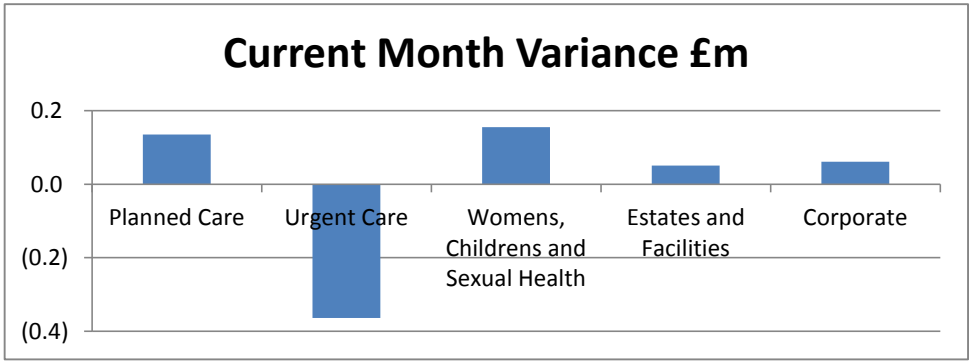
The Trust achieved £1.4m savings in June which was in line with the plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in June were £0.4m below plan.

Planned Care: £112k favourable compared to original CIP planned phasing, however £112k adverse in June when compared to the 'live' plan. The main areas of slippage relate to Diagnostics (£104k adverse), delay in procurement savings (£70k) and Cancer £32k adverse due to £17k of slippage relating to charging for private MDM appointments and £17k relating to 10% non pay saving (£15k).

Urgent Care: £0.4m adverse compared to the original plan however when compared to the 'live' plan the directorate are £282k adverse in the month which is mainly due to slippage in closing 1 ward (£0.2m), procurement (£67k) and drugs (£40k).

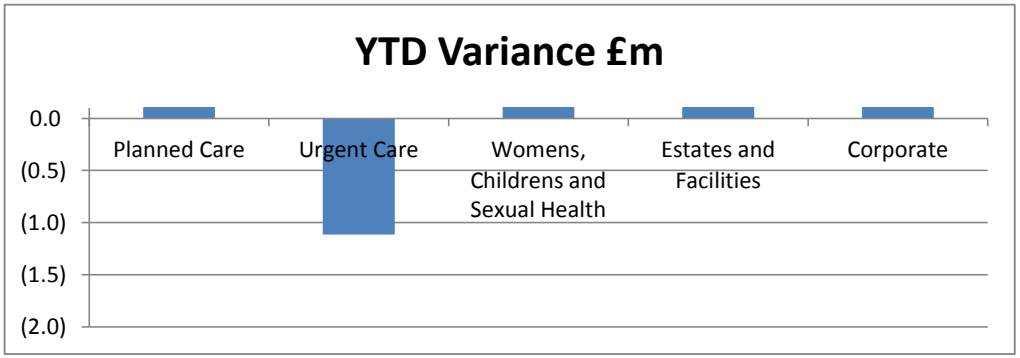
Womens, Childrens and Sexual Health: £0.2m favourable compared to the original plan however when compared to the 'live' plan the directorate were £19k favourable.



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.2	0.3	(0.1)
Critical Care	0.3	0.3	(0.0)
Diagnostics	0.2	0.2	(0.0)
Head and Neck	0.2	0.1	0.0
Surgery	0.2	0.2	0.0
Trauma and Orthopaedics	1.2	0.8	0.3
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**2.2**	**2.0**	**0.2**
Urgent Care	**0.3**	**1.4**	**(1.1)**
Womens, Childrens and Sexual Health	**0.5**	**0.1**	**0.3**
Estates and Facilities	**0.2**	**0.0**	**0.1**
Corporate	**0.3**	**0.2**	**0.1**
Total	**3.4**	**3.8**	**(0.3)**



Comment

The Trust has achieved £3.4m savings YTD which is £0.3m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved YTD were £0.8m below plan.

Planned Care: £0.2m favourable compared to original CIP planned phasing, however £0.4m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£290k adverse) which is due to procurement 10% savings target £210k and £40k delay in implementation of the new MLS contract. Cancer directorate (£114k adverse) due to procurement schemes slipping (£57k) and a delay on charging for private MDM appointments (£34k).

Urgent Care: £1.1m adverse compared to the original plan however when compared to the 'live' plan the directorate are £347k adverse YTD. This is due to £200k slippage relating to delay in closing 1 ward, £132k slippage in procurement savings and £40k slippage in drug savings.

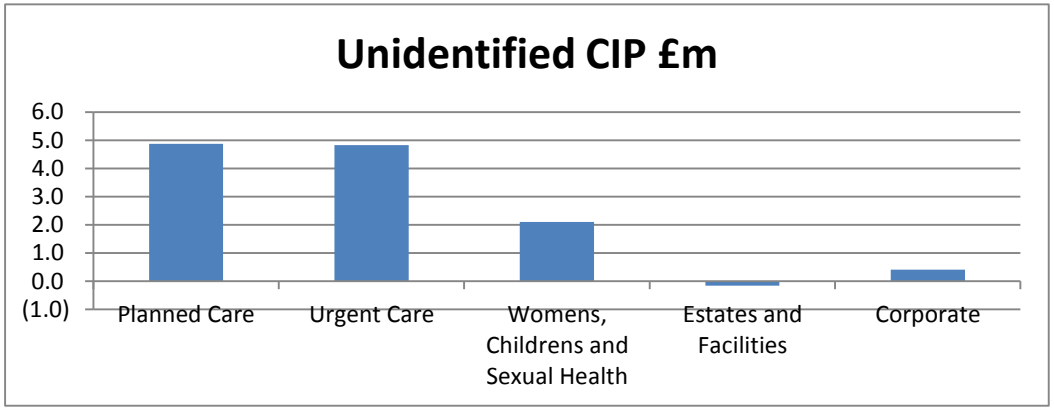
Womens, Childrens and Sexual Health: £0.3m favourable compared to the original plan however when compared to the 'live' plan the directorate are on plan and have achieved £467k savings YTD.

Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	*Unidentified (Risk Adjusted)*	*Plan*	*% Unidentified*
	£m	£m	£m	
Cancer and Haematology	1.1	0.9	2.0	44%
Critical Care	1.2	1.0	2.2	44%
Diagnostics	1.2	0.9	2.2	43%
Head and Neck	0.8	0.2	1.0	19%
Surgery	1.0	0.8	1.8	44%
Trauma and Orthopaedics	4.0	1.1	5.1	22%
Patient Admin	0.1	0.0	0.1	45%
Private Patients Unit	0.2	(0.0)	0.2	-9%
Total Planned Care	**9.6**	**4.9**	**14.5**	**34%**
Urgent Care	**4.1**	**4.8**	**8.9**	**54%**
Womens, Childrens and Sexual Health	**1.5**	**2.1**	**3.7**	**58%**
Estates and Facilities	**3.0**	**(0.2)**	**2.9**	**-6%**
Corporate	**1.5**	**0.4**	**1.9**	**22%**
Total	**19.7**	**12.1**	**31.7**	38%



The Trust has a £31.7m CIP plan for 2017/18 and has identified £27.4m (non risk adjusted) , £4.3m unidentified. The current forecasted risk adjusted identified savings is £19.7m, a shortfall of £12m.

Planned Care Division have identified £12.9m savings which is risk adjusted to deliver £9.6m. The division has £4.9m risk adjusted shortfall (34%).

Urgent Care Division have identified £7.8m savings which is risk adjusted to deliver £4.1m. The division has £4.8m risk adjusted shortfall (54%).

W&CH Division have identified £1.5m savings which t is forecasted to deliver in full. The division has £2.1m risk adjusted shortfall (58%).

5. Balance Sheet

5a. Balance Sheet

June 2017

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

	June			May	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	277.1	275.7	1.4	278.2	282.1	282.1
Intangibles	3.0	2.8	0.2	3.0	2.1	2.1
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.6	1.2	0.4	1.5	1.2	1.2
Total Non-Current Assets	**281.7**	**279.7**	**2.0**	**282.7**	**285.4**	**285.4**
Current Assets						
Inventory (Stock)	7.4	8.3	(0.9)	7.3	8.3	8.3
Receivables (Debtors) - NHS	42.0	28.0	14.0	37.6	21.0	21.0
Receivables (Debtors) - Non-NHS	15.9	9.5	6.5	16.2	9.5	9.5
Cash	4.9	7.4	(2.5)	7.8	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**72.0**	**53.1**	**18.9**	**70.7**	**39.8**	**39.8**
Current Liabilities						
Payables (Creditors) - NHS	(4.2)	(4.5)	0.3	(4.2)	(4.5)	(4.5)
Payables (Creditors) - Non-NHS	(70.6)	(37.3)	(33.3)	(69.1)	(13.6)	(13.6)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(19.1)	(19.1)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.5)	(5.5)
Provisions for Liabilities and Charges	(1.8)	(1.1)	(0.7)	(1.8)	(1.3)	(1.3)
Total Current Liabilities	**(83.7)**	**(50.0)**	**(33.7)**	**(82.4)**	**(44.0)**	**(44.0)**
Net Current Assets	(11.8)	3.1	(14.9)	(11.7)	(4.2)	(4.2)
Finance Lease - Non- Current	(196.8)	(197.4)	0.5	(197.3)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(12.3)	(12.3)	0.0	(12.3)	(10.2)	(10.2)
Interim Revolving Working Capital Facility	(29.0)	(29.0)	0.0	(29.0)	(16.1)	(16.1)
Provisions for Liabilities and Charges	(1.2)	(0.6)	(0.6)	(1.2)	(0.4)	(0.4)
Total Assets Employed	**30.4**	**43.4**	**(13.0)**	**31.2**	**61.8**	**61.8**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(205.0)	(0.0)	(205.0)	(208.6)	(208.6)
Revaluation reserve	(30.3)	(30.3)	0.0	(30.3)	(36.2)	(36.2)
Retained Earnings Reserve	204.8	191.9	12.9	204.1	182.9	182.9
Total Capital & Reserves	**(30.4)**	**(43.4)**	**12.9**	**(31.2)**	**(61.8)**	**(61.8)**

Commentary:
The balance sheet is £13m or 30% less than plan, primarily due to significant variations in current assets and current liabilities. Key movements to June are in working capital where receivables increase by 54.8% and payables increased by 78.9% over plan. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets (PPE) - The value of PPE has decreased from the May's position as assets are depreciated. The in-year capital programme has been prioritised and business cases are currently being prepared.

Current Assets - Inventory has increased slightly from the reported May's position, mainly due to increase in pharmacy stock from £3.1m to £3.3m. Materials management stock remains at £1m, whilst cardiology stocks decreased from £1.0m to £0.8m. Inventory reduction is a cash management strategy.

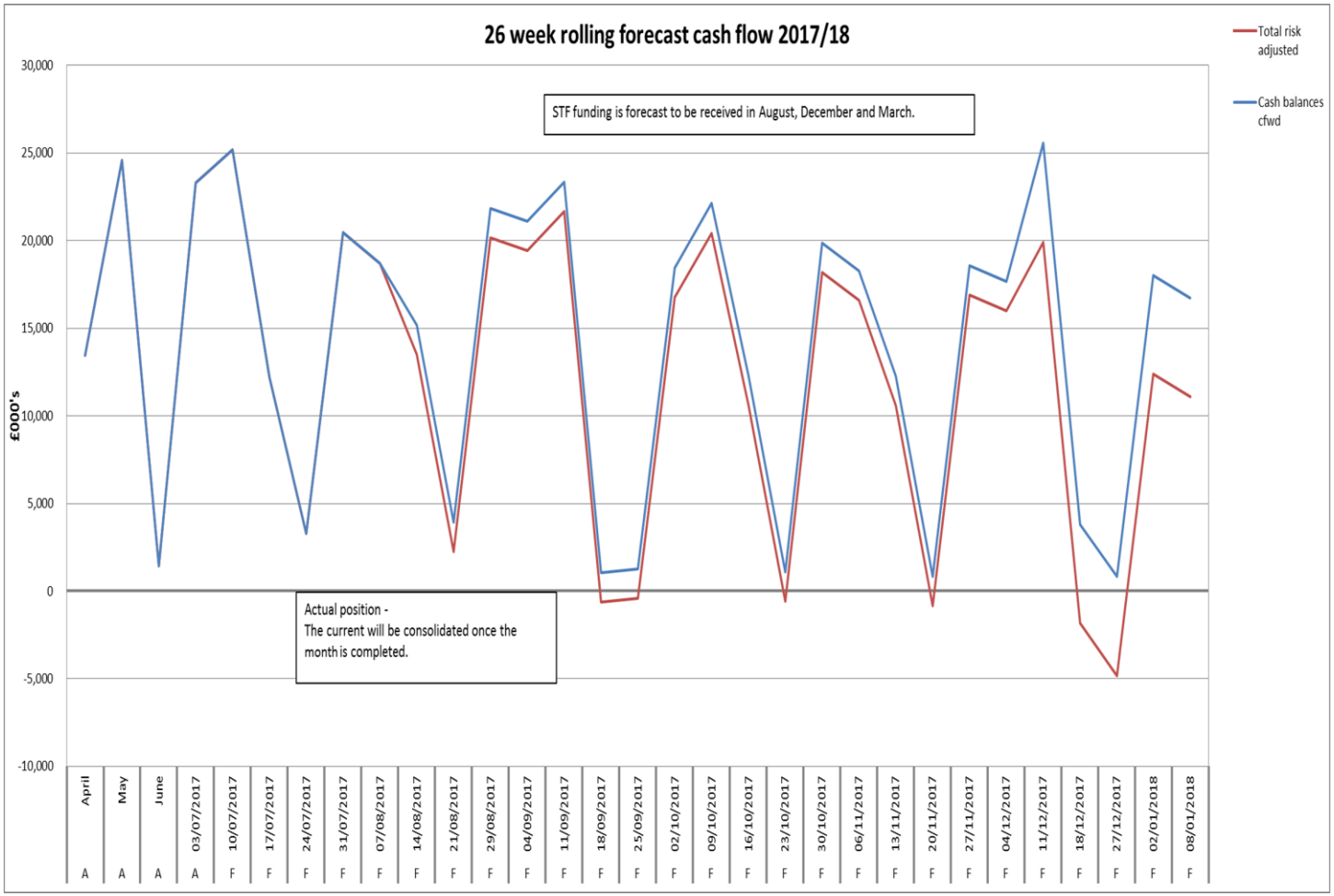
NHS Receivables has increased by £4.4m over the May reported position, remaining significantly higher than the plan value. Of the £42m balance, £19.4m relates to invoiced debt of which £6.6m is aged debt over 90 days. Debt over 90 days has increased by £2.8m compared with the May reported position. The remaining £22.6m relates to accrued income. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned.

Trade receivables has decreased slightly compared with the May reported position, and is above plan by £6.5m. Included within this balance is trade invoiced debt of £2.5m which has reduced by £400k compared to May and private patient invoiced debt of £0.6m which has remained consistent with the May position.

Current Liabilities - NHS payables has remained consistent with the May reported position and the plan of £4.5m. Non-NHS trade payables has increased since May by £1.5m, although remaining significantly above plan of £37.3m.

Of the £74.8m creditor balances, £22.8m relates to invoices, £28.7m is deferred income primarily relating to double block from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA. The remaining £23.3m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

5b. | Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving a double block from West Kent CCG, High Weald CCG and Medway CCG.

For 17/18 the Trust is assuming no receipt of external Revenue financing, compared to 2016/17 where the Trust received £12.1m IRWCF.

The risk adjusted items on the graph relate to STF funding for qtrs 1,2 and 3, along with £1.7m asset sales forecast for receipt in December. If this income is not received these will be mitigated by proposed strategies.

The other two risk adjusted items relate to capital funding for 2 linacs £3.6m and capital loan of £4m, these are mitigated by reducing the in year capital spend.

The cash flow is based on the Income and Expenditure plan along with working capital adjustments.

6. Capital

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	74	2,273	2,199	8,873	8,873	0
ICT	136	580	444	1,664	1,664	0
Equipment	36	1,117	1,081	5,909	5,909	1
PFI Lifecycle (IFRIC 12)	0	0	0	502	502	0
Donated Assets	0	150	150	450	450	0
Total	**247**	**4,120**	**3,873**	**17,398**	**17,398**	**1**
Less donated assets	0	-150	-150	-450	-450	0
Asset Sales (net book value)	0	0	0	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**247**	**3,970**	**3,723**	**15,221**	**15,221**	**1**

The Trust has an approved Capital Plan of £17.4m, which is made up by Capital resources of £14.8m depreciation; the Net Book Value of £1.7m for the proposed asset sales (Springs and Hillcroft properties); an estimate of donated assets of £0.45m; requested Central PDC funding for 2 Linacs of £3.6m ; and a proposed Salix loan of £4m for the Energy Infrastructure programme; less £7.7m of existing capital loan repayments.

The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by Estates Department. A major scheme for the Energy Infrastructure will be dependent on the successful application for a Salix loan. The ICT schemes have been prioritised and agreed with the Execs in May, the PAS replacement project is ongoing. The list of equipment schemes has been approved by the Execs. Build work on Linac 1 bunker at Maidstone started in mid May, delivery of the Linac on site is due Jul/Aug, commissioning the equipment will start ready for clinical use by Dec17.

The additional PDC funding for the next 2 linacs is planned for the last quarter of the financial year, however the equipment will be put into storage until ready for delivery to the Trust in 18/19. The donated equipment is mainly made up of the remaining Cardiology legacies.

Trust Board meeting - July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-11 Staffing: 6 monthly review of ward and non-ward areas — Chief Nurse

The attached paper provides an update on the strategic nurse staffing review undertaken in October 2016, along with the background context to setting and reviewing nurse staffing.

This review focused on the main in-patient areas, using the methodology described by the National Quality Board (NQB) and the National Institute for Health and Care Excellence (NICE).

The paper provides an overview of the methodology used and the underpinning principles, including engagement with the Ward Managers and Matrons.

Key highlights from this review would indicate that Ward Managers are confident that the staffing levels agreed and budgeted for are acceptable. However the day to day challenge lies in recruiting and retaining staff to meet the agreed staffing level.

The wards where adjustments made to skill mix following the review in October 2016 were a key focus. Whatman Ward and Ward 20 had a review of their skill mix as part of a service development to establish them as wards caring for patients who are medically fit for discharge (MFFD) but not yet ready to return to their own homes or who have continuing health care needs. This review indicated that whilst the staffing levels appear to be safe, further review is required as the wards become established. There is some concern about the sustainability of supply of appropriate patients and the potential impact on the acuity of the case mix.

In all respects ward care is impacted on by the availability of support services. Areas such as Trauma and Orthopaedics, Stroke and Respiratory medicine have good support from therapies, pharmacy and facilities. However some of the medical wards have shared support or reduced input from these support services which impacts on the available patient care hours. This is particularly evident for the Short Stay Surgery Unit (SSSU) at Tunbridge Wells, where there is often a need to support the site with longer stay patients.

There is a strong focus on recruitment and an increasing focus on the wider issues surrounding retention. For the latter focus is being placed on understanding what the drivers for career progression may be and what initiatives may be put in place to facilitate movement within the trust such as revisiting rotation programmes, and more streamlined processes for internal transfer within and across directorates.

Further reviews are scheduled for key non-ward areas including Women's and Children's services, Emergency Departments and Out-patients.

Which Committees have reviewed the information prior to Board submission?
Quality Committee, 05/07/17

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 NHS
Tunbridge Wells
NHS Trust

Report to: **Quality Committee**

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

Date: **5th July 2017**

Subject: **Ward Staffing Review**

1.0 Introduction:

This paper sets out to inform and update the Committee on staffing levels for in-patient wards. It also provides an update on the strategic staffing review conducted in October 2016.

The paper provides detail on the current staffing position against national recommendations, and makes recommendations to support either current course or to build a case for change.

2.0 National Guidance

As part of a wider response to the Francis Report (2013) the National Quality Board (NQB) published a guide to nursing, midwifery and care staff capacity and capability 'How to ensure the right people, with the right skills, are in the right place at the right time' (2013), which was updated in 2016.

Expectations from this report are, in part, fulfilled by this review. The guidance for setting safe staffing levels with the NQB report have had subsequent endorsement by the National Institute for Health and Care Excellence in their clinical guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (July 2014), and follow up review published in February 2017.

The principles recommended by the NICE clinical guideline have been used to set the terms of reference for the staffing reviews. A key recommendation from NICE is the use of average nursing hours per patient per day; this is based on acuity (the clinical support a patient needs) and dependency (support required for daily living activities such as personal hygiene, eating, drinking). The process for collecting this data is currently under review as part of the wider electronic roster implementation programme. For this review, data from the previous Shelford tool where available was considered.

There is also a requirement to review 'red flags' as part of the staffing review. Currently this based on Datix reports and anecdotal evidence. The current implementation of the electronic roster system will enable a more robust and 'real time' reporting system to be established as part of the Safe Staffing module.

Red Flags include delays in administration of drugs or delays in undertaking planned clinical observations as a result of insufficient staff.
The approach for using average hours per patient day is also supported by the Carter Review, with the use of Care Hours Per Patient Day (CHPPD) as an average over the 24 hour period.

The NQB require Trusts to report safe staffing levels to the national data repository (UNIFY) and to the Trust board on a monthly basis. Reports to the Board also include CHPPD. The fill rates for safe staffing are also triangulated monthly with patient feedback (Friends & Family Test scores) and nurse sensitive indicators, specifically the incidence of hospital acquired pressure ulcers and falls, and are published on the trust website.

3.0 Ratios:

3.1 Registered to Un-registered ratios

There is a body of evidence to support the national bench mark of a ratio of Registered to Un-registered nurses of 60/40.

The Royal College of Nursing has always maintained the ideal ratio should be 65/35. A large scale study led by Dr Linda Aitkin published early in 2014 supported the overall view that a ratio of between 60 – 65% of the direct care should be undertaken by Registered Nurses. The evidence also suggests that if 60% of the registered nursing workforce is educated to degree level this has a direct correlation to patient outcomes including early detection of deterioration and a reduction in mortality. The limit to this study is that the sample group relates only to surgical wards.

Maidstone and Tunbridge Wells NHS Trust (MTW) in-patient staffing ratios are set at 60/40 in line with the national benchmark.

However more recent guidance from NHS England suggests that for some specialties this may be altered provided other nurse sensitive indicators are used to triangulate impact. Areas where this approach may be considered include wards where the primary case mix is made up of patients who are medically fit for discharge (MFFD) or where there is greater level of need for the fundamental aspects of care such as personal hygiene and feeding.
These would include wards such as Ward 20 and Whatman.

3.2 Nurse to patient ratios

The body of evidence cited previously indicates that optimum care can be delivered with a nurse to patient ratio of between 1:5 and 1:8; the majority of wards within the Trust run at these ratios. Exceptions are changes to acuity or when wards are unable to meet their planned quota of staff in any given shift.

Acuity is a particular concern for the respiratory wards, with the increasing number of patients who have a 'ceiling of care' set at non-invasive ventilation (NIV). These patients often do not meet the admission criteria to the main Critical Care Unit or High Dependency Unit. The Respiratory wards have the appropriate skill mix to manage these patients provided the number of patients on NIV does not breach the number for which the establishment was set. With the introduction of a 24 hour critical care outreach service, there has been an increase in the number of referrals to the respiratory wards to support NIV. Currently this need is being met, however the Directorates are monitoring this, and staffing levels will be reviewed earlier if the increase is sustained.

4.0 Methodology

The methodology for the staffing reviews has followed the key recommendations from the NQB and NICE. Two methods were utilised as part of the review, the professional judgement tool and the Safe Staffing Tool.

Additional intelligence was sourced from data relating to patient experience, including local ward satisfaction surveys, friends and family feedback and complaints relating to nursing care.
Patient safety nurse sensitive indicators were also considered. These included the number of facility acquired pressure ulcers, falls and medication errors.
There is strong reliability for pressure ulcer and falls incidence, however it is acknowledged that there is under reporting of incidents related to medication errors. This is forming a specific strand of work in collaboration with pharmacy, patient safety and ward teams. The Trust undertook a small scale implementation of the Medicines Safety Thermometer last year, and is now planning to roll this out trust-wide by having a rolling programme of point prevalence audit.

The data set reviewed was for the previous Quarter (i.e. Quarter 4)

The review process was undertaken by the Chief Nurse supported by the Deputy Chief Nurse. Each Ward Manager and their Matron were involved in the review process with the Ward Manager taking an active part in the review process and formation of final recommendations.
This review follows on from the annual strategic staffing review undertaken in October 2016.

5.0 Principles:

A number of key principles for setting staffing levels were already in place. These were reviewed against the recommendations from NQB published last year. Further review against recommendations from NICE were also taken into account, as these were circulated widely as part

of the NICE review. These were largely unchanged when published in July 2014, and support the findings emanating from the NQB and the Royal College of Nursing.

NICE recommend using a decision support tool (Safe Staffing Tool) and informed professional judgement to make the final assessment of requirements.

The key principles utilised are:

- Supervisory time for ward managers to be built into establishments (4 days supervisory and 1 day clinical)
- Number of Band 6's per ward (usually 2 per ward)
- RN to patient ratio (between 1:5 and 1:7)
- RN to Clinical Support Worker ratio (aim for 65/35 split)
- Headroom allowance (to cover leave, sickness, study)
- Practice Educator support and supervision

6.0 Review of progress against recommendations from October 2016.

Following the review undertaken in October 2016 a number of changes were made to the establishments.
Some high level changes were made in particular a reduction in the overall headroom allowance from 23% to 21%.

There was also a reduction in the number of days supervisory time for the Ward Managers with this being reduced from 5 days to 4 days, or in some cases from 4 days to 3 days.

Skill mix was also reviewed and where appropriate (guided by discussions with Ward Managers and triangulation of evidence from nurse sensitive indicators) a switch between Registered Nurse (RN) to Clinical Support Worker (CSW) was made.

The changes were a reduction in RNs on early shifts and night shifts with an increase in CSWs for:

- Chaucer
- Foster Clarke
- Mercer
- Whatman
- John Day
- Ward 2
- Ward 20

This is evidenced in the attached appendix (Appendix 1) and is indicated by a variation of the RN:CSW ratio from the generally accepted standard of 60/40 to range of 45/55 to 55/45.

Impact in these areas has been minimal. It is noted that there has been no significant change in the incidence of hospital acquired pressure damage or complaints related to specifically to nursing care.
Other indicators not referred to here, but reported to the Patient Experience Committee include the average call bell response time which has remained at an average of 3 minutes.

John Day, along with Ward 21 has reported an increase in the demand for non-invasive ventilation requirements following the introduction of a 24 hour critical care outreach service. Both wards have been able to meet this demand by flexing and altering their shift patterns within their existing budgets.

Ward 20 and Whatman ward have a case mix that is primarily patients who are medically fit for discharge and as such have different needs from the average acute hospital in-patient ward.

6.1 Critical Care Outreach Service

The MTW Critical Care Outreach Team (CCOT) was established initially as a five day per week service, extending to firstly weekends and then following the CQC Report in Sept 2014 was finally

extended to a 24 hour service, on both sites in Sept 2015. This has been staffed with one Band 7 nurse on each shift. There has been further investment for a Band 6 developmental rotation post which recruits internally from candidates with suitable acute care skills for a six month rotation. These nurses are generally recruited from the Trusts ITU's and less often from the A&E's.

The prime purpose of the CCOT is to support nursing staff in the care of deteriorating patients on the general wards as well as following up those discharged from ITU and teaching a number of established courses (AIMS, ALS, Mandatory Sepsis, NIV, Tracheostomy) and undertaking ad hoc teaching on the wards. The team also support the Vascular Access nurse with her training, undertake AKI data collection and currently run the F1 and F2 induction days.

Following the staffing review in October 2016, the CCOT were asked to provide an enhanced service at night in response to a perceived increased need following the staffing review. Service investment was provided to enable the recruitment of an additional 2.6 wte at Band 7 to ensure provision of a second CCOT nurse at night on the Tunbridge Wells Hospital site.

This provision of service is proving challenging for the team to provide as their efforts are hampered by the wider challenges facing recruitment of suitably qualified staff.

Challenges for the team with regards to staffing include the heavy burden on night shifts, the requirement to cover Tunbridge Wells with 2 at night, although on many occasions the CCOT workload at Maidstone Hospital is higher. A senior member of the team is mapping this activity with a view to seeking additional support for Maidstone Hospital when needed, whether that be by risk-assessing the 2 sites each evening, or by additional staffing at Maidstone Hospital similar to that at Tunbridge Wells.

Whist these challenges remain, it evident that the close working between the CCOT, Critical Care Units and the Clinical Site Managers, provision of higher level clinical support is being provided as noted by the Ward Managers for the respiratory wards.

7.0 Recommendations for change

There are no significant recommendations for change following this review.

A recommendation for change within existing establishments has been made for a small number of wards to meet the changing needs of the case mix.

An almost universal view of the Ward Managers was that if they could reduce or eliminate their vacancy, their establishments were generally appropriate and safe for their wards.

8.0 Staffing Challenges

The key challenges currently to providing safe staffing relate to pool of staff from which we can recruit.

There a number of national challenges related to changes in regulation of health professionals most notably the introduction of the IELTS assessment for any nurse not educated in the UK. This has had significant impact on the numbers of overseas nurses applying for admission the register.

The trust is taking a proactive approach to recruitment, and is aiming to maximise the opportunities provided by the emerging Sustainability & Transformation Plan (STP). Initiatives include:

- Collaborative/joint tendering for overseas recruitment
- Development of joint appointments
- Development of rotational programs between organisations
- Exploration of emerging recruitment markets (e.g. Ireland)
- Utilisation of emerging roles and apprenticeship schemes to support succession planning
- Exploring options for internal rotation programmes
- Exploring options for streamlining internal transfer of staff

This is in addition to the ‘business as usual’ recruitment activity including ‘one stop shop’ open days and presence at county wide events.

Increasing focus is being placed on initiatives to retain staff, and increased effort is being placed on this. This work has been significantly supported by the Head of Staff Engagement who has provided guidance and support in gaining meaningful and timely staff feedback beyond the national staff surveys and local surveys.

9.0 Limitations of this review:

This review has only considered adult in-patient wards.

Further reviews are in process for women’s’ and children’s’ services and will be reported to the Board separately.

Staffing reviews for the Emergency Department and the Out-patients Department are also scheduled.

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q4)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
Maidstone	AMU	35.54	33.24	2.23	60/40	1;4	3	4	0	1	16%/98%	Vacancy reflects true vacancy, in addition to this there are 3 wte Band 5 RNs due to start. Falls relates to three months. Limit set at 4 per month, limit not breached for 3 months. Nursing complaint relates to wider complaint spanning several depts.	No change to establishment
	Chaucer	41.83	34.14	7.69	48/52	1:8. 1:8. 1:11	2	17	0	0	28%/81%	Falls limit for quarter is 18. Ward has good MDT support. Vacancy minimal and recruitment on hold as ward relocating to Edith Cavel with a reduction in beds.	No change to establishment; however will need re-review in 4 months following relocation to Edith Cavel
	Culpepper/CCU	33.21	27.38	5.83	70/30	1:4 Culp, 1:3 CCU	1	5	2	0	75%/90%	RN:CSW ratio reflects CCU dependency. CCU and med combined (6 CCU beds, 13 medical. No changes in establishment previously. Establishment consistent with case mix unless escalation into Cath Lab recovery.	No change to establishment
	Foster Clark	35.04	23.04	12	55/45	1:7, 1:7, 1:9	0	8	0	0	25%/75%	High reliance on temporary staffing. Ward established as winter escalation and will be closing in July	No change to establishment
	John Day	44.89	34.23	10.66	65/35	1:5, 1:5, 1:6	4	22	15	3	48%/92%	The ward had a reduction in RNs in 2016 at night, there has been an increase in medication errors at night. This may be due to work done around more robust reporting of incidents. The ward team have piloted an additional CSW for early shift from within existing budget with good effect.	No change to establishment.
	Lord North	31.93	29.65	2.28	75/25	1:4, 1:4, 1:6	1	5	0	1	80%/100%	High ratio of RNs to cover chemo regimes. WM is supervisory all week for this reason. RN:CSW ratio	No change to establishment
	Mercer	35.39	33.39	2	55/45	1:6, 1:6, 1:8	1	12	2	2	38%/95%	Falls limit for quarter is 18. Ward has a stable workforce. RN:CSW ratio acceptable for specialty.	No change to establishment
	MSSU	18.63	15.63	3	55/45	1:6, 1:6, 1:9	0	0	1	1	>90% overall	Establishment generally good. Increased activity noted, particularly in relation to additional surgical capacity to allow wider use of in-patient surgical beds.	No change to establishment
	Peale	22.62	20.16	0	60/40	1:4. 1:4, 1:6	0	1	0	0	38%/93%	Ward over-established on Band 5s following review in October'16. This is being resolved through natural movement. Support provided to other wards when required. High RN:Pt ratio reflects high proportion of single rooms.	No change to establishment
	Pye Oliver	38.07	27.27	10.8	50/50	1:7, 1:7, 1:9	0	9	1	0	40%/92%	RN:CSW ratio reflects the client group (gastro) who need help with basic care needs and risk of wandering.	No change to establishment

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q4)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
Tunbridge Wells	Stroke	41.78	32.78	9	70/30	1:5, 1:5, 1:7	0	29	0	0	40%/95%	RN:PT ratio assumes Thrombolysis nurse in numbers. When this role is off the ward ratios increase to 1:6 and 1:9.	No change to establishment
	Whatman	31.7	21.7	10	50/50	1:9, 1:9. 1:9	1	19	0	1	34%/77%	Ward has recently changed specialty (was acute med now MFD). This has resulted in a turnover of staff. Specialty is reflected in the RN:PT ratio and RN:CSW split.	No change to establishment. Review in 3 months
	SSSU	24.5	15	9.5	60/40	1:6, 1:6, 1:12	0	5	1	1	0	RN:Pt ratio based on 24 patients. Unit is frequently escalated into recovery. High reliance on temp staffing which will reduce once vacancy filled. Good medical consultant & physio cover for medical outliers. No support for catering.	No change to establishment
	SAU	20.73	19.86	0.87	75/25	1:4, 1:4, 1:4	1	3	1	2	0	Capacity is 9 bed + 3 assessment bays. Takes GP and A&E referrals. Covers surgical assessment clinic. Over est on Band 5 by 1, support provided to SSSU.	No change to establishment
	2	44.07	30.7	13.37	45/55	1:8, 1:8, 1:10	0	40	1	1	73%/82%	Falls peaked in Jan. RN:CSW ratio shift following review in October '16. Is outside of accepted practice however need to fill vacancy before final impact of change be assessed.	No change to establishment
	10	41.17	33.58	7.59	60/40	1:5, 1:7, 1:7	1	7	0	0	23%/93%	Ward takes all traumatic head injury so need for enhanced care at night is high. Ward has scope to move a CSW from days to nights to address this.	Division to support the ward to pilot the move of CSW from days to nights.
	11	40.43	32.41	7.85	70/30	1:5, 1:7, 1:7	0	10	0	0	36%/96%	RN:CSW ratio reflects the ward specialty and the high number of 'new' or risky tracheostomy patients.	No change to establishment
	12	40.42	27.42	13	60/40	1:6, 1:6, 1:10	1	30	2	0	16%/92%	Falls have been subject to intensive review with no specific nursing trends identified.	No change to establishment
	20	33.64	27.84	5.8	50/50	1:10, 1:10, 1:10	3	41	0	0	20%/6%	RN/PT ratio reflect MFFD case mix. However, there is some concern voiced that the number of appropriate pts is less therefore acuity is becoming higher than the current establishment would naturally support. Falls been reviewed, with pattern identified at meal times. local working patterns reviewed.	Directorate to monitor case mix and review in 3 months.
	21	43.28	37.28	6	70/30	1:5, 1:6, 1:6	1	16	1	0	10%/100%	RN:CSW ratio reflects acute respiratory care. Potential impact on case mix from introduction of 24hr critical care outreach as referrals for NIV have increased.	No change to establishment
	22	53.48	37.48	16	60/40	1:5, 1:5, 1:6	1	38	1	0	60%/94%	Combined acute stroke and rehab plus 10 medical beds. Falls subject to review with no nursing care trends identified. Good input and support from therapies.	No change to establishment

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q4)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
	30	42.65	28.55	14.1	60/40	1:5, 1:7, 1:7	5	28	1	2	13%/80%	11 bed now ring fenced for elective surgery. Falls rate high, under review, with a number of patients who were repeat falls.	No change to establishment
	31	42.55	24.55	18	60/40	1:5, 1:7, 1:7	4	14	0	0	22%/100%	PDN appointed between ward 30 & 31 to support new staff. Once vacancy filled then WM feels staffing would be appropriate.	No change to establishment
	32	43.91	29.91	14	60/40	1:5, 1:5, 1:9	1	19	0	1	36%/30%	Staffing recently reviewed to reflect change in focus and increase in NHS beds. FFT reflects need to manage	No change to establishment
	33	23	22	1	60/40	1:7, 1:7, 1:7	0	11	0	1	26%/77%	Ratios for RN:Pt reflect the in-patient beds. The staff also cover the EGAU.	No change to establishment

Trust Board meeting - July 2017

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7-12 Safeguarding Children Annual Report 2016/17 Chief Nurse

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

The full report was presented to and discussed by TME and the Quality Committee in July 2017 and covered the period April 2016 – March 2017.

The Executive Lead for Safeguarding Children Adults is the Chief Nurse; this agenda is supported by the Named nurse for safeguarding children.

The report includes a declaration which states the Trust's compliance with section 11 of the Children Act and outlines how these statutory requirements are met.

This report details the structure of the Trust' Safeguarding Children's team in the Trust and outlines governance arrangements internally and externally in terms of committee structures and reporting arrangements.

The report includes a section (3), "What does the Board need to know?", on the basis that this provides the necessary instruction for the Trust Board i.e. above and beyond what individual Executives may be required to do, as part of their mandatory training.

The report provides a number of updates relating to key and pertinent issues relating to safeguarding children. Of note the Trust Child Protection policy has been revised this year and once ratified in July will be updated on the Trust intranet. The revised policy reflects local and National policies.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 05/07/17
- Trust Management Executive, 12/07/17

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

Information & assurance

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

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Safeguarding Children Declaration

Maidstone and Tunbridge Wells NHS Trust is fully committed to ensuring that all patients including children are cared for in a safe, secure and caring environment. The Trust adheres to its statutory duties in line with Section 11 of the Children Act. A number of Safeguarding Children arrangements are in place in order to support this. A section 11 audit was presented to the Kent Safeguarding Children Board in February 2017.

These include:

- Maidstone and Tunbridge Wells NHS Trust meets its statutory requirements in relation to Disclosure and Baring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment.
- The Trust Child Protection policies and systems are up to date and robust and are reviewed on a regular basis, ultimately by the Trust Board. The last policy review occurred in April 2017 and will be ratified on 7th July 2017. Policies and procedures are available to staff through a dedicated safeguarding children intranet site.
- The Trust has a process in place for following up children who are not bought to outpatient appointments within any speciality to ensure their care and health is not affected in any way.
- The Trust has a system in place for flagging children who are subject to a child protection plan. The Trust is working towards the implementation of the national Child Protection Information Sharing System (CP-IS) but no date set as yet.
- All eligible staff are required to undertake relevant Safeguarding Children training and this is regularly reviewed to ensure it is up to date. The Trust has a training strategy in place with regard to delivering safeguarding training.

Safeguarding Professionals

- The Trust has Named Safeguarding Professionals who lead on issues in relation to the safeguarding of children. They are clear about their role, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. This complies with the current Working Together Guidelines (2015)
- The total number of professionals in these roles is 6.4 WTE which includes a Named Nurse Safeguarding Children, 2 x Safeguarding Children Nurses, a Deputy Named Midwife Safeguarding Children and a Peri-Natal Mental Health Nurse; there is also a name Midwife (1.0 WTE), Named Doctor Safeguarding Children and a Named Doctor who leads on Child Death.
- The Chief Nurse is the Executive Director lead for Safeguarding Children.
- The Trust's Safeguarding Children Committee leads and supports all Safeguarding Children activity and ensures that the Trust executes its statutory duties in relation to the safeguarding of children

- The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues. A bi-monthly Safeguarding Children report is presented to the Safeguarding Children committee
- The Trust continues to be an active member of the Local Safeguarding Children Boards (LSCBs). This is through membership and work of the Boards and the sub committees. Any issues related to safeguarding children will be discussed at these Boards each quarter.
- The Trust has an audit programme to provide assurance that safeguarding systems and processes are working. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.
- The Trust continues to review and challenge its arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to any changing guidance and national reviews.

July 2017

Alison Jupp Named Nurse Safeguarding Children

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1.0 – Introduction

The purpose of the annual report is to update the Trust Board on the governance arrangements and progress made in relation to safeguarding children since the last report in 2016. Every Trust Board requires an update at least every year advising of key issues relating to the safeguarding of children and this has been scheduled to go to the July Trust Board Meeting. The Board is reminded that children are defined by the Children Acts as young people up to but not including their 18th birthday.

The Safeguarding Children Team has undergone a period of change since mid-2016 following the appointment of new Named Nurse in October 2016. Currently the team comprises 2 x band 7 Safeguarding Children Nurses, 1 x Band Safeguarding Midwife and 1 x Band 7 Peri-Natal Mental Health Nurse; the team is supported by an admin assistant. The Named Nurse Safeguarding Children provides overall line management to the team.

Our mission is to continue to provide a high quality and accessible Safeguarding Children service to the whole Trust. We expect all staff to meet their statutory responsibilities and comply with best practice guidance. This includes ensuring that the child's welfare is paramount and that the child's safety and welfare is their first concern, as enshrined in the Children Act 1989.

A revised Safeguarding Children Policy and Practice Document was ratified on 7.7.17; this document alongside statutory guidance from the Kent Safeguarding Children Board and HM Government provides the strategic framework for our day to day working.

The Safeguarding Children team continues to 'flag' all children of concern on the Maidstone and Tunbridge Wells NHS Trust IT systems (PAS and Symphony); this system works well.

Our key message is that Safeguarding is everyone's responsibility.

2.0 - Children's Specialist Services

Maidstone and Tunbridge Wells NHS Trust submitted 262 referrals to Children's Specialist Services in the 12 months to 31.3.17. This is an increase on the previous 12 months. We believe that this figure may not be a true reflection of the actual number of referrals. As a team we continue to remind staff to send a copy of any referral to the Safeguarding team. Since 1.4.17 the team has been notified of **64** new referrals. The majority of referrals are made by ED or Paediatric staff with Midwife's being the next group.

As a team the quality of the referrals are reviewed. We provide training on 'how to make a quality referral' and staff are encouraged to get referrals reviewed by Safeguarding prior to submission.

A number of referral s (since January 2017) and subsequent DATIX have resulted in SI's being raised; these include two children who were assaulted by a third party whilst in-patients at Tunbridge Wells Hospital. The investigations are on-going.

The Safeguarding Children team work very closely with Children's Specialist Services; the Named Nurse regularly meets with Children's Specialist Services colleagues in both the Maidstone and Tunbridge Well's areas. These forums provide an excellent opportunity for joint working, information sharing and developing new working relationships. The Named Nurse sits on a number of Local Authority led West Kent multi-disciplinary panels including the Adolescent Risk Management Panel.

The Safeguarding Children Nurses attend Child Protection Conference's for high risk children known to Maidstone and Tunbridge Wells NHS Trust to support staff whose experience in Safeguarding may be limited. The Safeguarding Children Nurses support staff to provide high quality reports for Child Protection Conference's; the Named Nurse will also attend conferences as time permits.

At some stage in late 2017 (date not yet agreed) the Local Authority will revise the process for making Safeguarding Children referrals. The Local Authority will triage all referrals as they are submitted and will decide whether the referral meets the threshold for Early Help, Child in Need or Child Protection. Professionals will be able to challenge any decisions made in this way. The Local Authority is keen to adopt a single referral system to ensure all concerns are treated equitably across the county. Training will be introduced to ensure Maidstone and Tunbridge Wells NHS Trust follows the new processes.

An OFSTED inspection of the Local Authority (Kent County Council) services for vulnerable children was carried out in March 2017. The inspectors reported that the service/care provided was good; this follows on from previous inspections which rated the Local Authority as inadequate (2010) and adequate (2103). Kent County Council have 1176 children subject to a Child Protection Plan and 9193 vulnerable children to look after out of a total population of 370,300 (2016). Learning from this inspection report will be disseminated as and when it is shared.

3.0 - What does the Board need to know?

3.1 - The Children and Social Worker Act 2017[1]

- Received Royal assent on 27.4.17.
- It enacts wide ranging changes to the regulation of the Social Worker profession
- It ensures that all care leavers (previously Looked After Child) have support (from a personal advisor) up until the age of 25 (previously 18) and mandates Local Authority's to provide information on the educational achievement of all Looked After Children in their area.

[1] http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

- It mandates the Secretary of State to establish a Child Safeguarding Review Panel (CSRP), the function of which is to '*identify serious child safeguarding cases in England which raise issues that are complex or of national importance*.' It will address Safeguarding issues at an overarching national level as currently the local Safeguarding Children Boards only focus on local issues. The CSRP will also have authority to review these serious cases as appropriate complimenting the current duty of the Children's Commissioner to also review such cases.
- The Child Death process will be strengthened to recognise the importance of analysis which identifies matters concerning a death, or deaths, *"relevant to the welfare of children in the area or to public health and safety"*; requiring the partners to consider whether change is needed; and requiring review and follow-up on how effective the arrangements have been.

3.2 - NHSE Guidance on Learning from Deaths[2]

This guidance published in 2017 follows on from the Mid-Staffs enquiry and the CQC report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' (2016)[3]. It has been recognised that learning from deaths is not being given sufficient priority and as a consequent of this valuable opportunities for improvement were being lost.

This guidance places certain duties on all Trusts in relation to deaths (which includes the death of a child under its management or care). It mandates that each Trust should publish an updated policy by September 2017 on how it responds to, and learns from, the deaths of patients who die under its management and care. Case record reviews should also be carried out and each Trust must ensure it has robust processes for managing and reviewing all deaths. Where a child dies at Maidstone and Tunbridge Wells NHS Trust we follow the national guidance for Child Death (contained in the current Working Together Guidelines 2015[4]) and link in with the Kent Child Death Overview Process (CDOP). We have a named Doctor for Child Death (Dr Kala Pathy); the Named Nurse (Alison Jupp) is also involved whenever a child dies at Maidstone and Tunbridge Wells NHS Trust. We raise a DATIX for every child death but not all of these will reach the threshold for a SI investigation. Our current Safeguarding Policy and Practice Document details the processes to follow when a child dies. New national guidance will be produced in late 2017. The Wood Review (2016)[5] has also made recommendations regarding the investigations of child death to ensure that learning is disseminated.

From April 2017 From April 2017 Maidstone and Tunbridge Wells NHS Trust Trusts will be required to collect and publish on quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to

[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

[3] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
[4] http://www.workingtogetheronline.co.uk/chapters/chapter_five.html
[5] https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards

set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). The quarterly mortality report produced by the Paediatric Matron informs the Trust mortality report which is discussed at board level.

Kent is a very safe place for a child to live. Since 1.1.2017 the Named Nurse has been notified of 18 child deaths in the West Kent area. Not all of these children were seen (or were known) at Maidstone and Tunbridge Wells NHS Trust. The total for 2016 was 23.

The Paediatric Matron and Named Nurse will produce a Practice Guidance document (to be completed Autumn 2017) on the correct processes to follow when any child or young person (who has not yet reached their 18th birthday) dies at Maidstone and Tunbridge Wells NHS Trust. This will form part of the current Safeguarding Policy and Practice Document.

We follow the national and Kent Safeguarding Children Board guidelines for child death and contribute to any investigations following a child death.

3.3 - Kent and Medway Safeguarding procedures

The above procedures were updated (March 2017) to include new information on (amongst others) Female Genital Mutilation (FGM), concealed pregnancy and Children missing from education[6]. These have been included in the updated Safeguarding Policy.

3.4 – CP-IS (Child Protection –Information System)

CP-IS is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. It will be part of the NHS spine portal information and will allow clinicians in urgent care to access Child Protection information when any child presents. It should remove the need to 'flag' up children on our own IT systems.

Presently Maidstone and Tunbridge Wells NHS Trust does not have the capability to run this system as our IT systems do not support it. It is envisaged that when Symphony is updated CP-IS will be used.

It is envisaged that CP-IS will go live in October 2017 once the new Symphony system has been embedded.

3.5 – Female Genital Mutilation

- The new FGM policy has been ratified and is available for all staff on the intranet
- The policy reinforces the statutory reporting obligations on all staff regarding disclosures of FGM or those believed to be at risk of FGM
- Since January 2017 Maidstone and Tunbridge Wells NHS Trust has reported on 3 cases of FGM to the national reporting mechanism

[6] http://www.proceduresonline.com/kentandmedway/chapters/amendments.html

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4.0 - Safeguarding Children Training

4.1 - The Safeguarding team has placed a high priority on ensuring that all the Safeguarding Children training delivered is robust, fit for purpose and follows the national guidelines as agreed in the Intercollegiate Document (2014)[7]

4.2 - Traditionally compliance for level 1 and 2 Safeguarding Children Training has been high at greater than 90%. Level 3 compliance has traditionally been less than 85%. It is unclear why this may be so but may be due to the commitment required (1 day) and the difficulty in releasing clinical staff for this period of time.

4.3 - All the Safeguarding Children Training packages have been reviewed and updated since October 2016. The Safeguarding Children team will deliver 10 sessions at level 3 by the end of December 2017 and are encouraging staff to access further training outside of Maidstone and Tunbridge Wells NHS Trust. Internal training is well received and the aim is to raise compliance above 85% by 31.12.17. The Named Nurse is also an associate trainer for the Kent Safeguarding Children Board.

4.4 - The Safeguarding Children team are also accessing training to ensure their own professional development is up to date. The Named Nurse and one of the Safeguarding Children Nurses will be completing MSc's at the University of Greenwich. The team also access training with the Kent Safeguarding Children Board.

5.0 – Child Sexual Exploitation

5.1- In June 2016 an Overview Report[8] was published by the Kent Safeguarding Children Board following an investigation into Child Sexual Exploitation in the Thanet area of Kent. In 2013 Operation Lakeland identified a number of children who were victims of Child Sexual Exploitation and a task force was established to identify both victims and perpetrators. A court case in February 2015 collapsed.

5.2 - In December 2015 Operation Willow was established alongside the Child Sexual Exploitation Team (CSET). The CSET is a Kent wide multi-agency team that identifies victims and aims to disrupt exploitative activity. Its terms of references (TOR's) are set and reviewed by the MASE (Multi-agency Sexual Exploitation Group) which also identifies the Child Sexual Exploitation profile of Kent and oversees the Kent Safeguarding Children Board Child Sexual Exploitation Strategy and Action Plan. The Named Nurse sits on the MASE as the lead for Child Sexual Exploitation within Maidstone and Tunbridge Wells NHS Trust.

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[7] http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf
[8] http://www.kscb.org.uk/__data/assets/pdf_file/0011/59249/Review-into-CSE-in-Kent-Overview-Report-Final.pdf

5.3 – To date the CSET has identified 496 high risk victims in Kent with a number of live investigations on-going (2 in West Kent). Maidstone and Tunbridge Wells NHS Trust regularly liaises with the CSET and shares information on vulnerable children as appropriate.

5.4 – On March 18th 2017 the Safeguarding team took part in the National Child Sexual Exploitation Awareness day and provided information to frontline staff on the signs and symptoms of Child Sexual Exploitation, identifying potential victims and 'what to do if you're worried about a child.'

6.0 – PREVENT

6.1 - In line with our mandatory training requirements the Trust is now offering PREVENT training to all staff. The Named Nurse Safeguarding Children, Matron Safeguarding Adults and General Manager-Facilities are facilitating the training using a Home Office directed package.

6.2 - PREVENT is part of the Governments counter terrorist strategy CONTEST and is aimed at preventing individuals from supporting terrorism. The training is aimed at all clinical staff and is designed to raise awareness of who might be vulnerable to radicalisation and what to do if you are concerned. To date 27 sessions have been organised with extra bespoke sessions. Training is well received.

7.0 – Serious Case Reviews (SCR) –

Maidstone and Tunbridge Wells NHS Trust will be providing an IMR (Individual Management Report) for a SCR commissioned following the death of a child. There is no date set for submission as yet.

Learning from SCR's is included in all training.

8.0 – Safeguarding supervision

8.1 - The Safeguarding Children team have reviewed the trust policy for Safeguarding Children supervision provided to staff working with children.

8.2 - One to one supervision will be mandatory for all Midwifery staff and specialist Paediatric Nurses who hold caseloads. For all other Paediatric nursing staff (including those in the ED) group supervision can be accessed with ad hoc one to one supervision as requested. The new policy needs to go out for consultation and ratification; it is anticipated this will be ratified by 30.09.17.

9.0 – Safeguarding Children Processes in the ED (Emergency Department)

9.1 - The Safeguarding Children team has been reviewing the role of the Safeguarding Children Nurses within the ED's at both Maidstone General Hospital and Tunbridge Wells Hospital. The Safeguarding Children nurses provide a high quality advice and support

service to the ED (Emergency Departments) and other departments across both sites. Historically the nurses have been based in the ED thereby allowing easy access to all staff requesting advice and support. It has been recognised that the role of the Safeguarding Children Nurse within A&E requires some redirection and change. The SGCN are expert in Safeguarding Children and these skills need to be utilised effectively for the entire organisation in both training and supervision.

9.2 - Currently the Safeguarding Children Nurses 'read' and review every casualty card for every child that presents at our ED's, determine if there are any further safeguarding concerns to be acted upon and share information with our community health partners (Health Visitor and School Nurse teams). GP's (as per current ED guidelines) are also informed of every Paediatric admission/presentation.

9.3 - An audit of the Paediatric casualty cards was carried out in November 2016 to determine the total number of children who presented with concerns that should come to the notice of the Safeguarding team. It was identified that only 10% of children seen needed to come to the attention of the Safeguarding Children team.

9.4 - The Health Visitor and School Nurse teams have traditionally found the service we provide is not fit for purpose; they do not wish to be informed of every child seen in A&E but only to be informed of the 'high risk' children – specifically those known to Children's Specialist Services or other professionals. They also do not wish to receive paper copies of discharge letters as they use electronic records.

9.5 - From the beginning of July 2017 the following process will be in place -

- The SGCN will continue to be based in the ED at both Maidstone General Hospital and Tunbridge Wells Hospital for the foreseeable future
- ED staff will ensure that EVERY child has a Safeguarding assessment completed whilst in the department
- The Safeguarding Children Nurses will only review the casualty cards of the following ; this will include (but is NOT necessarily limited to) –
    - All children under the age of 2
    - Any child presenting with unexplained/unwitnessed injuries
    - Children presenting with injuries not compatible with age or developmental progress
    - Bruising in a non-mobile child (to include children with complex needs)
    - All children who self-harm in any way, including accidental ingestion
    - All children with a diagnosed learning disability/difficulty
    - All children presenting with an alleged assault (physical and/or sexual)
    - All children presenting with any mental health concerns
    - All Looked After Children (LAC), children subject to a Child Protection Plan or a Child in Need plan
    - Any other child who staff assess may be at risk of emotional abuse, sexual abuse, physical abuse or neglect
    - Any child presenting with a confirmed pregnancy (concealed or otherwise)

- **Adults who present as victims of Domestic Abuse, or who have Mental Health or substance misuse concerns** – ED staff must ensure that they document whether these adults are responsible for any child and document their names, DOB's and whereabouts. ED staff must demonstrate that they have acted to safeguard the children identified; advice can be sought from the SGCN, Children's Specialist Services or Matron Safeguarding Adults as appropriate.
- The SGCN will review all cards as above and liaise with the relevant community partners/professionals
- During the 6 month trial period the Safeguarding Children team will carry out short audits of Paediatric 'casualty cards' (falling outside the above categories) to ascertain the effectiveness of the new process

9.6 - All Paediatric 'casualty cards' will be scanned overnight as per process for adult cards and set aside for the Safeguarding Children Nurse to triage (as per the agreed policy). Those not being reviewed will be archived as per current policy

9.7 - Discharge advice letters will continue to be sent to our community partners (including GP's, Health Visitor's and School Nurse's)

9.8 – ED staff are able to identify which children are at risk and it is the responsibility of all ED staff to act on any safeguarding concerns at the time that they are identified; this new process does not NEGATE this responsibility.

9.9 - This change has been agreed at the Safeguarding Children committee and the proposal was sent to relevant stakeholders. No adverse comments have been received and the ED department are supportive of this change. The new process will start at the beginning of July 2017 with a 6 month review date. Any 'teething issues' will be identified and acted on as the process becomes embedded. Audits of '*how are we doing'* will be carried out monthly to provide assurance that we continue to fulfil our statutory responsibilities. A&E has agreed to this change.

10.0 – Safeguarding Audits
10.1 - No current audits planned

11.0 - Areas of risk for ongoing monitoring and review

- The Safeguarding Children Committee will continue to monitor compliance with training with a particular focus on improving the compliance at level 3
- New processes in A&E
- A focus on Safeguarding supervision for all staff working with children

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12.0 – Conclusion

- Significant work has been completed in the last 12 months in relation to improving training, services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust.
- There is still work to do to improve the standards and processes but we are assured that the right practitioners and processes are in place
- The Safeguarding Children committee will continue to monitor the Safeguarding Children team and will report to the Quality Committee

Alison Jupp

Named Nurse Safeguarding Children

June 2017

Trust Board meeting - July 2017

Maidstone and Tunbridge Wells NHS Trust

7-13 Safeguarding Adults Annual Report 2016/17 Chief Nurse

Summary / Key points

The Trust is required to produce an annual Safeguarding Adults report, which should have oversight by a committee of the Board and cover the key elements of safeguarding including the provision of policies, procedures, training and safeguarding alerts. The report provides assurance that statutory requirements are met, particularly in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. The report has been prepared by the Safeguarding Adults Matron with oversight of the Safeguarding Adults Committee. The full report was presented to, and discussed by, the Trust Management Executive Committee and Quality Committee in July 2017.

The Executive Lead for Safeguarding Adults is the Chief Nurse; this agenda is supported by the Deputy Chief Nurse and Matron for Safeguarding Adults. The Trust has a mature multi-agency Safeguarding Adults Committee, chaired by the Deputy Chief Nurse, with Local Authority and Clinical Commissioning Group representation.

The Trust's Safeguarding Adults at Risk of Harm Policy has been reviewed this year in order to strengthen the role of Directorate Matrons, to include information about giving feedback to patients and referrers, describe the Local Authority Designated Officer role and cross reference to the Enhanced Care policy.

Level 1 and Level 2 Safeguarding Adults training compliance is above the Trusts target of 85% compliance overall. The Trust awaits the final publication of the NHS England Intercollegiate Document in order to finalise our Training Needs Analysis. All safeguarding adults training delivery has either been reviewed or is under review, so as to include PREVENT basic awareness. A programme of PREVENT Wrap training has been developed for the year with the expectation that 1000+ staff will receive this training.

Trust staff continue to follow the new Care Act definitions and raise safeguarding alerts appropriately.

Law Commissions review and recommendations of the Mental Capacity Act and Deprivation of Liberty Safeguards will have an impact upon Acute Trusts processes and will have a new budgetary implication if the Government agrees with the recommendations.

The Trust engages well with the Kent & Medway Safeguarding Adults Board, and has good working relationships with the Central Referral Unit.

The Trust has contributed to two Safeguarding Adults Reviews in the last year. Learning and recommendations from these reviews is not yet published.

The report includes a section (5), "What does the Board need to know?", on the basis that this provides the necessary instruction for the Trust Board i.e. above and beyond what individual Executives may be required to do, as part of their mandatory training.

Three Key Achievements in 2016 – 2017

•Development of PREVENT training programme, delivering in excess of 29 WRAP training sessions this year.

•Trust staff showing an understanding of the difference between the definitions of a 'vulnerable adult' and an 'adult at risk of harm' and completing KASAF's in accordance with this change in threshold.

•Continued 'buy in' from all Trust staff to adhere to the Care Act 2014 and to continue to raise safeguarding concerns about patients, visitors and staff.

Three Key Challenges in 2016 – 2017

•Inconsistent application of the 'adult at risk of harm' definition from external partners.

•Identification of resource to support the Learning Disability agenda including the provision of a Learning Disability Nurse.

•DOLS applications that the Supervisory Body have not been able to apply the safeguards to, due to volume of referrals.

Future Plans 2017 - 2018

•To work with the Medical Director and Clinical Directors to ensure that the Mental Capacity Act 2005 is embedded in all medical practitioners practice.

•To develop Level 3 Safeguarding Adults training without reliance upon external, or paid speakers.

•To secure a learning disability nursing resource

Which Committees have reviewed the information prior to Board submission?

Quality Committee, 05/07/17

Trust Management Executive, 12/07/17

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

Information and assurance

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

Trust Annual Safeguarding Adults Report 2017

1. Introduction

The Executive Lead for Safeguarding Adults is the Chief Nurse, supported by the Deputy Chief Nurse (DCN) and the Matron for Safeguarding Adults (Matron SA's). However, it is made clear in all Trust training delivery that it is every staff members duty to protect adult's from being placed at risk of harm or from being harmed. It is also their duty that if they are concerned about an adult at risk that they must report the matter to the Local Authority, who are the lead agency for deciding if the threshold for an enquiry to take place is met.

Matron for Safeguarding Adults is the lead for the following areas of work:-

- Safeguarding Adults ensuring staff are knowledgeable about, and are applying the key components of the Care Act 2014 (enacted April 2015) and ensuring the Kent & Medway Safeguarding Adults Policy, Procedures and Guidance is adhered to by Trust staff.
- Design and delivery of training in relation to all aspects of safeguarding adults including
    - The fact that the Care Act 2014 puts adult safeguarding on a statutory footing.
    - The principles, new definitions and types of abuse in the Care Act.
    - The role of the lead agency – the Local Authority.
    - Application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
    - Domestic Abuse.
    - PREVENT – anti-terrorism and radicalisation agenda and who to report concerns to.
    - Learning Disability.
- PREVENT Lead for the organisation. The Trust now has two other Home Office approved trainers in PREVENT, Named Nurse Safeguarding Children and the General Manager for Estates and Security, who are assisting this year with training delivery.
- Learning Disability – Matron SA's is a Registered Nurse for Learning Disability so is suitably qualified to provide strategic guidance and oversight of this agenda. The wider safeguarding agenda dilutes the opportunity for targeted and focussed work at a clinical level. The Trust is exploring a range of opportunities to enable the appointment of a specific Learning Disability Nurse. This includes the potential for a joint appointment with a partner acute care trust.
  There is a good relationship and continued support from the Community Learning Disability Liaison Nurses.
- Domestic Abuse Lead – to date all Domestic Homicide Reviews, where the Trust has had involvement, have been reviewed by Matron SA's and an Independent Management Review (IMR) compiled and submitted by Matron SA's.
- Safeguarding Adults Reviews – Matron SA's is also the IMR author for any requests relating to serious harm or death of an adult at risk of harm that we have had involvement with.

The Trust has a mature Safeguarding Adults Committee, which is chaired by the DCN. It has representation from practitioners within our hospitals and also has Social Services representation from Safeguarding Adults Co-ordinators from Kent, Clinical Commissioning Group (CCG) Designated Nurse representation and Community Learning Disability Nurses in attendance. The agenda is aligned to the CCG Safeguarding Metrics for ease of reporting to our Commissioners. This Committee reports into the Trust Clinical Governance Committee.

2. Actions taken to Improve Effectiveness

Policies and procedures –

The Safeguarding Adults at Risk of Harm policy and procedure has been reviewed this year to include

- To remove Patient Experience Matron Role and thence to strengthen the role of directorate matrons and line managers.
- Clarified Site Report reporting mechanisms and expected responses.
- Changes to flow chart – quick reference guide.
- Insertion about responsibilities in relation to Duty of Candour and giving feedback to referrers and the adult at risk.
- Insertion of Local Authority Designated Officer Role (LADO)
- Clarified the role of Bank and Agency Manager in relation to safeguarding investigations involving a Bank or Agency members of staff
- Cross referenced to the Enhanced Care to Adult Inpatients Policy and Procedure.

The consultation period has ended on these revisions and the policy will now be ratified at the Policy Ratification Committee.

Training Delivery and Compliance

The Trust's suite of training presentations have been/or are in the process of being reviewed in line with developments from the Care Act 2015, and also to ensure that basic awareness of our duties in relation to the PREVENT agenda is incorporated into all Safeguarding Adults training delivery.

Training compliance is good and at year end, 95% of staff had completed Level 1 training, 86% of staff had completed Level 2 Training and 96.7% of staff had completed Mental Capacity Act training which is incorporated into Level 2 and 3 training.

There were some whole day training sessions delivered for Level 3 training and 102 staff attended these sessions. It has proven challenging this year to deliver this training as we have been reliant upon unpaid external speakers who are now unable to commit their time to the delivery of this training. This programme is currently being reviewed and restructured to ensure safe and appropriate delivery of this training and education to the relevant staff groups.

Along with the redesign of the Level 3 training package, consideration is also being given to enhance the training on MCA for staff. There is a particular emphasis to tailor this to needs of the Consultant body. Nationally it is recognised that this legislation has not been embedded into all practitioners practice and the House of Lords Post-Legislative Scrutiny report dated March 2014 indicated:-

'The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives'.

This remains the case, some three years on and Maidstone and Tunbridge Wells NHS Trust is no different with regards to this statement.

A PREVENT training timetable has been advertised to all clinical staff and it is expected that at least 1000 staff will have received the Home Office WRAP training by year end. There are three Home Office approved trainers in the Trust who have undertaken to deliver this training. It is mandatory for all clinical staff to complete this training and in light of recent events nationally, staff are engaging well with this training. At the time of this report 244 staff have received the WRAP PREVENT training.

Safeguarding Children's Named Nurse and Matron for SA's have plans to develop systems to capture the Domestic Abuse training delivery that is currently on offer in the Trust via all safeguarding training.

Attendance at Kent and Medway Executive Board, Sub-groups and Associated Meetings

The Kent & Medway Safeguarding Adults Board (K&MSAB) have held an away day to discuss the structure and attendance at the Board (attended by the DCN) and hence the subsequent sub-group structure of the K&MSAB. The structure that is in place, at present, is likely to change however, at present the structure is the same as previous year as follows:-

The DCN represents the Trust at the KMSAB and provides feedback to the Chief Nurse and the Trust's Safeguarding Adults Committee. The Matron SA's deputises when required.

MTW continues to value the opportunity to contribute to the strategic direction of the KMSAB in this way. It is also seen as an ideal opportunity to network effectively and to take on board innovations that could assist the Trusts work to safeguard adults in its care effectively.

Matron SA's attends the following KMSAB sub-groups

- ☐ Quality Assurance Working Group – QAWG
- ☐ Learning and Development Group – L&D
- ☐ Policy, Procedure and Guidance Group – PPG

Along with attendance at:

- ☐ Mental Capacity Act Local Implementation Network – MCA LIN

This enables the Trust to be involved in the strategic and operational developments in Adult Safeguarding in Kent.

The Matron for SA's also assists within the multi-agency setting by proactively assisting in task and finish groups to work on particular issues where appropriate, to help with shaping the growing agenda of safeguarding adults.

Matron SAs' is a regular attender and contributor of the Health Leads Meeting which is co-ordinated by the CCG Designated Nurses within Kent. This offers opportunities to network and share best practice effectively with a range of providers and commissioners from adult safeguarding.

Mental Capacity Act and Deprivation Liberty Safeguards

The Law Commission conducted a review of the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DOLS); the outcome of this review was published March 2017
(http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf).

The Law Commission suggests that the tenets of the MCA should remain and be strengthened with a new Code of Practice developed so as to incorporate case law that has shaped practice over the past nine and a half years. They also suggest strengthening the ideal that a person's previous wishes and feelings, views and beliefs should be given greater weight when considering what is in the persons Best Interests.

The 'Acid Test' from the previous Supreme Court Judgement P&Q vs Surrey Council and P vs Cheshire West will remain in place and that is, that if a patient is assessed as not having the Mental Capacity to decide on admission to place of treatment, if staff have

- Continuous Supervision and control of that person **and**
- They would not be free to leave

This meets the 'Acid Test' for a patient to be deprived of their liberty.

The current DOLS processes are deemed not fit for purpose and the Law Commission has made suggestions, which in its view, streamlines the application process and lessens the bureaucracy. The Trust is aware of the Law Commission's recommendations and is in the process of assessing impact on current delivery, whilst waiting for statutory approval.

In the last reporting year the Trust has authorised 179 Urgent DOLS but it remains unclear how many have been converted to an authorised Standard DOLS, meaning that they have been reviewed and authorised by the Local Authority. Collaborative work is ongoing with the DOLS office to ensure that there is a process in place whereby the DOLS office copies Matron SA's into all outcomes of DOLS applications that have been assessed.

Some resistance locally and nationally, was noted in relation to the fact that previously, if someone died under a DOLS it was treated as a Death in Custody. This would have had to be reported to the Coroner with an inquest ensuing. This is no longer the case and a communication has been sent out in relation to this. In addition, when a DOLS application has been made to the Local Authority they have not been able to put the safeguards in place. There have been occasions where Trust staff have requested a DOLS authorisation and the Local Authority have stated that they would not be able to review that patient for at least 2 months. The Local Authority in this context, before this Supreme Court judgement were dealing with approximately 300+ applications per year; this year they have had 5000+ applications. So there is not an appetite from Trust staff to complete forms in the knowledge that the Local Authority are unable to respond effectively and in a timely manner. The Trust experts continue to advise staff about the 'Acid Test' and to urge that they apply for a DOLS when a patient meets the 'Acid Test' criteria.

Safeguarding Adults Activity

April 2016 – March 2017	OUTCOMES										Total
	TWH at PEMBURY					MAIDSTONE					
	Upheld	Not Upheld	Inc.	Await Report	Closed by LA	Upheld	Not Upheld	Inc.	Await Report	Closed by LA	
April	1*	2	0	0	0	0	2	0	0	0	5
May	1* 2	3	0	0	0	0	0	1	0	0	7
June	1*	1	0	0	1*	1*	0	0	0	0	4
July	1*	0	0	1	0	0	2	0	0	0	4
Aug	1** 1***	2	0	0	0	0	0	0	0	0	4
Sept	0	2	0	0	0	0	1	0	0	0	3
Oct	1*	1	0	0	1**	3**	3	0	0		9
Nov	1+ 1++	0	0	0	0	0	0	0	0	1**	3
Dec	0	0	0	0	0	0	0	0	0	0	0
Jan	0	0	0	2	0	1***	1	0	1	0	5
Feb	1+++ 1	0	1	5	0	0	0	0	1	2*	11
March	0	0	0	2	0	0	1+	0	0	1*	4
Total	13	11	1	10	2	5	10	1	2	4	**59**

TWH at PEMBURY

* Partially upheld - Hospital acquired Pressure Ulcer or neglect.
** Perpetrator most likely a visitor – psychological abuse
*** Alleged neglect covered 2 areas. Partially upheld for one area, discounted in the other area
* Husband to patient interaction closed at CRU
** Closed at CRU as appropriate action being taken by the Trust
+ DNACPR form completed without adherence to the Mental Capacity Act 2005
++ Injury/Pressure ulcer; neglect.
+++ Patient to patient incident whereby we had been unable to provide 1:1 care

MAIDSTONE

* A CSW was overheard to be rude to a patient and admitted this straight away - disciplined
** A Bank RN neglected three patients in her care in one night, dismissed and referred to the NMC
*** Hospital acquired Pressure Ulcer
+ One case with two elements of suspected abuse – neglect discounted and physical abuse there was insufficient evidence
* Closed down by the Local Authority at Central Referral Unit (CRU) as Trust processes in place
** Psychological abuse between partners on the ward – closed down at CRU

Therefore there were 59 referrals raised about hospital practice last year 38 of which were raised by external sources and 21 having been raised by Trust staff.

In addition, Trust staff raised Safeguarding Referrals in relation to concerns external to the Trust (Community Referrals) for 79 patients; that is 45 from Maidstone Hospital and 34 from TWH at Pembury.

3. Strategic Issues for the Trust

Thresholds – Trust staff have been trained to adhere to the definition held within the Care Act Guidance in relation to raising safeguarding alerts for adults at risk.

The following is taken from the Care Act Guidance updated 2017

"14.2 The safeguarding duties apply to an adult who:

- **has needs for care and support (whether or not the local authority is meeting any of those needs)**
- **is experiencing, or at risk of, abuse or neglect**
- **as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect"**

As a result of this Trust staff are raising safeguarding alerts (KASAF's) that the Local Authority would not have accepted in the past. Some practitioners in the Local Authority appear to be struggling with the change of concept from 'Vulnerable Adult' to 'Adult at Risk'. Matron for SA's has called for a meeting with Senior Managers in the Local Authority, Health Practitioners and Safeguarding Adults Co-ordinators from across Kent, in Adult Safeguarding, to debate where the level should rest at. Until such a meeting is convened the Trust continues to raise KASAF's where it is thought that the above duty is met so that the Local Authority can discharge their statutory duty under the Care Act and make their decision about the level of Section 42 Enquiry that they will undertake.

Learning Disability Hospital Liaison Nurse – The Trust is aware of the need to recruit a Learning Disability Hospital Liaison Nurse. Review of existing financial resources and changes in the way teams work is being explored to enable this. The Trust is also exploring opportunities to consider a joint appointment with a neighbouring acute care trust or the mental health trust. A risk analysis has been completed previously and is kept under review.

Matron for SA's advises where possible when a patient has a Learning Disability and staff are having difficulty meeting their complex needs. Positive links have been built up with the Community Learning Disability Nursing teams to assist when patients with a LD are admitted to our Trust.

Matron SA's delivers basic Learning Disability training to FY1's and FY2's as part of their years programme. Basic awareness of Learning Disability is also included in the Safeguarding Adults Clinical training delivery.

MCA and DOLS Processes – These areas are entwined with each other, as without a mental capacity assessment for the decision to be admitted to hospital and remain here for care and treatment a DOLS application should not be completed. As previously stated it remains challenging to ensure staff are confident and competent in discharging their duties in relation to the Mental Capacity Act 2005.

Following the recent appointment of a new Medical Director, a review of the clinical leads has been undertaken. The Safeguarding/MCA Medical Lead is currently vacant; however the outgoing Lead and the Medical Director are providing support along with colleagues from the Legal Services team.

The Consultant body, as with other staff groups, sometimes lack confidence in applying the principles of MCA to the daily their practice and that of their teams. As noted previously consideration is being given as to how best to tailor education and training activity to meet this specific need.

We also await the proposed Law Commission changes to be agreed and accepted by the government of the day and Matron SA's will advise and respond accordingly.

Meetings with LA and CCG – Meetings are scheduled with the Local Authority Safeguarding Co-ordinator and the CCG Safeguarding Designated Nurse on a monthly basis to discuss referrals and progress of investigations where KASAF's have been raised about Hospital Incidents. This is a valued process and gives external scrutiny to the Trusts processes and outcomes of investigations. It is here that a decision is made as to whether or not abuse occurred and whether the investigation has been full and proper.

The Trust welcomes this external scrutiny and challenge to the Trusts process. As a result of this process it became clear that the Trust needed to ensure that feedback was given to both adults at risk, and referrers in relation to outcomes of cases and as such the Safeguarding Adults at Risk of harm Policy was reviewed to include this process.

Intercollegiate NHS England Training Document – The Trusts Training needs Analysis will be updated once the final version of this document is published.

4. Frontline Staff Operational Issues

At times it has been difficult for allocated Investigating Officers to complete a safeguarding investigation with the competing demands of day to day work. Not every safeguarding referral raised about Trust practice is raised as a Serious Incident and as such there is often less strategic oversight of the investigation progress.

Investigations need to be completed in a timely manner so that learning can take place from these investigations. Also so that prompt responses of outcomes can be shared with adults at risk and the referrers of such concerns.

Putting MCA into their everyday practice for practitioners remains a challenge in relation to their knowledge, confidence and competence. Master Classes, facilitated by the Matron for SA's are being developed to support staff to apply MCA knowledge into their practice.

There needs to be clarity about when a Best Interest Meeting needs to be held as opposed to a Best Interest Discussion Also clarity about what constitutes a Best Interest decision., It is not yet universal practice for all practitioners to think about what the person's wishes, feelings, beliefs and values would have been,

5. What the Trust Board Need to Know

Kent and Medway Safeguarding Adults Board - (KMSAB)

Interagency co-operation and working is essential in Adult Safeguarding. The lead agency for receiving and risk assessing Safeguarding Alerts are the Local Authority. It is for the Local Authority to decide if a referral warrants a Section 42 Enquiry under the Care Act 2014.

Maidstone and Tunbridge Wells NHS Trust works collaboratively, both strategically and operationally, with the KMSAB and its sub-groups (detailed above). There are proposed changes to the membership of the KMSAB and the Trust keenly awaits these to be published. As a result the sub-groups of the board will be changed and added to so that all partners have a voice in this important domain.

When safeguarding alerts are raised about practice within the Trust and these meet the threshold of being considered a crime the police are welcomed in to the Trust to carry out any necessary criminal investigations. The Trust will dovetail their investigation with the police investigation in these cases.

Matron for SA's attends Adult Safeguarding multi-agency Strategy Meetings and Case Conferences when invited by the Local Authority, in cases that we have been involved in.

The Trust has to follow both the Care Act 2014 and the local policies, procedures and guidance that the KMSAB have published. The Trusts Safeguarding Adults at Risk of Harm Policy and Procedure is regularly updated to include updates from both a national and a local perspective.

There is agreement that information will be shared on a need to know basis and staff are asked to talk with the adult at risk when making a referral to the Local Authority so that staff can include the adults wished for outcome, within that referral. Staff are reminded that the Trust is not the decision maker in relation to whether or not a Section 42 Enquiry should take place but that is for the Local Authority to decide, therefore they should err on the side of making a referral if they believe that an adult has either been harmed or placed at risk of harm and they meet the definition of being an adult at risk. (See above for definition).

Outcomes of investigations are shared with the Safeguarding Adults Co-ordinator who is aligned to the Trust and the Designated Nurse for Safeguarding Adults at West Kent CCG. A meeting is held monthly to review investigation reports, where allegations are raised about Trust practices, and to decide if abuse has occurred or not. These outcomes are shared with the adult, the referrer and the Directorate.

The KMSAB commissions multi-agency training that Trust staff are able to access.

The Care Act 2014

This Act has been in full force since April 2015 and now puts Adult Safeguarding onto a statutory footing. This Act replaces previous DOH Guidance 'No Secrets' and changes the definition of who should be considered to be 'an adult at risk' and removes the 'vulnerable adult' definition. The Act also includes more types of abuse which have been included in the Safeguarding Adults at Risk Policy and Procedure as soon as possible after publication of the Act and the updated Kent and Medway Policy, Procedures and Guidance.

Trust staff appear to be confident to apply the new definition of an adult at risk and continue to raise safeguarding alerts, on the whole, appropriately.

The Trust is recognised within the multi-agency setting as a high referrer of safeguarding adults concerns both for community investigation and hospital investigations to be undertaken. We have a reputation for wanting to get things right for our patients and to learn from any mistakes so that practice can be improved.

The threshold as to when a safeguarding alert should be raised is developing within Kent and as stated above Matron for SA's is keen to open a dialogue with partner agencies and peers with regards to this threshold. Until such agreement is reached, Trust staff are advised to continue to make safeguarding adults referrals that they deem meet the current threshold and definition.

Trust Safeguarding Adults Committee

This committee sits every other month and the agenda is set to be aligned to the CCG Safeguarding Metric that has been agreed. This has been set up as a multi-agency committee and has good attendance from Directorates, Social Services, Learning Disability Nurse and the West Kent CCG Designated Nurse. This committee is chaired by the Deputy Chief Nurse.

Scrutiny is given to safeguarding cases raised about the Trusts practice, outcomes of investigations, reports submitted, learning and action plans developed.

The DCN gives feedback from the KMSAB decisions and direction of strategic travel in relation to Adult Safeguarding in Kent.

National and local policy updates are discussed at this committee.

When Safeguarding Adults Reviews and Domestic Homicide Reviews that the Trust can learn from are reported these are considered at this committee.

Care Quality Commission – CQC

CQC have a regulatory authority to inspect providers of care and hospitals against Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

> ***"To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:***
>
> ***neglect***
> ***subjecting people to degrading treatment***
> ***unnecessary or disproportionate restraint***
> ***deprivation of liberty" (CQC Website)***

All Trust safeguarding alerts, whether raised by Trust staff or by external sources are copied in to the CQC by the Local Authority. All outcomes of these cases are also copied to the CQC Inspector aligned to the Trust by the Local Authority.

The CQC Inspector has enquired of the Local Authority practitioner aligned to the Trust if she should be concerned about the level of referrals raised in relation to the Trust. Reassurances have been given that the Trust is keen to raise safeguarding alerts in line with the new definitions of the Care Act and until the threshold level of raising a safeguarding alert has been set and agreed throughout Kent that this will continue.

It is understood that CQC inspections have a focus on the application of Mental Capacity Act and Deprivation of Liberty Safeguards and safeguarding in general.

Safeguarding Adults Reviews (SAR's) and Domestic Homicide Reviews (DHR's)

The Trust has been involved in two SAR's one in relation to East Sussex and one in relation to Kent.

We have a duty, when requested, to provide information requested by a SAR or DHR panel and on both occasions relevant information has been provided. The Trust awaits the learning from both of these cases to share with practitioners within the Trust, in order that responses and practice can be improved.

The Mental Capacity Act and Deprivation of Liberty Safeguards - MCA DOLS

As previously stipulated Trust staff need to grow in their confidence about applying the Mental Capacity Act principles into their everyday working life.

The Matron SA's continues to offer expert advice in relation to this area of work and has developed tools for practitioners to use. The Medical Director has been asked to support

this area of work with the Consultant body as perhaps this important law has not gained prominence in every Doctors practice.

The Trust also keenly awaits the government's response to the Law Commissions Review of MCA and the DOLS processes.

PREVENT

PREVENT is part of the Government counter-terrorism strategy. It is designed to tackle the problem of terrorism and far right thinking at its roots, preventing people from supporting terrorism or becoming terrorists themselves.

The Trust's PREVENT Lead is Matron for SA's and as such any referrals in relation to suspected radicalisation of either staff members or patients must be reported to her. The Trusts Children's Named Nurse is also engaged with this agenda. If it is felt that a child is being radicalised in any way this must also be referred to the Children's Named Nurse.

With the assistance of the Chief Nurse, Medical Director and the Executive Director for Workforce and Planning a decision will be made about referral out to the local Chanel Panel when suspicions arise that a person is being radicalised in any way.

There is now an agreed training plan for PREVENT for this year with an expectation that this training will be continued to be offered year on year – or until such time as the Home Office revises and changes the training delivery.

6. Conclusion

The agenda for people with learning disability continues to be a growing area of work that the Trust needs to take a more robust approach to resource. Matron SA's is a Registered Learning Disability Nurse however due to demands of the wider safeguarding adult's agenda she is only able to give limited resource and effort to this area of work.

The Trust acknowledges that there remains room for improvement in relation to MCA, DOLS and Learning Disability agendas.

The Trust has good mechanisms in place to ensure that we endeavour at all times to safeguard patients. Staff use their professional judgement to effectively raise concerns to the Local Authority and the Matron SA's. Upon review of these, on the whole, referrals are appropriate and contain relevant information.

Trust Board meeting - July 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

7-14 Estates and Facilities Annual Report 2016/17 — Chief Operating Officer

The enclosed report provides a broad perspective of the Estates, Capital and Facilities Management functions for the financial year 2016/17. The report was reviewed by the Trust Management Executive in July 2017.

Which Committees have reviewed the information prior to Board submission?
Trust Management Executive, 12/07/17

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

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

Estates and Facilities Management Annual Report 2016-17

Inside this year's Annual Report

The directorate is responsible for;

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

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

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

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

Key Highlights

Annual Staff Star Awards:

- CHAIRMAN'S AWARD, Winner:
  - Kemi Adams, Traffic Officer
- DELIVERY AWARD, Team Winner:
  - Domestics, cross-site
- EMPLOYEE OF THE YEAR, Runner up:
  - Matthew Hitchcock, Head Chef
- INNOVATION, Runner up:
  - Inci Patel, Cashier and Valerie Shield, Reception

Developments:

Tunbridge Wells

- Bed Re-configuration

Maidstone

- MOU
- PET CT
- Linac 1
- Backlog Maintenance

Our year in numbers

901,185 In-patient main meals requested	**3,930,768** Laundry and Linen pieces processed per annum for MTW	**54,094,473** kWh of Electricity, Gas & Oil Consumed
£2,157,762 Capital Investment for improving existing buildings	**131,414m^2** Gross internal floor area	**£1,985,762** Investment to reduce backlog maintenance
91 False Fire Alarm Activation	**23.84** Hectare Land Area	**£2,400,994** Cost to eliminate backlog
2,127.24 Waste Tonnes Volume	**£1,988,679** Income from Services provided to others	**2,737** Parking spaces

1 Introduction

This is the Estates and Facilities Management (EFM) annual report to update the committee with a broad perspective of the Estates, Capital and Facilities Management function and includes a review of the key developments and improvements achieved in the financial year 2016/17 and to look ahead to the planned areas of focus for the financial year 2017/18.

The figures and information included within this report are those reported for the annual Estates Return Information Collection (ERIC) submitted to the Department of Health on 30th June 2017.

2 Financial Overview

2.1 Revenue

2.1.1 The Directorate completed 2016/17, as follows;

	Division		
	Actual £	Budget £	Variance £
Pay	15,930,569	15,807,548	-123,021
Non Pay	18,226,103	17,626,166	-599,937
Income	-6,225,463	-6,075,350	150,113
Depreciation	-7,269	0	7,269
Reserves	0	-153,648	-153,648
	27,923,940	27,204,716	-719,224

2.1.2 The Directorate achieved £2.2m savings within the year.

2.1.3 The Directorate commenced the new financial year 2017/18 with a balanced business plan, with a proposed cost improvement programme (CIP) of 9.33% equating to approx. £2.9m defining an annual budget of £28,535,250. The savings are monitored on a fortnightly basis to ensure delivery and any risks that materialise during the year are managed and mitigated accordingly.

2.1.4 An additional stretch target of £600k has subsequently been issued, increasing the annual CIP target to £3.4m.

2.1.5 The directorate have identified a total of £3.6m in savings. Risk adjusted the forecast is over £3m and are currently delivering to plan.

2.2 Capital

2.2.1 The Estates Capital for the year was £1,985,762 for backlog maintenance and £2,157,762 for improving existing buildings. All planned and in year projects were delivered to plan and budget.

2.3 Cost Pressures

The cost pressures to the Directorate which are service demand led included; non-emergency patient transport service, extended winter escalation period, and postage.

2.3.1 Patient Transport

A new provider for the Kent and Medway service was introduced on 1 July 2016 by West Kent CCG. Despite efforts, poor performance of the Kent and Medway Non-Emergency Patient Transport Service continues. Issues are being raised by all Acute Trusts in Kent and Medway to the commissioners. In the interim the Directorate incurs costs for private vehicles and crews necessary to move our patients.

2.3.2 Post

There are three streams of outgoing mail in the organisation; Neopost (internally managed) Xerox and Whistl (both external providers). Both the external provider contracts overseen by procurement and the PMO office causing the overspend. These contracts are now being looked into further to understand their usage.

3 Workforce

3.1 Staff Annual Awards and Recognition 2016

- **Chairman's Award**, Winner: Kemi Adams, Traffic Officer
- **Delivery Award,** Winner – Team: Domestics, cross-site
- **Employee of the Year**, Runner up: Matthew Hitchcock, Head Chef
- **Innovation,** Runner up – Team: Inci Patel and Valerie Shield (Cashier and Reception)

3.2 Staff Monthly Awards

	Team	Employee
March 2016	Portering M/S	Ann Foster, Patient Transport
May 2016		Margaret Bray, Domestic M/S
July 2016		Mary Chapman, Domestic M/S
February 2017	Facilities Team TWH	

3.3 External Recognition

In May 2017 the team were shortlisted into the top three for the Delivering Innovation Award by the Hospital Estates and Facilities Management Association (HEFMA).

3.4 Training Compliance

The directorate continue to achieve the Trusts mandatory training compliance targets for its c.700 workforce.

4 Estate Strategy and Capital Development Projects

4.1 Refreshing the Estate

4.1.1 Members of the Estate development team are working collaboratively with STP colleagues to review current estate efficiency and productivity within the Kent and Medway network. An assessment of the impact of the emerging Local Care model in terms of where future activity will be delivered, alongside an assessment of the current public sector estate footprint will help to identify where any development may be needed.

4.1.2 The Estate Strategy previously agreed by the Trust Board plans until 2017. The new Trust Five Year Strategy is being developed incorporating the strategic direction of the organisation and will indicate the sequencing of investments required over the next 3-5 years.

4.2 Capital Projects

4.2.1 Projects Approved

Instruction to proceed with the Capital programme was given in August 2015 and through the concentrated period of seven months; the Capital Project team have delivered the following projects within the £2,157,762 allocation;

- TWH bed reconfiguration
- Maidstone PET CT
- Linac no. 1

4.2.2 Additional In-year Project

The previously decommissioned Maidstone Orthopaedic Unit was recommissioned during a 15 week window to reinstate the Theatre and 12 bed facility ready for utilisation and occupation on 19 December 2016.

4.2.3 Backlog maintenance

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

The estates department has delivered backlog maintenance at Maidstone Hospital worth £1,985,762 this included;

- Block U Plate Heat Exchangers
- Fire Prevention works, including; compartmentation, escape routes, doors, dampers, wire testing
- Ventilation ductwork and grills
- Block S Chilled water system
- Block A&D controls
- Access ladder safety works
- Backup generator replacements
- Medical Gas improvement works
- Asbestos removal
- Equality Act compliance
- Window replacement scheme
- Signage improvement
- Road infrastructure
- Security and Lighting

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

Recommendation 6 of the report states;

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

The directorate have submitted a Green RAG status defined as; *Successful delivery of EFM Carter Recommendation appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly.* For each of the Carter recommendations. These were tabled and presented to the April 2017 Executive Performance Review panel.

A copy of the MTW NHS Estates and Facilities Dashboard for 2015-16 is attached in Appendix A.

6 Directorate Activity and Operational Performance

During 2016/17 a new management structure was implemented with the welcome addition of two new Associate Directors; Darren Bulley, Facilities Management and Kev Pearson, Estates. This has enabled dedicated leadership within the specialist fields and an improvement within the directorate teams structure and resources.

6.1 Premises Assurance Model

The NHS Premises Assurance Model (NHS PAM) is a series of self-assessment questions grouped into five domains, for NHS Providers to use as a basis for assessing compliance and providing assurance on estates and facilities safety and quality and subsequently to compare efficiency with peer NHS providers.

The Directorate, led by the new Associate Directors undertook a self-assessment review this year and the summary report is attached in Appendix B for review. Where improvements have been identified an action plan has been developed and agreed for implementation.

6.2 Energy Performance contract (EPC)

Continued development of the EPC business case for both sites which will be submitted to the July Finance Committee for approval.

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

6.3 PLACE

The annual PLACE inspections were undertaken during May 2017, the provisional outcome from the audits is shown in Appendix C. The final confirmed figures are due to be officially released during August 2017.

6.4 Non-Emergency Patient Transport Services (NEPTS)

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

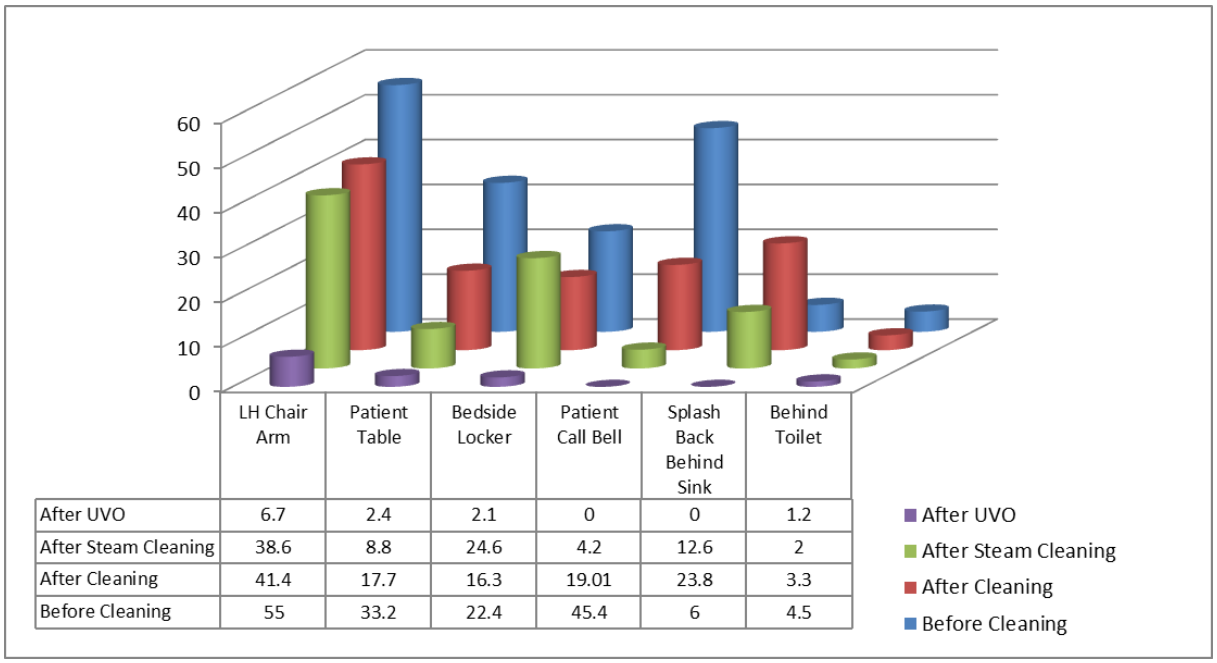
6.5 Risk Register

The directorate is continuing to proactively manage its risk register with open risks reviewed by the Directorate on a monthly basis. Where necessary red and amber items are escalated

to the Trust risk register and Board Assurance Framework. There are no red risks currently identified on the corporate register.

6.6 Cleanliness

Prior to the winter period, the team introduced the new Ultra-V cleaning (UVc) decontamination system. The UV-C rapidly decontaminates the environment, and requires no vapour-impermeable sealing in order to operate in the hospital environment. This technology provides an opportunity to decontaminate areas previously inaccessible with other technologies including hydrogen peroxide decontamination. The use of the system enables a room to be made available within one hour, reducing the bed downtime by three hours in comparison to cleans undertaken using hydrogen peroxide Vapourisation (HPV). Within quarter four of the financial year 2016-17 a total of 20 beds days were saved through the reduction in HPV cleaning by using the new UVc technology. The results (shown below0 of the trail undertaken prior to implementation demonstrate the level of contamination found on surfaces following the different methods of cleaning that the Directorate provides.



	LH Chair Arm	Patient Table	Bedside Locker	Patient Call Bell	Splash Back Behind Sink	Behind Toilet
After UVO	6.7	2.4	2.1	0	0	1.2
After Steam Cleaning	38.6	8.8	24.6	4.2	12.6	2
After Cleaning	41.4	17.7	16.3	19.01	23.8	3.3
Before Cleaning	55	33.2	22.4	45.4	6	4.5

6.7 EFM Scorecard

The Directorate commenced monthly performance reviews with the Executive team within the year, developing their monthly scorecard and performance criteria. The team report monthly on quality, performance, effectiveness, exceptions, risk register, workforce and Finance. These sessions have been received well by all involved and provide a robust review of the services being delivered.

6.8 Laundry

The laundry services were successful in winning a new large contract within the year and now provide a full linen and laundry service to Carillion Health for the Darenth Valley Hospital, processing in excess of 200,000 items per month.

7 Estates and Facilities Management Key Objectives for 2016/17

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

7.1 Project Management

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

7.2 Building

- To ensure compliance with Statute

7.3 Operational Management

- To review procedures and workforce for future delivery of services
- Ensure ongoing training works towards improved VFM and an increased in-house skill base
- Continue implementation of UV decontamination system
- Review Laundry service business opportunities
- Investigate opportunities around liquidity of building assets or alternative funding/management solutions
- Evaluate single EFM system solutions for simplicity and continuity in recording and reporting, together with ability to operate single help desk

7.4 Support Services

- Recruitment
- Retention
- Schedules, structures, procedures and hierarchies to be reviewed in relation to current and anticipated demand.

Jeanette Rooke
Director, Estates and Facilities Management
7th July 2017

Appendix A – MTW Estates and Facilities Dashboard 2015-16

NHS ESTATES AND FACILITIES DASHBOARD 2015-16

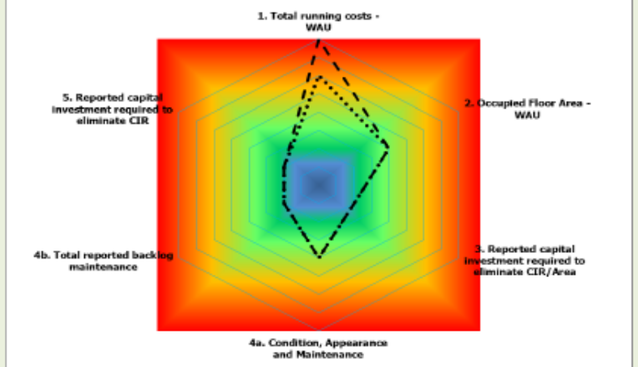
CODE	RWF	TRUST NAME	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

TRUST OVERVIEW

Organisation type	ACUTE - LARGE
Commissioning region	SOUTH OF ENGLAND

		2015-16	2014-15
Total occupied floor area	m2	124,274	125,011
Total estates and facilities running costs	£	48,555,947	58,186,036
Potential total E & F running cost saving by moving to the trust type median	£	826,957	13,491,499
Potential targeted E & F running cost savings from individual cost elements	£	4,879,371	4,823,679
Amount of empty and underutilised space	%	0.3%	not collected
Potential cost savings from full utilisation of empty and underutilised space	£	145,253	not collected
% of occupied floor area operated under a PFI contract	%	51%	51%
% of occupied floor area under direct NHS management	%	49%	49%
E & F running cost of floor area operated under a PFI contract	£/m2	671.79	402.98
E & F running cost of floor area under direct NHS management	£/m2	96.87	529.97
Total trust income	£	400,978,000	403,358,000

Trust metrics plotted against the trust type median



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

WAU (Weighted Activity Unit) is a measure that utilises a cost-weighted output figure based on the Health Episode Statistics and Reference Cost data to provide a relative assessment of the activity in the trust. It is then adjusted by the market forces factors to reflect different cost levels nationally. Further details on WAU can be found in the Dashboard Guidance available on DH Exchange.

METRICS SOURCED FROM NATIONAL DATA

Domain 1 - Efficiency - Cost		TRUST METRIC 2015-16	Trend	2014-15	Trend	2013-14	2015-16 QUARTILES FOR ACUTE - LARGE Lowest	Lower Quartile	Median	Upper Quartile	Highest
Total estates and facilities running costs / WAU	£ / WAU	474.74	↓	598.55	n/a	not collected	262.00	419.23	461.94	525.56	823.24
Total estates and facilities running costs / area	£ / m2	390.72	↓	465.45	↑	385.62	227.62	305.01	384.06	411.74	585.26
Total Hard Facilities Management costs - WAU	£ / WAU	93.54	↑	93.53	n/a	not collected	41.14	92.04	110.67	135.88	191.00
Energy costs	£ / Units	0.09	↓	0.11	↓	0.11	0.03	0.05	0.06	0.07	0.24
Building and engineering maintenance costs	£ / m2	23.62	↑	17.82	↑	15.99	3.20	22.44	26.30	36.60	108.98
Portering	£ / m2	21.61	↑	18.62	n/a	not collected	7.63	13.70	16.17	19.09	26.33
Water and sewage costs	£ / m2	4.58	↓	4.61	↓	4.66	1.17	2.85	3.73	4.88	6.13
Special and Clinical Waste costs	£ / tonnes	438.17	n/a	not collected	n/a	not collected	143.96	345.31	398.50	536.99	16,615.42
Total Soft Facilities Management costs - WAU	£ / WAU	210.78	↑	205.74	n/a	not collected	81.86	145.25	178.15	202.10	252.58
Laundry and linen costs	£ / item	0.29	↓	0.31	↓	0.33	0.22	0.29	0.33	0.36	0.43
Food costs	£ / meal	3.46	↓	3.83	↑	3.04	1.65	3.12	3.84	4.48	8.11
Cleaning costs	£ / m2	58.68	↑	57.14	↑	51.87	17.48	32.98	40.87	44.27	58.68

Domain 2 - Effectiveness - Productivity		2015-16	Trend	2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Occupied Floor Area - WAU	m2 / WAU	1.23	↓	1.25	n/a	not collected	0.97	1.16	1.29	1.42	1.67
Amount of empty space	%	0.3%	n/a	not collected	n/a	not collected	0.0%	0.0%	0.8%	3.1%	19.5%
Amount of underutilised space	%	0.0%	n/a	not collected	n/a	not collected	0.0%	0.0%	0.4%	3.0%	24.8%
Amount of non-clinical space	%	26.1%	↓	44.7%	↓	46.3%	20.9%	27.9%	34.2%	37.2%	49.8%
Total income earned per area	£ / m2	3,227	↓	3,227	↑	2,921	2,215	2,626	2,935	3,238	4,136
Estates and facilities staff sickness absence rate	%	5.7%	↓	6.2%	→	6.2%	0.3%	4.8%	5.6%	6.1%	8.9%
Amount of energy used	Units / m2	408.64	↑	277.57	↓	287.51	71.94	393.90	424.90	489.90	663.39
Portering	Beds/WTE	8.75	↑	7.39	n/a	not collected	5.66	8.25	9.34	10.99	22.38
Special and Clinical Waste - WAU	WAU ratio*	0.0061	n/a	not collected	n/a	not collected	0.0009	0.0061	0.0073	0.0091	0.0161
Laundry and linen - WAU	WAU ratio*	36.91	↓	43.22	n/a	not collected	12.95	30.04	35.40	40.21	46.02
Food service productivity	Meals / Beds / Day	3.15	↓	3.48	↑	3.32	0.81	2.91	3.20	3.46	4.53
Cleaning productivity	m2/WTE	515.17	↑	504.08	↑	470.78	250.11	350.83	633.89	715.85	1,898.41

Domain 3 - Safety		2015-16	Trend	2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Reported Critical Infrastructure Risk (CIR)/Area	£/m2	4.31	↓	4.83	↓	109.77	0.00	22.23	36.75	127.51	294.51
Reported Critical Infrastructure Risk	£	535,063	↓	604,248	↓	14,122,000	0	3,716,116	7,695,606	19,331,130	41,526,074
Fires recorded	No.	0	→	0	→	0	0	1	3	8	20
False Alarms	No.	92	↓	96	↑	91	6	67	101	132	233
Number of people injured resulting from fire(s)	No.	0	→	0	→	0	0	0	0	0	1
Number of patients sustaining injuries during evacuation	No.	0	→	0	→	0	0	0	0	0	0

Domain 4a - Quality - Patient Environment		2015-16	Trend	2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Condition, Appearance and Maintenance	%	95.32%	↑	92.32%	↓	93.94%	85.37%	91.03%	93.32%	95.38%	98.39%
Cleanliness	%	99.36%	↑	98.97%	↓	99.27%	90.17%	96.89%	98.68%	99.24%	99.98%
Food	%	92.96%	↑	91.52%	↑	79.61%	73.04%	84.65%	88.72%	91.96%	99.13%
Privacy, Dignity, Wellbeing	%	89.21%	↓	91.03%	↑	78.12%	64.83%	78.39%	82.84%	87.17%	97.46%
Condition, Appearance and Maintenance	%	95.32%	↑	92.32%	↓	93.94%	85.37%	91.03%	93.32%	95.38%	98.39%
Dementia	%	87.70%	↓	89.09%	n/a	not collected	53.71%	65.76%	73.28%	80.12%	96.00%
Disability	%	89.59%	n/a	not collected	n/a	not collected	62.66%	70.79%	79.04%	82.99%	94.28%

Domain 4b - Quality - Infrastructure		2015-16	Trend	2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Total reported backlog maintenance	£/m2	22.24	↓	24.73	↓	138.58	6.60	86.31	169.67	343.34	664.94
Amount of functionally suitable space	%	100.00%	→	100.00%	↑	66.38%	47.18%	73.45%	92.44%	99.17%	100.00%
Single bedded rooms	%	56.46%	↓	66.62%	↓	67.08%	14.97%	22.42%	26.67%	31.83%	64.34%
CO2 emissions	kg/m2	159.17	↑	53.63	↓	55.67	35.87	130.76	144.90	162.98	205.37

Domain 5 - Organisation Governance & Processes		2015-16	Trend	2014-15	Trend	2013-14	Lowest	Lower Quartile	Median	Upper Quartile	Highest
Capital investment required to eliminate CIR	£	535,063	↓	604,248	↓	14,122,000	0	3,716,116	7,695,606	19,331,130	41,526,074
Capital investment required to eliminate backlog	£	2,763,579	↓	3,092,854	↓	17,829,000	1368091	13,773,252	24,830,743	47,354,337	160,571,221
Capital spend as % of NBV of land and buildings	%	2.4%	↑	0.8%	↓	1.1%	0.3%	1.9%	2.8%	5.7%	24.5%
Income from areas leased out for retail sales	£/m2	504	↑	460	n/a	not collected	0	313	536	673	1,875
Income from other organisations (exluding retail sales)	£	353,794	n/a	not collected	n/a	not collected	0	435,004	1,215,957	2,921,886	16,815,739

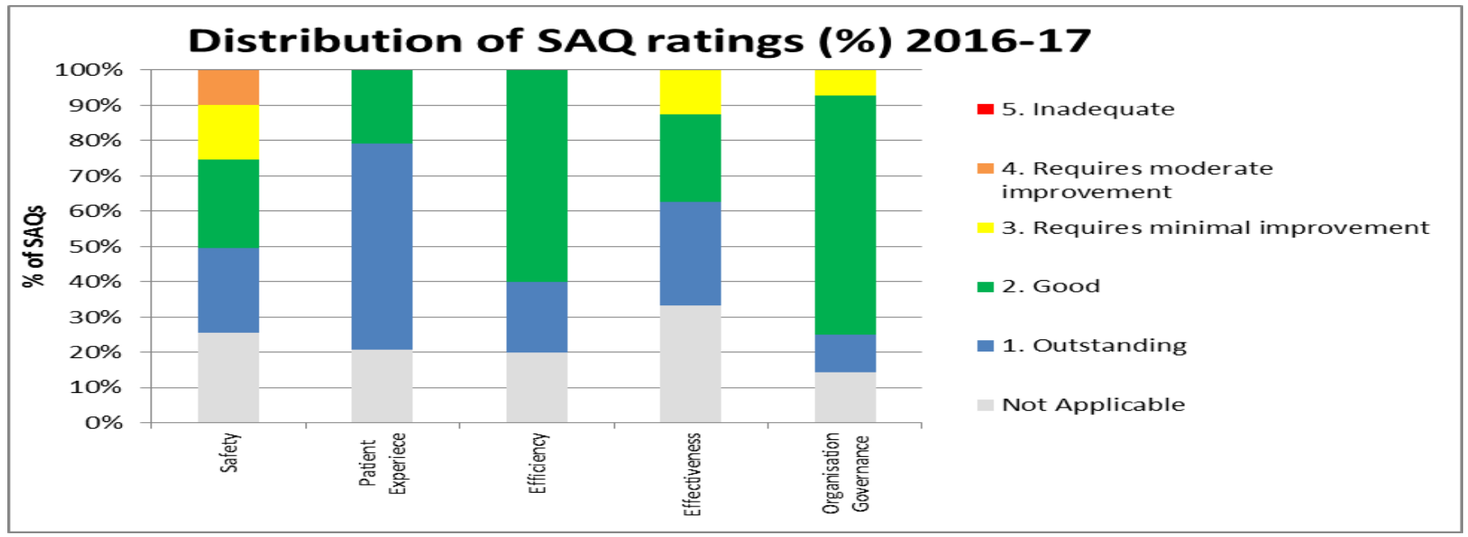
Produced by: Estates and Facilities Management Efficiency Project Team, Department of Health

For further information please refer to the NHS Estates and Facilities Efficiency Dashboard Guidance document or contact the dedicated mailbox efmefficiencyteam@dh.gsi.gov.uk

Sources: ERIC 2015-16, 2014-15 and 2013-14, PLACE 2016, 2015 and 2014, Electronic Staff Records 2015-16, 2014-15 and 2013-14, Trust Financial Accounts 2015-16, 2014-15 and 2013-14

Version 2.0 January 2017

Appendix B –NHS Premises Assurance Model 2016-17



Legend

Domain	Domain statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Patient experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Organisation governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

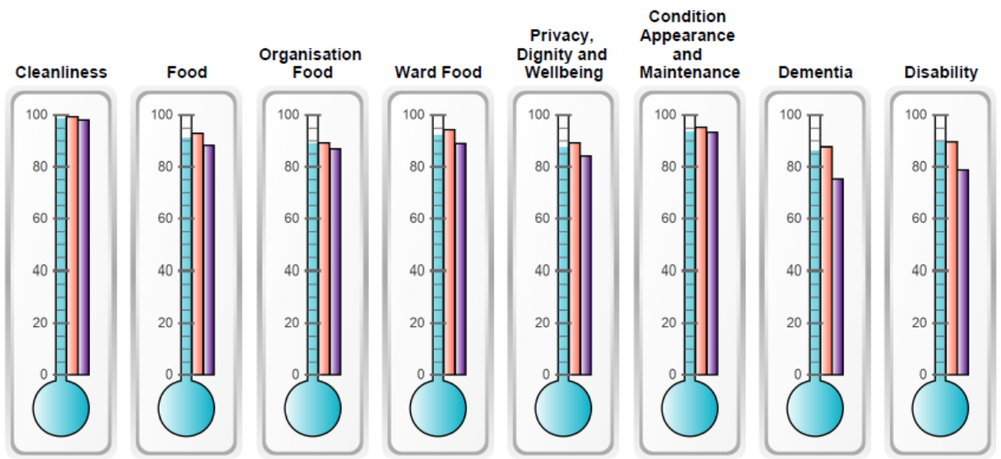
		Safety	Patient Experiece	Efficiency	Effectiveness	Organisation Governance
		£	£	£	£	£
2016-17	Capital cost to achieve compliance	95,000	0	0	2,500	0
	Revenue consequences of achieving compliance	0	0	0	0	0

The following table shows, the number of Self-Assessment Questions that receive a certain rating in the different domains

	2016-17						
Overall Domain Rating:	Not Applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	**Total**
Safety	59	56	58	36	23	0	232
Patient Experience	5	14	5	0	0	0	24
Efficiency	5	5	15	0	0	0	25
Effectiveness	8	7	6	3	0	0	24
Organisation Governance	4	3	19	2	0	0	28

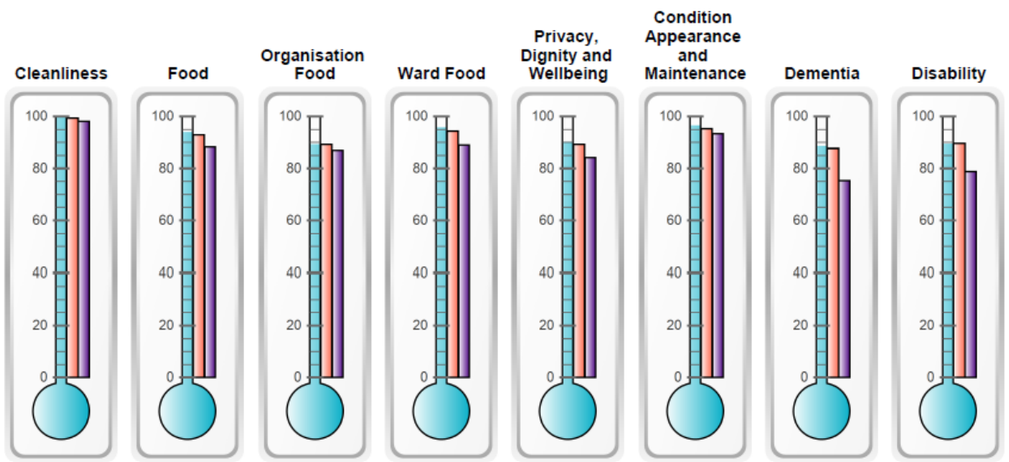
Appendix C – MTW PLACE Audit submission

MAIDSTONE GENERAL HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3333.0000	318.5039	102.1090	216.3949	326.0000	1391.0000	815.9117	459.6680
Available Score (Actual)	3376.0000	348.8737	114.5880	234.2857	372.0000	1486.0000	944.8571	512.3697
Site Score	98.73%	91.29%	89.11%	92.36%	87.63%	93.61%	86.35%	89.71%
Organisation Average	99.36%	92.96%	89.21%	94.40%	89.21%	95.32%	87.70%	89.59%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

THE TUNBRIDGE WELLS HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3487.0000	414.5081	102.2981	312.2100	298.0000	1438.0000	778.9117	483.6680
Available Score (Actual)	3494.0000	440.4703	114.5880	325.8823	330.0000	1490.0000	878.8571	540.3697
Site Score	99.80%	94.11%	89.27%	95.80%	90.30%	96.51%	88.63%	89.51%
Organisation Average	99.36%	92.96%	89.21%	94.40%	89.21%	95.32%	87.70%	89.59%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

Trust Board meeting July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-15 Responsible Officer's Annual Report 2016/17 — Medical Director

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The Board is asked review the report and approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2017).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. To review the report and;
2. To approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

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

Maidstone and Tunbridge Wells NHS
NHS Trust

ANNUAL REPORT: MEDICAL APPRAISAL AND REVALIDATION AT MTW

1. Executive summary

Maidstone and Tunbridge Wells NHS Trust (MTW) is responsible for providing an annual appraisal to all doctors who have a prescribed connection. Of the 392 MTW doctors with such a connection, 359 completed an appraisal in the 2016/17 appraisal year ending 31.03.17. This is an overall appraisal rate of 92%. The rate varied with the grade of doctor: 95% consultants and 88% staff and associate specialists had an appraisal and 83% of the trust grade/locums and other grades had an MTW appraisal. As at 12th May 2017 96% of connected doctors had submitted an appraisal where it was appropriate (ie excluding those which were not yet required).

Quality assurance of the appraisal process was maintained with 150 appraisal output forms (30%) being reviewed with the NHS England tool for reviewing appraisal outputs. A random sample of the 14 portfolios of supporting information of MTW doctors were reviewed against NHS England standards to audit the information being submitted to the appraisal process.

The national phased roll out of the medical revalidation instigated in 2012 allocated all registered doctors to have been revalidated by March 2016. This resulted in a large drop in the numbers of doctors whose revalidation fell due in 2016/17. The MTW advisory panel met monthly to advise the Responsible Officer (RO) about these recommendations as they fell due through the year. The RO made 20 positive revalidation recommendations, 18 deferral recommendations and no recommendations of 'non-engagement' to the General Medical Council (GMC).

2. Purpose of the report

As a designated body, Maidstone and Tunbridge Wells NHS Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The purpose of revalidation is to give assurance to patients, employers, doctors and regulators that doctors are up to date, fit to practice and safe within their entire scope of practice (not just their NHS work). This paper seeks to give Board assurance that MTW meets its statutory requirements surrounding appraisal and revalidation of its doctors.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations2 and it is expected that provider Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The responsible officer has a defined overall responsibility for the management of all aspects of medical appraisal and revalidation. At MTW aspects of this are delegated to a deputy medical director who acts as the Trust's appraisal lead. Administrative support is provided by the Medical Director's personal assistant. Although systems for medical appraisal have been a requirement since 2001 these were overhauled at MTW in 2008. New systems of monitoring and quality assurance have evolved since then, as national guidelines have developed and clarity around the revalidation process has emerged.

Appraisers have been trained either internally or through external providers and updated annually, just prior to the commencement of the annual appraisal round.

Quality assurance processes are led by the appraisal lead. There is no designated HR lead for medical appraisal and revalidation processes.

The MTW 'Revalidation Advisory Group' met to assist the responsible officer with making and documenting revalidation recommendations for MTW doctors. The group has terms of reference and consists of the medical director, two deputy medical directors and the associate director of workforce. The group met monthly and triangulated the appraisal records, as well as any information about complaints, claims, incidents and disciplinary issues concerning the doctor whose revalidation is due. The RO may make one of 3 recommendations:

- A positive recommendation to revalidate
- A recommendation to defer revalidation for up to one year
- A notification that a doctor has not engaged adequately with the appraisal process.

[2] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Data about all doctors connected to MTW is kept on a spreadsheet which is regularly updated with information about previous appraisals and any concerns about their practice. This list is adjusted as doctors new to MTW establish a prescribed connection through a list held on the 'GMC connect' website. Changes are cross referenced with Medical Staffing, the Director of Medical Education and with clinical directorates to ensure that the link is appropriate and reflects the true employment status of the doctor.

Data on appraisal and revalidation processes is supplied to the regional team of NHS England on a quarterly basis by the appraisal lead.

Benchmarking of appraisal and revalidation processes also takes place through RO and Appraisal Lead attendance at Regional network meetings (3 times per annum).

a. Existing Policy and Guidance

- MTW Appraisal and Revalidation Policy 2016
- MTW Management of concerns about the performance of doctors policy 2011
- MTW Back on track policy 2012
- NHS England appraisal policy 2014
- GMC: supporting information for appraisal and revalidation 2013
- GMC: framework for revalidation 2012

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

- 392 doctors connected to MTW as at the end of 15/17 on 31.03.17
- 359 doctors had a completed appraisal (92%)
- 248/243 consultants (95%); 52/59 SAS doctors (88%) and 59/71 of other doctors (83%) completed an appraisal.

(See also **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

75 MTW doctors are listed on the MTW list of approved appraisers, (10 SAS doctors and 65 consultants). Three new appraisers were trained in 2016/17.

MTW appraisers attended one of four mandatory appraiser update sessions held in August and September 2017 by the appraisal lead. The content was determined by the action plan from the previous annual report and emphasised areas identified to have been poorly addressed in the 2016/17 appraisal round.

Appraisers received personal feedback about their performance in the 16/17 round with anonymised comments from their appraisees.

The RO attended 3 of the 3 regional RO network meetings. The appraisal lead attended and facilitated three appraisal workshops with a neighbouring trust to permit sharing of practice.

c. Quality Assurance

Outline of MTW quality assurance processes:

For the appraisal portfolio:

- Review of 5% of MTW medical appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate.
- Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard -by whom and sign offs. An MTW defined checklist is used to ensure that appraisal outputs meet minimum standards required for certification of completion.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs. A flag is used on the appraisal spreadsheet to identify any pieces of information that the RO has asked the doctor to discuss at appraisal, to ensure a written reflection is present.

For the individual appraiser:

- An annual record of the appraiser's participation in update meetings
- 360^0 feedback from doctors for each individual appraiser. A standard questionnaire is sent out to each appraisee upon receipt of the appraisal output. This is collated on a spreadsheet and used to feedback to appraisers in an anonymised format at the close of the appraisal round.

For the organisation:

- Feedback about Trust processes is sought from all doctors completing an appraisal
- Scrutiny of all the appraisal outputs by the appraisal lead and RO permits an overview of themes, risks and concerns to be formulated.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

The MTW appraisal system is paper based. In MTW adopted the new national Medical Appraisal Guide ('MAG') forms produced by the NHS England in 2016. This is an interactive pdf which can be down loaded from the NHS England website and is available from the MTW RO office. Supporting information can be uploaded into the MAG form. Adoption of the form was not problematic and permitted a less paper based process compliant with national best practice.

The Medical Director's office holds spreadsheet information about MTW doctors on shared Q drive in the clinical governance section. These are password protected documents.

Portfolios of supporting information are held by the doctor and shared with the appraiser prior to the appraisal meeting. At completion of the appraisal the portfolio is returned to

the doctor who is required to keep until completion of the relevant revalidation cycle. The completed appraisal forms are held in the Medical Director's office for 6 years.

Doctors are reminded of their information governance responsibilities not to include patient or colleague identifiable information in their appraisal portfolios. At the close of the appraisal round appraisers are reminded of their responsibility not to retain any paper or electronic record of the appraisals they have undertaken. No appraisal related information governance breaches were notified in the 2016/17 cycle.

e. Clinical Governance

Medical appraisals are evidence based through the requirement for doctors to produce a portfolio of supporting information to demonstrate they are up to date in their entire scope of practice. Designated bodies are expected to assist this process by the provision of corporate data to support individual doctor's appraisals. This process is immature. The following data sources are available:

- Dr Foster data
- Results of clinical, network based and national clinical audits
- Workload and productivity data is available in some specialties but may be team based or consultant based, so not applicable to other grades.
- Data about income generation for the Trust by clinical teams
- Clinical governance meeting information, attendance and contribution at clinical governance meetings.
- Complaints, litigation and claims data.
- Information about participation in statutory and mandatory training
- A doctor may be directed by the RO to bring information and evidence of personal reflection about a specific complaint, incident, claim, coroner's inquest or disciplinary issue to his appraisal and its inclusion is monitored.

6. Revalidation Recommendations

20 MTW doctors were given a positive revalidation recommendation in the 16/17 year (71%). 8 doctors had deferred recommendations (29%) and on doctor remains 'on-hold' because of on-going GMC processes. No 'non-engagement' notifications were made.

The common cause of deferral of revalidation was the absence of sufficient information on which to make a recommendation. Often this was the absence of formalised patient feedback through the MTW 360 appraisal system or poor evidence of participation in quality improvement activity.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

MTW detailed recruitment processes require the credentialing and performance of background checks. Fair recruitment and selection is part of the Trust's wider commitment to equality of opportunity in employment and effective recruitment, selection and appointment of staff are key elements in ensuring the Trust's workforce have the skills and capabilities to achieve its business aims.

The Trust's recruitment policy and procedure outlines recruiting personnel obligations and clear processes to ensure that the Trust selects the best person for the job, in a process which is fair, open and transparent, and compliant with legislation, best practice and NHS Employers Employment Standards, and NHSLA Frameworks. The policy applies to the recruitment and selection of all Trust medical staff, irrespective of the contractual status of the vacancy, clinical speciality, or seniority.

Employment checks are an on-going requirement for Trust staff, and will be applied in relation to internal moves and promotions within the Trust.

Professional registration and entitlement to work / remain in the United Kingdom are also monitored via monthly reports, and utilisation of on-line checking systems.

Equally relevant employment checks are carried out in relation to medical temporary staff who are utilised within the Trust via agencies in order to ensure that current / valid professional registration is in place and checklists placed on file / available for audit.

Although no formalised system of language checking has been instigated, communication competency forms part of the interview process which is also attended by a member of the HR team.

See **Annual Report Template Appendix E**

8. Monitoring Performance

The Trust governance structures are in place and allow scrutiny of clinical performance throughout the organisation. Data on clinical outcomes, morbidity and mortality, readmissions and length of stay are regularly interrogated for clinical directorates allowing monitoring of clinicians performance.

9. Responding to Concerns and Remediation

Concerns regarding clinicians are handled under the umbrella of MHPS (maintaining high professional standards), and our Trust policies that encompass that national guidance. As appropriate, clinical or capability concerns are handled with advice from NCAS (National Clinical Advisory Service).

The Trust has a remediation policy, to address deficiencies of performance that are identified.

10. Risk and Issues

- The overall appraisal rate of 92% in 16/17 was the same as in the previous year. However the appraisal rates for substantive staff dropped in 16/17: consultants 95% (from 97%), SAS doctors 88% (from 97%) but improved for MTW doctors with fixed term contracts 83% (from 71% in 2015/16). This indicates an

improvement in appraisal systems in identifying doctors linked to MTW on fixed term contracts who need an appraisal. The overall number of appraisals performed in the cycle increased from 350 in 2015/16 to 359 in 2016/17.

- Systems to ascertain the appraisal and revalidation status of doctors employed on fixed term contracts and other new appointees has led to considerable improvement in this area although the appraisal rate still lags behind that of substantive medical employees.
- A reliable consistent mechanism that provides appropriate summary of Trust governance information about an individual doctor is still lacking and was identified as a risk in previous year's reports. This would allow all MTW doctors to include a statement of significant complaints and incidents in their portfolio that can be discussed with the appraiser and reflections and learning documented at appraisal. Current systems largely rely on the doctor remembering to declare adverse episodes and appraisers would much prefer to see a statement of such episodes provided by the trust to every doctor.
- 19% doctors took longer than 28 days to submit their completed appraisal (compared to 22% from 2015/16) but 32% doctors had their appraisal interview later than the last day of their assigned month (an increase from 28%).
- No doctors used the same appraiser for a 4th consecutive appraisal which has previously been an issue.
- There was some improvement in the consistency with which doctors declared their entire scope of practice and the supporting evidence they present in non-NHS roles.
- Doctors are required to present declarations from independent hospitals about current complaints or incidents. There is no effective means of monitoring compliance and this presents a risk to the RO's ability to have a complete knowledge of a doctor's performance.
- The NHS England tool for assessing the quality of appraisal summaries showed on-going problems in the overall quality of appraiser performance in 16/17. There is a particular weak area of documenting the reflective practice of doctors and the impacts this has on team working and improvements to patient care. This will require further reinforcement with appraisers and appraisees in the next appraisal round.
- Improvements to the GMC Connect website have eased monitoring of doctors who have recently connected to MTW as their Designated Body.
- There was continued poor use of the appraisal deferral form from doctors who anticipated that they would have difficulty in doing a timely appraisal.
- Individualised electronic revalidation folders for all MTW doctors were introduced in 2016; this comprises a dashboard style of cumulative information since the doctor's last revalidation. This has allowed a complete appraisal record to be easily available to the RO at the revalidation advisory group meetings. Other information about the doctor, such as 360 MSF and incident outcomes is also stored in the folder.

11. Board Reflections

- MTW has a high rate of medical engagement with the statutory requirements around appraisal and revalidation.
- Appraisal rates are taken as a crude marker of the quality of appraisal systems in designated bodies by NHS England, GMC and the media.
- Regulatory bodies can take action against a Trust should they suspect that the systems in place lack assurance of quality.
- These systems are an administrative burden and represent a major commitment of time, effort and professionalism for our trained appraisers.
- There is scope for improvement in the quality of medical appraisals. Increasing rate of late submission may be indicative that doctors do not value the process.

12. Corrective Actions, Improvement Plan and Next Steps for 17/18

- MTW will continue to use the national MAG form for appraisal.
- The documentation of reflective practice will be a focus of learning for the appraiser update sessions that precede the 17/18 round.
- Medical staffing and clinical governance teams will build on the improving assistance and support to the Medical Director’s office so that the administrative burden of this process is minimised and appropriate assurance given.
- Doctors need to value the appraisal process and understand how the MTW utilises the information that is gleaned from it. There needs to be renewed focus on appraisee training.

13. Recommendations

The Board is asked to accept this report and to approve the statement of compliance confirming that the Trust as a designated body, is in compliance with the regulations governing appraisal and revalidation (Appendix F)

Annual Report Template Appendix A: Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the ‘appraisal due window’	4
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter – unknown previous appraisal history	15
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	70
Lack of time of appraiser	2
Other appraiser factors (describe)	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B: Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		359
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	14	14
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	14	14
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	14	13
Patient feedback exercise: Has a patient feedback exercise been completed? (in this appraisal or within this revalidation cycle)	14	9
Colleague feedback exercise: Has a colleague feedback exercise been completed?	14	8
Review of complaints: Have all complaints been included?	14	12
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	14	13
Is there sufficient supporting information from all the doctor's roles and places of work?	14	9
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	14	12 Only 1 in year 5 and not complete 12
Appraisal Outputs		
Appraisal Summary	14	14
Appraiser Statements	14	14
PDP	14	14

Comments:

The standard was felt to be acceptable in all case and excellent in a few.
The following themes were detected:

1. Very little reflective documentation, eg, documenting no complaints / SIs etc.
2. Including old documentation that is no longer relevant.
3. Job plan not always present.
4. Scope of practice could be better described.

Annual Report Template Appendix C: Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	28
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	28
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor’s revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	
Other	N/A
Describe other	N/A
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix D: Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months	0	1	0	1
Conduct concerns (as the primary category) in the last 12 months	2	1	1	4
Health concerns (as the primary category) in the last 12 months	0	0	0	0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All DBs				
TOTALS				1

Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	4
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	0
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Annual Report Appendix E: Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	21
Temporary employed doctors	253
Locums brought in to the designated body through a locum agency	217
Locums brought in to the designated body through 'Staff Bank' arrangements (including doctors already employed by MTW but working bank shifts)	239
Doctors on Performers Lists	We do not hold this information
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	None
TOTAL	

A Framework of Quality Assurance for Responsible Officers and Revalidation

Appendix E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Appendix E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Appendix F – Statement of Compliance

Designated Body Statement of Compliance

The Board of Maidstone and Tunbridge Wells NHS Trust (MTW) has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Peter Maskell, Medical Director fulfils these requirements for MTW.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Changes introduced in 16/17 have ensured improved and more prompt inclusion in the appraisal process for all doctors linked to MTW.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: 75 medical appraisers are recognised by the Trust for this role.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: annual update sessions are held by the appraisal lead and there are strong quality assurance systems that permit feedback of performance to appraisers.

5. All licensed medical practitioners[3] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: The new national MAG form is used at MTW

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The Trust is looking to build on existing systems to ensure doctors have access to data and supporting information relevant to their practice

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: These areas are covered by existing Trust processes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: At MTW RO to RO communication is triggered by the recruitment of any new doctor establishing a prescribed connection to MTW. There is regular contact between MTW's RO and ROs at local independent providers. Ad hoc communication is conducted as circumstances dictate.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed; and

Comments: At MTW all mandatory pre-employment checks are carried out prior to start date to ensure that all licensed medical practitioners are qualified and experienced as appropriate for their role.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes – see actions emerging from the annual report.

Signed on behalf of the designated body

Name: Glenn Douglas,
Chief Executive

Signed: _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[4] Doctors with a prescribed connection to the designated body on the date of reporting.

Trust Board meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-16	**Summary report from Charitable Funds Committee, 26/06/17 (including approval of Annual Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund, 2016/17)**	**Committee Chair (Non-Executive Director)**

Summary / Key points

The Charitable Funds Committee met on 26th June 2017.

1. The key matters considered at the meeting were as follows:

- Under the Safety Moment, the Trust Secretary reported that the month's theme was Safeguarding Adults and outlined the various communications and training initiatives planned to increase awareness of this subject
- The draft Maidstone and Tunbridge Wells NHS Trust Charitable Fund Annual Report and Accounts 2016/17 were reviewed and agreed subject to minor amendments to wording (including an action to "Review and expand the wording on "staff benefits" within the "Expenditure" section of the Charitable Fund Annual Report and Accounts 2016-17 to better reflect the focus on staff training and its positive impact on patient care"). Subject to these amendments, the Committee recommended the Annual Report and Accounts (Appendix 1) for approval by the Trust Board
- It was confirmed that the Report and Accounts had been subject to an Independent Examiner's Report, rather than a full audit (due to the low income received) which confirmed that the Accounts presented a true and fair view. A small number of minor presentational and classification amendments (as recommended by the auditors) were noted
- The financial overview at M2, 2017/18 was noted, including total income of £8k and expenditure of £64k to date and an overall fund balance of £1.144m
- The balances of the Trust's individual funds was noted
- As part of the annual review of investment strategy, a review of alternative investment opportunities had been undertaken, specifically a review of CCLA products against the existing CAF holdings. Due to the very small difference in returns offered, it was agreed to retain existing investments with CAF and to consolidate bank account holdings, whilst continuing to monitor alternative investment opportunities
- A management and administration fee for 2017/18 representing a £900 decrease on the 2016/17 fee was agreed. The figure assumed a full audit in 2017/18 and this would be reviewed if the income threshold required only an independent examination. The fee did not include provision for the proposed new fundraiser role
- The updated job description for the role of Fundraising Manager was noted and momentum in appointing to the post was urged. There was discussion of the various options for allocating the costs of the post and it was proposed that, until the main focus of the role had been identified, the balance of the "TRUST MANAGEMENT DIR FUND" should be reserved for underwriting the first 6 months' costs of the role (subject to agreement by the Chief Executive). It was agreed that the intended focus of fundraising activities should be scheduled for review at the next meeting (October 2017)
- The results of the Association of NHS Charities' financial comparison survey 2016 were noted

2. In addition to the actions noted above, the Committee agreed that:

- N/A

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- For information and assurance
- To approve the Annual Report and Accounts for the Charitable Fund 2016/17

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts

for the year ended 31 March 2017

Charity Number 1055215

mtw mtw.nhs.uk
Charitable Fund

Contents

Annual Report for the year ended 31 March 2017

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds (the Charity's) annual report and the audited financial statements for the year ended 31 March 2017.

The financial statements set out on pages 19 to 32 comply with the charity's trust deed, applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015).

Trustee Statement

The generosity of the many people who have raised funds, given donations and made provisions in their will, is recognised by both the Trustee and staff. The Trustee and the staff would like to express their sincere gratitude to all those who have made a contribution which has enabled the Charity to enhance the standard of care, services and facilities provided by the Maidstone and Tunbridge Wells NHS Trust to patients, their relatives, visitors and staff.

The role of the Charity

The Maidstone and Tunbridge Wells NHS Trust ('the Trust') is the Corporate Trustee of the charitable fund under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Charity is constituted by a Trust Deed and registered with the Charity Commissioners under charity number 1055215, and includes funds in respect of the hospitals of the Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites at Maidstone and Pembury in Kent. These are Maidstone Hospital and The Tunbridge Wells Hospital at Pembury.

The Charity is a 'NHS Umbrella Charity' under which there are individual sub-funds that are held for administrative purposes, principally to respect the wishes of the donors.

Within the Umbrella there were a total of 39 individual funds at the 31st March 2017 with a total value of £1,200k. The number of funds in each category is as follows:-

- 16 restricted funds.
- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 21 unrestricted or designated Funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.

The major funds within each of these categories are disclosed in Note 8 in the accounts.

The Corporate Trustee

Maidstone and Tunbridge Wells NHS Trust is the Corporate Trustee of the Charity.

The Trust Board effectively adopts the role of Trustee as defined by the Charity Commission (it is considered to be the agent of the Trustee). Individual members of the Trust Board are not trustees under Charity Law.

Details of appointments and terminations within the financial year are tabled below:

Executive Directors	Non-Executive Directors	Other Directors
Glenn Douglas – Chief Executive	Anthony Jones – Chairman of Trust Board (until 28 Feb 2017) David Highton – Chair of Trust Board (from 8th May 2017)	Sara Mumford – Director of Infection Prevention and Control
Stephen Orpin – Director of Finance	Steve Tinton – Chair of Charitable Funds Committee (until 28 Sept 2016)	
Jim Lusby – Deputy Chief Executive	Sarah Dunnett OBE	
Paul Sigston – Medical Director (until 8 Feb 2017) Peter Maskell – Medical Director (from 8 Feb 2017)	Kevin Tallett	
Angela Gallagher – Chief Operating Officer	Sylvia Denton CBE (until 28 Feb 2017)	
Avey Bhatia – Chief Nurse (until 31 Jan 2017) Claire O'Brien – Interim Chief Nurse (from 28 Feb 2017)	Alex King MBE	
Richard Hayden – Director of Workforce		

None of the Members of the Trust Board have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee. (2015/16 none)

The principal office of the Charity is:

Trust Headquarters, Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Principal advisors:

External Auditor Grant Thornton UK LLP Grant Thornton House Melton Street London NW1 2EP	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers Scottish Widows 67 Morrison Street Edinburgh EH3 8YJ
Solicitors Capsticks Solicitors LLP 1 St George's House East St George's Road Wimbledon, London SW19 4DR	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB
	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB

Governance and Management of the Charity

Governance

The Board of the Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1 April 2000, following the merger of the Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells and the Mid Kent Healthcare Trust, which was located at Maidstone. The Trust Board delegates the daily stewardship of the funds to the Charitable Funds Committee of the Trust, which within its annual programme of meetings, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee plans to meet at least three times a year.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chair of the Committee and circulated to all members.

Recruitment and Training of Trust Board and Committee Members

All Trust Board and Committee members undertake an induction programme within the Trust upon joining. They are also able to focus on a particular area of the Trust in which they have a special interest or concern.

Management of the Charity

The Charitable Funds Committee has a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised fund holders. The fund holders consist mainly of senior department managers. Each individual fund holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions, that apply to Charitable Funds. Each fund holder receives a detailed financial statement of the fund each month.

Risk Management

The major risks to the Charity have been assessed, and in the opinion of the Corporate Trustee, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust also apply to the Charitable Funds. The Corporate Trustee has identified that the main area of financial risk for the Charitable Funds is the performance of the investments.

To mitigate the risk of investment performance the Corporate Trustee has adopted a relatively low risk policy, but 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85,000 per banking institution operating under a separate banking licence. Our policy is that the maximum investment is up to £85,000 in each banking institution outside the Government banking Scheme. Therefore there is no risk on these investments.

Investment Powers

The investment powers of the charitable fund are stated in the Declaration of Trust registered with the Charity Commission, which provides for the following:

‘‘*to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustee in their discretion think fit but so that the trustee:*

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures and traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.’’

Investment strategy

The investment strategy of the charity is defined, by the charitable fund committee on behalf of the corporate trustee as follows:

“*to maximise total returns whilst minimising any risk to the total value of the fund in both the short to medium term.*”

The strategy identifies the current preferred investment mix for the charity as:

- 50% Cash;
- 25% Equities; and
- 25% Bonds.

The Charitable Funds Committee monitors the performance of the investments on a regular basis.

Professional Advisors

The External Audit is performed by Grant Thornton UK LLP. For the 2016/17 financial year, an independent examination will be carried out due to the charity’s gross income falling below £1m.

In addition, TIAA, the internal auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust. The Trustees therefore consider that the charity clearly falls within the definition of a public benefit entity under the terms of FRS 102.

The Corporate Trustee confirms that the guidance provided by the Charity Commission has been referred to with regard to the need for public benefit when reviewing their aims and objectives and future activities.

The purpose of the Charity is to provide benefit to the public by supporting the prevention and treatment of illness in all its forms and to promote research and education in healthcare through:

- Improving the patient and carer experience;
- Improving healthcare facilities and equipment;
- Facilitating high quality research programmes;
- Encouraging and supporting innovation in the development of services; and
- Supporting the training, personal development and welfare of staff.

The objects of the umbrella Charity are stated in the Trust deed as follows:-

"*The Trustee shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for such purposes relating to Hospital Services (including Research); or to any other part of the Health Service associated with any hospital as the Trustee think fit.*"

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the umbrella Charity.

Strategy for Achieving its Objectives

The Charitable Funds are used to support the overall objectives of the Trust, and include the provision of a wide range of equipment and facilities for both patients and staff. This allows the Trust to develop its services through new equipment and facilities and to provide training for staff which enhances their skills and knowledge allowing them to improve their contribution to the provision of its services to the public benefit.

The development of the Trust's services may be dependent on both the Charitable Funds and the funds received from the Exchequer. This interdependency provides opportunities for the Charity to contribute to services which make a greater impact than the cash sum would make on its own.

Reserves and Commitments

Charity Reserves as defined by Charities SORP (FRS 102) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

The Corporate Trustee has not made any changes to policy during the year and still requires that commitments against each fund are made only when the resources needed are available.

Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and

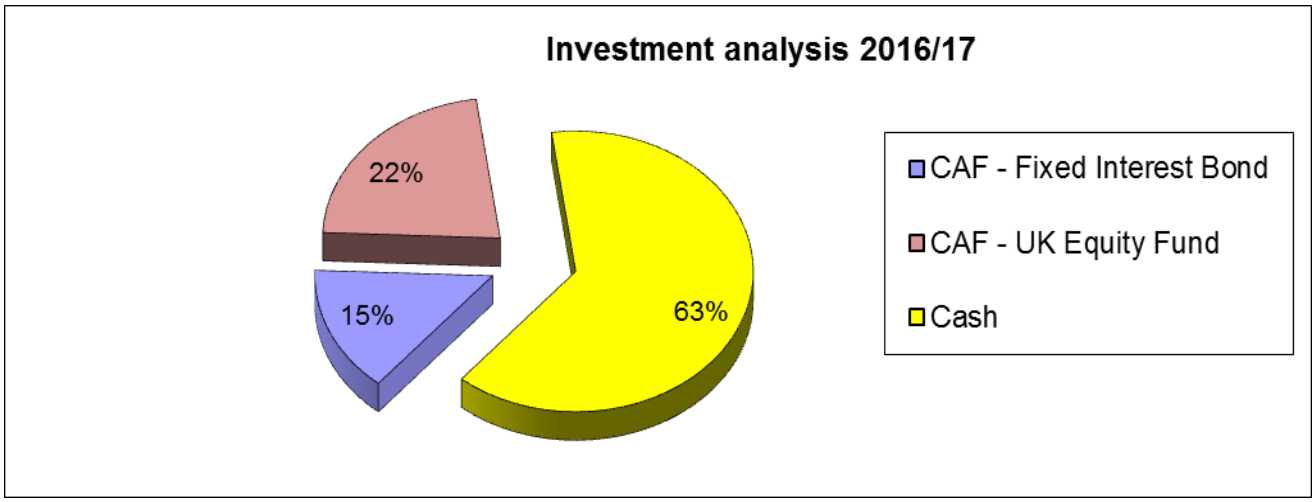
timely basis. None of the funds held by the Investment Managers are committed on a long term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

Investment income for the year was £21k (2015/16 £23k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The total performance return on the portfolio of the investments (equity and bond) was a gain of £50k which equates to 8.67% on the opening portfolio value (2015/16 3.49% loss). This reflects an improvement in market performance compared with the previous year. The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

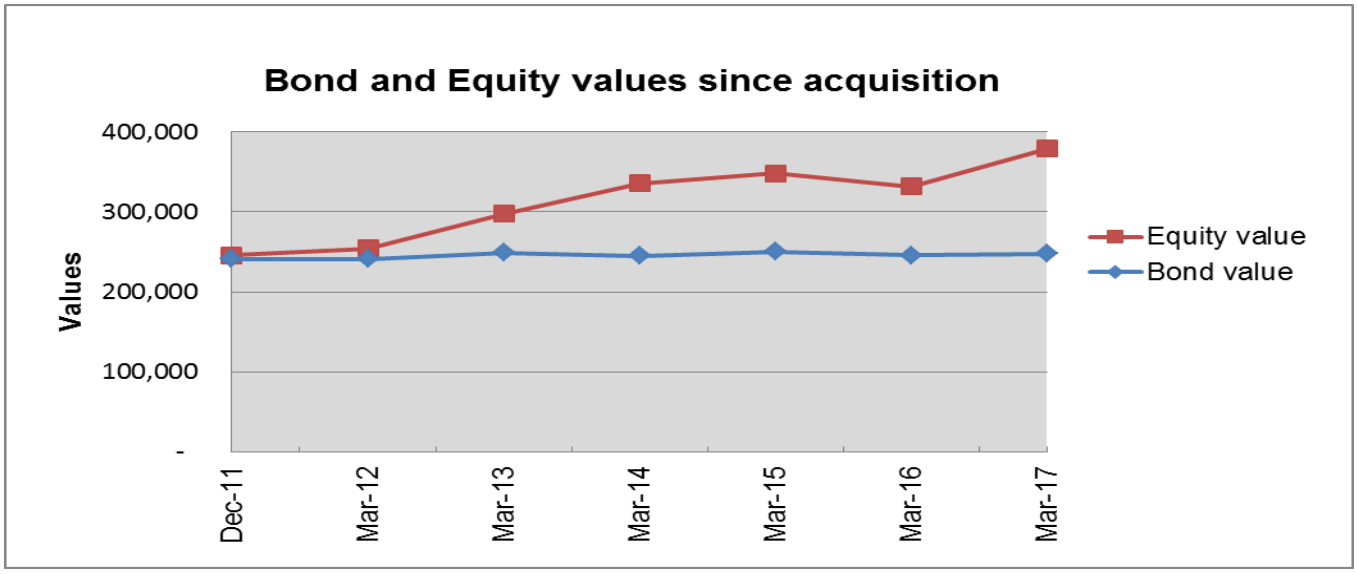
The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio increasing in market value to £627k at 31 March 2017 (£577k at 31 March 2016). The cash investment at 31 March 2017 was £1,081k (£1,514k at 31 March 2016).

The current asset portfolio of cash and investment allocation totalling £1,708k at 31 March 2017 is shown in the following graph:



The cash allocation at 63% exceeds the strategy of Cash of 50% due to the high level of legacy received in 2015/16 with matching plans to spend it in 2016/17.The plan to spend the legacies is still ongoing for 2017/18. As these plans are realised the level of cash held will reduce down to the level set out in the strategy. Consequently, the mix of bonds (15%) and equities (22%) is lower than the planned strategy. The bond and equity investments have performed better than the previous year, although equity investments continue to perform better than bond investments over time.

The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

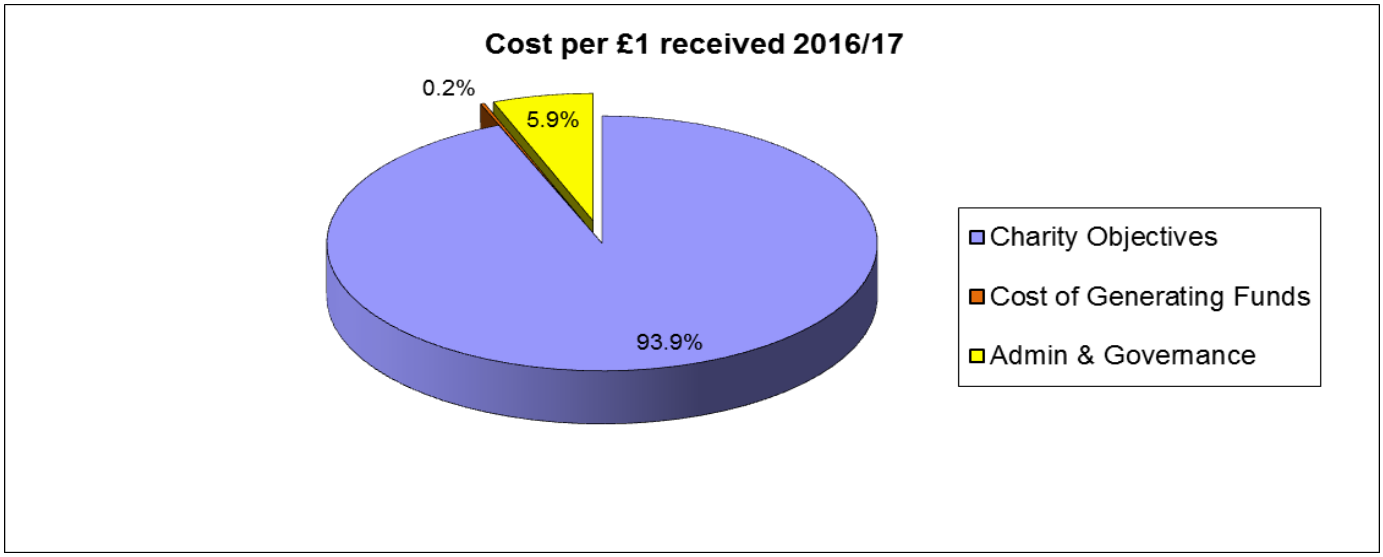


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

The Trust has achieved its objectives to enhance services and amenities for the public both as patients and visitors as well as staff through the purchase of equipment and support for projects.

The graph below shows that in this financial year for every £1 raised, 94 pence was spent in achieving the objectives of the charity. This is slightly higher than the equivalent ratio for 2015/16 (93 pence), it can be a useful guide to both donors and the corporate trustee.

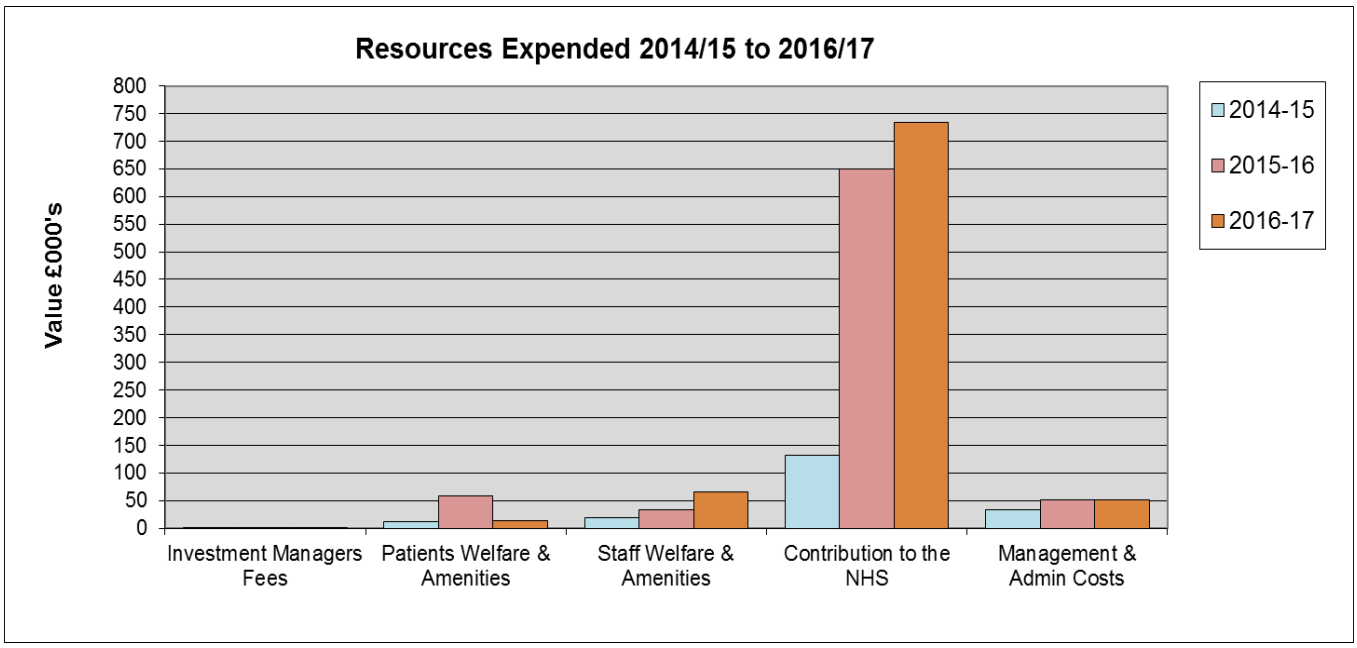


Expenditure

Total resources expended by the Charity within this financial year were £866k (2015/16 £795k), of which £785k (91%) was a contribution to Maidstone and Tunbridge Wells NHS Trust (2015/16 £700k, 88%), £14k spent directly on patient welfare, £65k on staff amenities which primarily was for further staff training to enhance the quality of patient care and £2k on

investment fees. Note governance cost of £51k is included in total contribution to NHS. The governance costs include the internal management fees for administering the funds. The fees are agreed each year by the Trustees. These costs are charged proportionately across the individual funds on a quarterly basis.

The following graph provides an analysis and comparison with previous years:



Charitable expenditure for the year is detailed below.

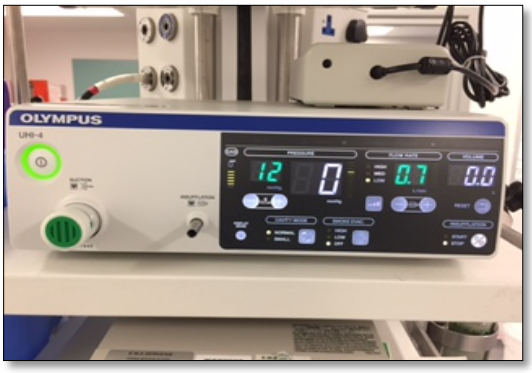
Medical Equipment – Total spend £497k (2015/16 £608k)

Medical equipment has been purchased within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities within the Trust.

The most significant purchases were:

- Additional Echo Machine funded by Mollie Hayling Legacy (£129k)
- EPIQ Ultrasound System funded by Mollie Hayling Legacy (£150k)
- 2 Cardiographs funded by the David Crow Legacy (14k)
- 3 Ultrasound Probes (£18k)
- Automated Dose Dispenser (£13k)

Insufflator for Theatres at TWH



Bladder Scanner each for Oncology at Kent & Canterbury and Maidstone

Cardiology Ultrasound for TWH Cardiology, Department (Mollie Hayling Legacy)

ECG machines for Cardiology Department at Maidstone (David Crow Legacy)

Gynae Treatment Chair for Maidstone Birth Centre

Automated Dose Dispenser for Nuclear Medicine at Maidstone

Patient Welfare and amenities – Total spend £14k (2015/16 £58k)

The most significant spends were:

- Complementary therapy (£7k)

Staff Amenities and Welfare – Total spend £65k (2015/16 £35k)

Staff throughout the Trust 'go the extra mile' to ensure the best quality of care for patients. The corporate Trustee recognises this commitment and the hard work and care given to patients and to those who visit the Trust.

The majority of the expenditure (86%) is focussed on additional training, allowing staff to develop within their roles and allowing them to enhance patient care and experience.

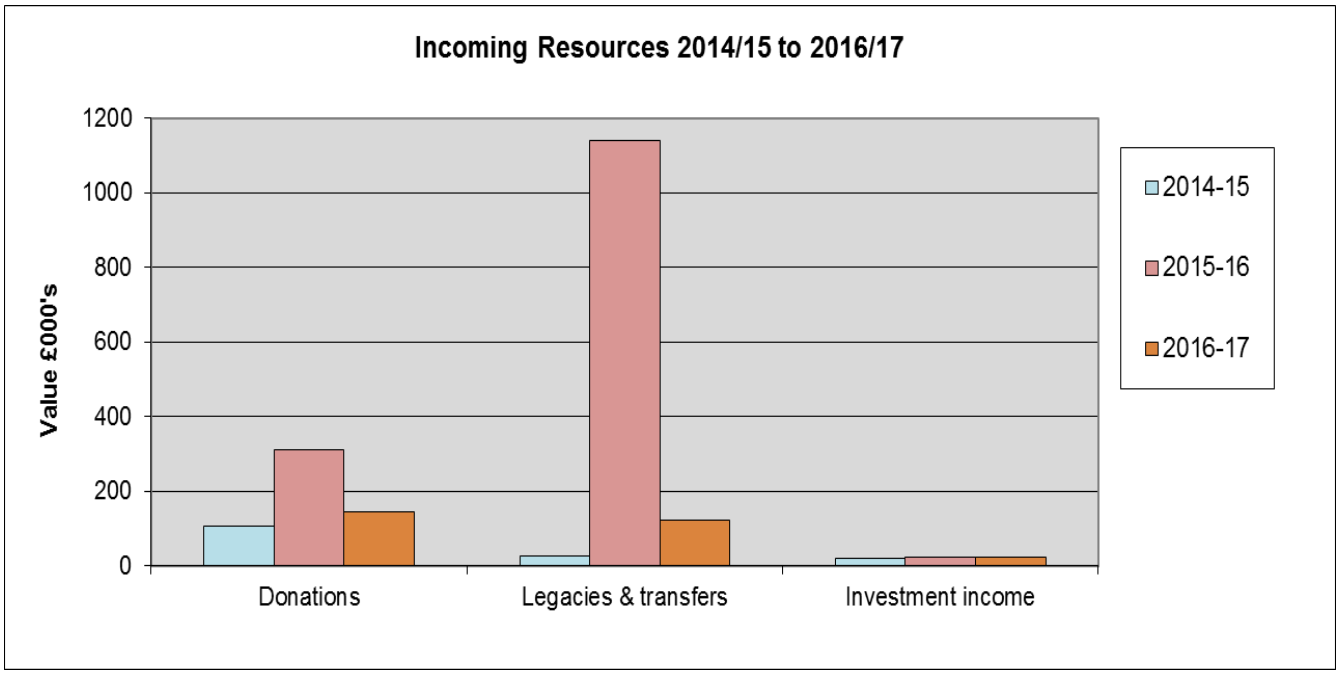
Other Direct Contributions to the NHS – Total spend £163k (2015/16 £40k)

84% of expenditure in this category has supported the purchase of fixtures and fittings. The most significant purchases were:

- 12 Volker Beds (£30k)
- 2 Gynae Couches (£16k)
- Upgrade to patient area in Oncology (£15k)

Income

The graph below shows an analysis of income sources for the current and two previous financial years:



The majority of income received by the Charity is from grateful patients and relatives who wish to support the Trust in appreciation of the work and care provided by the Trust staff.

A total of £145k was received from donations (£312k 2015/16) and £125k from legacies

(£1,139k 2015/16). We have immense appreciation of the generosity of all donors and their families. Significant donations and legacies over £10k are highlighted below.

The Trust received the following significant donations (over £10k) during the year:

	£000's
Prostate Cancer Support	49
TWADRA to purchase the Libre System for Type 1 Diabetic Patients	10

Legacies

Legacies were received from the estates of the following:

	£000's
Mollie Hayling Legacy (Final disbursement)	116
Walter Ashlee Legacy	9
Total legacy funding received	**125**

The Trust holds no material assets bequeathed to the charity but subject to a life tenancy interest held by a third party.

The Corporate Trustee is most appreciative of every gift and sends thanks to all who have supported the Trust in this way.

Fundraising

The Trust has an active 'just giving' page that received donations of £17k this year compared to £10k last year. The Trust did not undertake any other fundraising activity during 2016/17.

Gift Aid is being encouraged and staff are reminded to ask donors to use the donation and gift aid forms to increase their donation.

The Trust is exploring options around enhancing our fund raising activities.

Intangible Income

The Statement of Financial Activity does not include any estimation of intangible income in respect of volunteers' services or the free use of Trust premises.

Looking Forward - our plans for the future

The Trustee is dedicated to strengthening the long term viability of the Charity, working in partnership with the Trust to achieve their aim to deliver a first class healthcare service for our patients.

The Trust is a member of the Association of NHS Charities and continues to work with colleague organisations to ensure best practice in the Charity's activities.

The charity received good levels of voluntary income in 2016/17, thanks to the generosity of various donors, some of which are highlighted above. The Trust reviewed its investment income strategy in 2016/17, which was presented to the Charitable Funds Committee on the 28th May 2016.

Making donations

There are several ways that the generosity of those wishing to donate to our funds can be enhanced through tax saving schemes such as Gift Aid and through the internet on www.justgiving.com/mtwnhscharitablefund

We hope that you will continue to support the Trust as it seeks to enhance patient care and support staff in delivering a first class service to patients, relatives and visitors.

If you would like to find out more about the work of the Charity, make a donation, or raise funds, please contact the Trust at the principal office (details on page 4), via our website at www.mtw.nhs.uk or complete the attached form at the end of the report and send it to us.

Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

Under charity law, the Corporate Trustee is responsible for preparing the Annual Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the Charity and of the financial position at the end of the year.

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the charity and the group and hence taking reasonable steps for the prevention and detection of fraud and other irregularities. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.
The trustees are responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement as to disclosure to our auditors

In so far as the trustees are aware at the time of approving our trustees' annual report:

- there is no relevant information, being information needed by the auditor in connection with preparing their report, of which the group's auditor is unaware, and
- the trustees, having made enquiries of fellow directors and the group's auditor that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

By Order of the Trustee

Signed:

David Highton,
Chair of Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date: ……

Independent examiner's report to the trustees of Maidstone and Tunbridge Wells NHS Trust Charitable Fund

I report on the accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund for the year ended 31 March 2017, which are set out on pages 19 to 32.

Your attention is drawn to the fact that the charity's trustees have prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in May 2014 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustees have done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

This report is made solely to the charity's trustees, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my work, for this report, or for the opinions I have formed.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed. The charity's gross income exceeded £250,000 and I am qualified to undertake the examination by being a qualified member of CIPFA.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no other matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011; and
  - to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Charities Act 2011;

  have not been met; or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Darren Wells CPFA
Grant Thornton UK LLP
Chartered Accountants
2nd Floor
St John's House
Haslett Avenue West
Crawley
RH10 1HS

xx June 2017

Statement of Financial Activities for the year ended 31 March 2017

					2016/17	2015/16
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
		£000	£000	£000	**£000**	£000
Income	2					
Donations		84	61	0	**145**	312
Legacies		9	116	0	**125**	1,139
Total Donations and Legacies		**93**	**177**	**0**	**270**	**1,451**
Investment income		6	15	0	**21**	23
Total income		**99**	**192**	**0**	**291**	**1,474**
Expenditure	3					
Costs of generating funds	3.1	(1)	(1)	0	**(2)**	(2)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(306)	(558)	0	**(864)**	(793)
Total expenditure		**(307)**	**(559)**	**0**	**(866)**	**(795)**
Gains / (losses) on investments	4	12	38	0	**50**	(21)
Net income/expenditure		**(197)**	**(329)**	**0**	**(526)**	**658**
Fund transfer	4	0	0	0	**0**	0
Net movement in funds	4	(197)	(329)	-	**(526)**	658
Fund balances brought forward at 31 March 2016		410	1,307	9	**1,726**	1,068
Fund balances carried forward at 31st March 2017		**213**	**978**	**9**	**1,200**	**1,726**

The notes at pages 22 to 34 form part of these financial statements

Balance Sheet as at 31 March 2017

					2016/17	2015/16
	Note	Unrestricted Funds £000's	Restricted Funds £000's	Endowment Funds £000's	**Total Funds £000's**	Total Funds £000's
Fixed Assets	5					
Investments	5.1	112	515	0	**627**	577
Total Fixed Assets		**112**	**515**	**0**	**627**	**577**
Current Assets	**6**					
Cash at bank and in hand	6.1	191	881	9	**1,081**	1,514
Debtors due within one year	6.2	0	0	0	**0**	0
Total current Assets		**191**	**881**	**9**	**1,081**	**1,514**
Liabilities						
Creditors due within one year	7.1	(90)	(418)	0	**(508)**	(365)
Net Current Assets / (Liabilities)		**101**	**463**	**9**	**573**	1,149
Total Net Assets		**213**	**978**	**9**	**1,200**	**1,726**
Funds of the Charity	8					
Endowment Funds		0	0	9	**9**	9
Restricted Funds		0	978	0	**978**	1,307
Unrestricted Funds		213	0	0	**213**	410
Total Funds		**213**	**978**	**9**	**1,200**	1,726

For purposes of splitting assets / liabilities by category, restricted and unrestricted funds are categorised by transactions, whilst endowment funds are categorised only as cash.

The charitable funds financial statements were approved by the Trust Board on the 19 July 2017 and signed on its behalf as Trustee by:

_____ _____

David Highton, **Date**
Chair of Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows

Cash flow as at 31 March 2017		
Cash flows from operating activities:	**2016/17**	2015/16
	£000	£000
Net cash provided by (used in) operating activities	(455)	949
Cash flows from investing activities:		
Dividends, interest and rents from investments	22	23
Proceeds from the sale of property, plant and equipment	0	0
Purchase of property, plant and equipment	0	0
Proceeds from sale of investments	0	0
Purchase of investments	0	0
Net cash provided by (used in) investing activities	22	23
Cash flows from financing activities:		
Repayments of borrowing	0	0
Cash flows from new borrowing	0	0
Receipt of endowment	0	0
Net cash provided by (used in) financing activities	0	0
Change in cash and cash equivalents in the reporting period	(433)	972
Cash and cash equivalents at the beginning of the reporting period	1,514	542
Cash and cash equivalents at the end of the reporting period	1,081	1,514
Net income / (expenditure) for the reporting period (as per the statement of financial activities)	**(525)**	658
Adjustments for:		
(Gains) / losses on investments	(50)	21
Dividends, interest and rents from investments	(22)	(23)
Loss / (profit) on the sale of fixed assets	0	0
(Increase) / decrease in debtors	0	0
(Increase) / decrease in creditors	142	293
Net cash provided by (used in) operating activities	**(455)**	949
Analysis of cash and cash equivalents		
Cash in hand	1,081	1,514

Notes to the financial statements for the year ended 31 March 2017

1. Principal accounting policies

1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective 1 January 2015 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

The financial statements are prepared in accordance with the historical cost convention, except for Investments, which are included at market value. During the year, the Charity reviewed its accounting policies and made no changes.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts. The charity ended the year with £1.2m in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

1.2. Reconciliation with previous generally accepted accounting practices

These accounts are continued to be prepared in accordance with FRS 102 and the charities SORP FRS 102.

Governance and administration costs are classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities on a cost basis (see note 3). The Trustees consider this is an equitable treatment to avoid disadvantaging funds with high volume low value transactions. All funds attract administrative costs even without any expenditure as these have to be monitored, fund managers approached for future plans, investment transactions and overhead charges. The cost of the transaction does not necessarily reflect on the work involved to achieve that expenditure and therefore consistency is maintained by working with an activity cost based apportionment.

1.3. Income

Donations, grants, legacies and gifts in kind (voluntary Income)
All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, and then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is provable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is disclosed as a contingent asset.

Income resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods.

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

Investment Income
Investment Income and gains and losses on investments are credited / charged to the funds quarterly using the average fund balance to apportion the gain / loss.

1.4. Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. All expenditure is recognised when the following criteria are met:

- There is a present legal of constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads

from Maidstone and Tunbridge Wells NHS Trust and are apportioned on an average fund balance monthly across all funds.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the trustees and accepted by the beneficiaries.

Exceptional Items
Exceptional Items are shown on the face of the Sofa under the category to which they relate with further detail, where appropriate, provided in the notes.

Costs of generating funds
The costs of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with Investment Managers and other promotional and fundraising events including any trading activities.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of it charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and further analysis in relation to activity is provided in note 3.

1.5. Structure of funds

Unrestricted funds are general funds, which are available for use at the discretion of the Trustee in furtherance of the objectives of the Charity. Funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes are designated funds.

Where there is a legal restriction or a binding agreement with a donor, on the purpose for which a donation may be use, the fund is classified in the accounts as a restricted fund.

Endowment Funds are funds that hold capital in perpetuity. Investment income resulting from these capital holdings may be utilised in accordance with the donor’s wishes.

Transfers between funds are made at the discretion of the Trustee, taking account of any restrictions imposed by the donor.

The purposes of each fund with a balance in excess of £10,000 at the year-end are set out in note 8.1 to the financial statements.

1.6. Finance and Operating Leases

The Charity has no finance or operating leases

1.7. Fixed Assets

Tangible Fixed Assets
The Charity held no tangible fixed assets during the year.

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 7 for further information.

Investment properties
The Charity held no investment properties during the year

1.8. Stocks

The Charity held no stocks during the year

1.9. Gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later). Investment income and gains/losses are allocated quarterly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.10. Cash and Cash equivalents

Cash is represented by the balance maintained in the charity bank accounts and is used to meet the operational costs of the charity as they fall due.

Cash equivalents are short term liquid investments held for a period of 3 months or less in interest bearing accounts that are readily convertible to cash with no risk of change in value.

As a requirement of FRS 102, a statement of cash flows has been included in the accounts to provide information about the ways in which the charity uses the cash generated by its activities and about changes in cash and cash equivalents held by the charity.

1.11. Financial Instruments

The Charity only has financial assets and financial liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value.

1.12. Pensions

The Charity has no employees.

1.13. Prior Year Adjustments

There has been no change to the accounts of the prior years.

2. Income

				2016/17	2015/16
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Donations	67	61	0	**128**	302
Donations – website	17	0	0	**17**	10
Legacies	9	116	0	**125**	1,139
Total Donations and Legacies	**93**	**177**	**0**	**270**	**1,451**
Investment income					
Dividends from investment portfolio	5	13	0	**18**	18
Interest from investment portfolio	0	0	0	**0**	3
Bank Interest	1	2	0	**3**	2
Total Investment income	**6**	**15**	**0**	**21**	**23**
Total incoming resources	**99**	**192**	**0**	**291**	**1,474**

3. Expenditure

3.1. Cost of generating funds				**2016/17**	2015/16
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Investment managers fees	(1)	(1)	0	**(2)**	(2)

				2016/17	2015/16
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	0	0	0	**0**	0
Other	(8)	0	0	**(8)**	(46)
Complimentary Therapies	0	(6)	0	**(6)**	(12)
Total patients welfare and amenities	**(8)**	**(6)**	**0**	**(14)**	**(58)**
Staff welfare and amenities					
Training	(51)	(5)	0	**(56)**	(19)
Hospitality	0	0	0	**0**	0
Christmas Events	(7)	0	0	**(7)**	(6)
Other	(2)	(0)	0	**(2)**	(10)
Total staff welfare and amenities	**(60)**	**(5)**	**0**	**(65)**	**(35)**
Medical and Rehabilitation Equipment	(47)	(450)	0	(497)	(608)
Furniture and Fittings	(130)	(7)	0	(137)	(20)
Other	(28)	2	0	(26)	(20)
IT	(20)	(54)	0	(73)	0
Governance - Salaries & overheads	(11)	(36)	0	(47)	(49)
Governance - Audit Fees (external)	(1)	(3)	0	(4)	(3)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(237)**	**(548)**	**0**	**(785)**	**(700)**
Total cost of charitable activities	**(306)**	**(558)**	**0**	**(864)**	**(793)**
Total resources expended	**(307)**	**(559)**	**0**	**(866)**	**(795)**

Employee Information

The Charity does not employ any staff directly, although members of the finance team support the governance and administration function of the Charity. Their costs have been included in the table above.

During the year none of the members of the NHS Trust Board or senior NHS staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments, or expenses in the year and the Corporate Trustee has not purchased trustee indemnity insurance.

4. Net Movements in Funds

				2016/17	2015/16
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	(209)	(366)	0	**(575)**	679
Gains/Losses on Investments	12	38	0	**50**	(21)
Total net movement in funds	**(197)**	**(329)**	**0**	**(526)**	**658**
Funds transfers	0	0	0	**0**	0
Total net movement in funds after transfers	**(197)**	**(329)**	**0**	**(526)**	**658**
Fund balances at 1 April 2016	410	1,307	9	**1,726**	1,068
Fund balances carried forward at 31 March 2017	**213**	**978**	**9**	**1,200**	**1,726**

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/16	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	**Carrying value at 31/03/2017**
	£000	£000	£000	£000	**£000**
CAF Bond Income Fund (UK)	245	0	0	3	**248**
CAF Equity Growth Fund (UK)	332	0	0	47	**379**
Total Fixed Asset Investments	**577**	**0**	**0**	**50**	**627**

6. Current Assets

6.1. Cash and cash investments	**2016/17**	2015/16
	Total Funds	Total Funds
	£000	£000
Cash Investments:		
Santander	**82**	82
Clydesdale	**86**	86
CAF	**80**	80
Nat West	**0**	0
Operational Bank Accounts:		
GBS bank account	**750**	1,219
Nat West bank account	**83**	47
Total Cash and Cash Investments	**1,081**	1,514

6.2. Debtors	**2016/17**	2015/16
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year	**0**	0
Total Debtors due within one year	**0**	**0**

7. Current Liabilities

7.1. Creditors	**2016/17**	2015/16
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year		
Trade Creditors	**(157)**	(68)
Other Creditors	**0**	0
Owed to Maidstone and Tunbridge Wells NHS Trust	**(342)**	(291)
Accruals	**(9)**	(6)
Total Creditors due within one year	**(508)**	**(365)**

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2016	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2017
			£000	**£000**	**£000**	**£000**	**£000**
A.Haines – Cip	67020	Endowment	7	0	0	0	7
E.C.Beedle Fund - Cip	67010	Endowment	2	0	0	0	2
Total Endowment Funds			**9**	**0**	**0**	**0**	**9**

Description	Fund number	Fund Type	Balance 01-Apr-2016	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2017**
			£000	£000	£000	£000	**£000**
Cardiac Equip Fd Ms Crow Legac	65450	Restricted	179	2	(18)	5	**169**
Cardio Equip TW Hayling Legacy	65460	Restricted	682	124	(473)	20	**353**
E&M Dir Diabetes Fund Tw	65410	Restricted	51	11	(2)	2	**61**
Gastrointestinal Fund	65340	Restricted	12	0	(0)	0	**12**
MH Med Equip Fund Restricted	61040	Restricted	34	0	(30)	1	**6**
Neurology Fund	65990	Restricted	17	0	(6)	0	**12**
Oncology Centrifuge Fund	61490	Restricted	24	0	(0)	0	**25**
Oncology Equipment Fund	67170	Restricted	157	53	(59)	5	**156**
Oncology Prostate Equip Fund P Ward Legacy	61310	Restricted	10	0	(0)	0	**10**
Pierre Fabre Grant Fund	61720	Restricted	65	1	(4)	2	**63**

E&M Directorate - Frances Gibson Legacy	65180	Restricted	25	0	(0)	1	**26**
Other Restricted Funds (closing balances <£10,000)			50	1	33	1	**85**
Total Restricted Funds			**1,307**	**192**	**(559)**	**38**	**978**

Description	Fund number	Fund Type	Balance 01-Apr-2016	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2017
			£000	**£000**	**£000**	**£000**	**£000**
Radiology Fund	61590	Unrestricted	71	7	(41)	2	**39**
Special Care Baby Unit Fund TW	65660	Unrestricted	17	16	(9)	1	**25**
Surgery Directorate Fund	61140	Unrestricted	63	3	(38)	2	**30**
Trust Management Dir Fund	61000	Unrestricted	57	6	(38)	2	**27**
Cardiac Fund	65400	Unrestricted	(43)	0	83	0	**40**
Haematology Development Fund	65600	Unrestricted	15	0	(1)	0	**14**
Other Unrestricted Funds (closing balances <£10,000)			229	66	(263)	6	**38**
Total Unrestricted Funds			**410**	**98**	**(307)**	**12**	**213**

8.1. Nature and Purpose of Material Funds (Closing balance > £10,000)

Restricted Funds	Nature and purpose of Fund
Medical Equipment Maidstone	Supports Maidstone Hospital
Haematology Fund	Supports the Haematology Department at Maidstone Hospital
Oncology Equipment Fund	Supports the Oncology Centre for the purchase of Equipment.
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures.
Gastrointestinal Fund	Supports the Gastrointestinal Unit at Maidstone Hospital
Neurology Fund	Supports the Neurology Department at Tunbridge Wells Hospital
Oncology Centrifuge Fund	Supports the purchase of a centrifuge for the Oncology Centre
Oncology Prostate Equip Fund	Supports the purchase of Prostate equipment for the Oncology Centre
E&M Directorate Gibson Legacy Fund	Supports the Emergency & Medical Directorate
Cardio Equip Hayling Legacy Fund	Supports the Cardio Respiratory Unit at the Tunbridge Wells Hospital
Cardiac Equip Crow Legacy Fund	Supports the Cardiac Unit at Maidstone Hospital
E&M Dir Diabetes Fund TW	Supports the Diabetic Unit at Tunbridge Wells Hospital
Unrestricted Funds	
Cardio Respiratory Fund	Supports the Cardio Respiratory Unit at the Tunbridge Wells Hospital
Haematology Department Fund	Supports the development of Haematology across all sites of the Trust
Special Care Baby Unit Fund	Supports the Special Care Baby Unit at Tunbridge Wells Hospital
Surgery Directorate Fund	Supports the Surgery Directorate
Trust Management Directorate Fund	Supports Maidstone & Tunbridge Wells NHS Trust
Radiology Fund	Supports the Radiology Department at Maidstone Hospital

9. Charity Tax

Maidstone and Tunbridge Wells NHS Trust Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

10. Related Parties

The Charity is established to hold the charitable funds of the Maidstone and Tunbridge Wells NHS Trust.

During the year none of the NHS Trust Board or members of key management staff or parties related to them has undertaken any material transactions with the Maidstone and Tunbridge Wells NHS Trust.

The Charity has made revenue and capital payments, in the form of grants, to the Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition £47k (2015/16 £49k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration of the Charity. The amount due at the balance sheet date to Maidstone and Tunbridge Wells NHS Trust was £342k (2015/16 £291k).

11. Events after the reporting year

The Trust has not been advised of any potential significant legacies to be received in 2017/18.

mtw.nhs.uk
Charitable Fund

Donation Form

Registered Charity Number 1055215

Name: _____

Address: _____ Post Code: _____

Email: _____

Whilst recognising that this does not form a binding trust I would wish my donation of

£……..to be used for: (please tick one of the following)

☐ Wherever it will be most useful within the whole Trust to benefit patients and staff as determined by the Charity (This will be the default if no additional information is provided)

☐ The Directorate fund that supports ……..….Ward / Department.

Payment Methods

1 Cheques made payable to **Maidstone and Tunbridge Wells NHS Trust Charitable Fund**
2 Standing Order - Please call us on 01622 224500 to arrange for documentation to be sent
3 Make A Donation By Phone – If you would prefer to make a donation over the phone, please call 01622 224500. If you have an email address, we can send you bank details for electronic payments. We will require a remittance advice to enable us to receipt your donation. We currently accept the following cards: Maestro UK; MasterCard; Visa;
4 Visit our 'just giving' page www.justgiving.com/mtwnhscharitablefund

Gift Aid

If you are a UK taxpayer the Maidstone and Tunbridge Wells NHS Trust Charity (MTW) can reclaim the tax you have paid on every donation you make. You must have paid sufficient UK income or capital gains tax to cover the claim. For every £1 you give we can claim 25p back from the HM Revenue & Customs at no extra cost to you.

☐ YES, I am a UK taxpayer and would like MTW to reclaim tax on this and any future donations

Date……../……./……. Signature……..……

☐ Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by phone or post about our work

☐ Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by email.

Please return to:

Maidstone and Tunbridge Wells NHS Trust, Financial Services, Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ. Telephone 01622 224500 Website: www.mtw.nhs.uk

THANK YOU FOR YOUR SUPPORT

Trust Board Meeting – July 2017

Maidstone and Tunbridge Wells NHS Trust

7-17 Summary report from Quality C'ttee, 05/07/17 C'ttee Chair (Non-Executive Director)

The Quality Committee has met once since the last Board meeting, on 5th July (a 'main' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **progress with actions** from previous meetings was noted
   - The Chief Nurse & Medical Director reported on the **quality matters arising from the plans to exit Financial Special Measures (FSM)**, and it was agreed to provide the Chair of the Trust Board with some examples of completed Quality Impact Assessments (QIAs), so he could better understand the QIA process. It was also agreed to schedule the receipt of an overview of QIAs at each 'main' Quality Committee
   - The Chief Operating Officer reported on the **work being undertaken to reduce Length of Stay**. The opening of the Frailty Unit at Maidstone Hospital (MH) was commended, & an appeal was made for the Unit at Tun. Wells Hospital (TWH) to be expedited
   - The Medical Director reported an **updated response to the relevant recommendations within the 'Learning, candour and accountability report' from the CQC**, and the Committee agreed to the request to merge the work with the Trust's overarching strategy and action plan to improve investigations and learning from mortality
   - The Chief Nurse submitted an **updated assurance report on the "Summary of findings" within the CQC's Quality Report for the Trust** (from Feb. 2015), which included the introduction of Corporate Quality Rounds. The likelihood of a CQC inspection in the autumn was discussed, as was the potential for an external audit against the Well Led Framework
   - A report of recent **Trust Clinical Governance C'ttee** meetings was discussed, & the Medical Director identified 2 issues he felt warranted consideration at a Quality C'ttee 'deep dive' meeting: compliance with the Mental Capacity Act (which had already been scheduled for the Quality C'ttee 'deep dive' on 08/08), and whether lessons were being learned. Each Directorate then highlighted their key issues, which included the following:
     - Diagnostics & Pharmacy reported concern at Pharmacy staffing levels, which had been adversely affected by the changes to the IR35 off-payroll working rules. The adverse impact on waiting times was noted, but it was reported that these were similar to London-based Trusts. The increasing demand for cross-sectional imaging was reported as threatening the achievement of the 6-week turnaround time target for reporting GP scans
     - Specialist Medicine & Therapies reported that their key issues were staff turnover and vacancies. There were circa 150 Nursing vacancies, but 2 Band 7 Practice Development Nurses had been recruited, and it was hoped these would reduce turnover
     - Acute and Emergency reported that the A&E 4-hour waiting time target had been achieved in June, and the Symphony IT system upgrade was scheduled for Sept. 2017
     - Surgery reported that the key issue was the 62-day Cancer waiting time target performance for Lower GI, Upper GI and Urology. Improvements had however been made in GI, and a daily Cancer huddle had started. Urology had not however seen similar improvements, so the other actions that could be taken were being discussed
     - Head and Neck reported that ENT follow-up appointments been a challenge, but a retiring Consultant was intending to work with ENT to assist in this. It was also noted that adult Day Case tonsillectomies were now being performed at MH (such procedures had been performed for years at TWH)
     - Trauma & Orthopaedics reported that staffing issues remained a key concern, but a Skills Facilitator was now in post, which was helping. It was also acknowledged that the backlog in elective activity needed to be addressed, whilst the fractured Neck of Femur pathway was included in the Listening into Action (LiA) programme
     - Critical Care also reported that staffing was a concern, particularly in relation to Theatre escalation at TWH. It was also noted that Endoscopy capacity was still an issue
     - Cancer & Haematology reported that the concern regarding the 62-day Cancer waiting time target continued, and Radiotherapy Physics had again become a major problem, as there was currently a 40% vacancy rate and the morale of staff was very low. The

Clinical Director agreed to ask that the Director of Medical Physics explore the feasibility of outsourcing Medical Physics activity (including potentially outsourcing overseas)
    - Women's & Sexual Health reported that the availability of Sonographers remained a concern, and May saw the largest number of births ever at the Trust
    - Paediatrics reported that the gaps in covering the Paediatric rota, particularly at night; and a lack of Paediatric trained Agency Nurses to support staff, remained their key areas of concern. The number of young persons requiring a community Child and Adolescent Mental Health Services (CAMHS) bed was also noted to be very challenging for staff, but the Directorate was continuing to liaise with the CAHMS service
- An **update report on the Trust's Acute Frailty Units** was reviewed (which had been the subject of the Quality Committee 'deep dive' meeting in June 2017)
- The Committee reviewed the **Mortality Update report** that had been considered by the Trust Board on 28/06/17, and the **2016/17 Annual Reports for Safeguarding Adults and Safeguarding Children**
- The latest **Ward staffing review** was reported, which included feedback from Ward & Critical Care Outreach staff following the implementation of the changes from the Nursing establishment review in autumn 2016 (which the Quality Committee had been asked to consider by the Trust Board at its meeting in October 2016)
- The latest **Serious Incidents** were reported, and the Complaints & PALS Manager attended to present the **Complaints Annual Report for 2016/17**
- The final report of the **External Audit of the Quality Accounts 2016/17** was noted
- The **minutes of the Quality Committee 'deep dive' meeting** on 14/06/17, and summary report from the **Patient Experience Committee** on 13/06/17 were noted

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

- The Medical Director, Chief Nurse, and Associate Director, Quality Governance should liaise, to reconsider the format of the report submitted to the 'main' Quality Committee from the Trust Clinical Governance Committee, in light of the Quality Committee's desire to ensure the issues reported by Clinical Directorates reflected their key risks
- The Chief Operating Officer should pass on the concerns expressed at the meeting regarding the efficiency of the process for submitting recruitment requests to the Vacancy Control Panel

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-18 Summary of the Trust Management Executive (TME) meeting, 12/07 Dep. Chief Exec.

The TME met on 12th July. The key items that were covered were as follows:

- The **safety moment** noted the work to mark the month's theme, Safeguarding Children
- A request to appoint a **replacement Consultant Haematologist** was approved
- A **Site Development Plan** was reviewed, and the proposed plans for the use of the £645k funding for GP streaming were supported. It was also agreed that a small group should be convened to agree the possible options that should be considered when identifying a suitable environment to house the Cardiac Catheter recovery trolleys at Tunbridge Wells Hospital
- The **performance for month 3** was discussed, which included commending the achievement of the A&E 4-hour waiting time target; the reduction in Hospital Standardised Mortality Ratio (HSMR); the continued challenges in meeting the 62-day Cancer waiting time target; and the latest financial position (of a year to date deficit of £3.5m). The latest **infection prevention and control** position was also reported, which noted that 9 cases of Clostridium difficile had been seen for the year, but the increase seen in May had not continued in June
- The **key issues from the Divisions** were reported, which included the common challenges relating to capacity and staffing. The various recruitment initiatives being deployed for the latter issue were noted, but the TME heard of the failure to interview any candidates from the recent attempt to recruit Nurses from the Republic of Ireland
- The **key issues from recent Clinical Directors' C'ttee** meetings were reported, which included notification that Henry Taylor had been appointed as the new Clinical Director for Cancer & Haematology (so a new Trust Lead Cancer Clinician now needed to be appointed)
- The TME was notified of the intention to increase the visibility of the issues considered at **Executive Team meetings**, and an update on the **"Listening into Action"** programme was given, which noted the success of the formal launch, and again prompted the completion of the 'pulse' survey, so the programme's impact could be measured
- The latest position on the **national 7 day service programme** was reported, which noted that the diagnostic phase was now concluding and the operational phase was starting
- The **service models and hurdle criteria for the Kent and Medway STP** were considered (this was a reduced version of the report considered by the Trust Board on 28/06/17)
- The summary report from the **Trust Clinical Governance Committee** was reviewed, and the **recently-approved business cases** were noted
- The **Board Assurance Framework** (BAF) for 2017/18 **& Trust Risk Register** was reviewed, and it was agreed that the BAF should contain the specific details of the agreed 2017/18 trajectory for the 62-day Cancer waiting time target
- The Director of Health Informatics attended to present an update on the **implementation of the SAcP (replacement PAS+)**. The TME approved the recommendation from the PAS Programme Board to proceed to next phase (i.e. fixed validation), but that certain milestones still needed to be achieved before the mooted 'go live' date was confirmed
- An update on the **2017/18 Internal Audit plan and outstanding actions** was given
- The **Safeguarding Adults** & **Safeguarding Children Annual Reports, 2016/17** were received
- An update on the development of the **Health and Wellbeing Centre** at Maidstone Hospital was received, & the TME gave its support to proceed with scoping the project and the development of the associated Case, which required funds of £1.5m to be raised. It was noted that further consideration was needed on whether a separate charity should be established for the project
- The Director of Estates and Facilities presented the **Estates and Facilities Annual Report 2016/17**, and summary reports were received from the recent meetings of the **Health & Safety, Policy Ratification, Information Governance** & **Clinical Operations & Delivery Committees**

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

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

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

Trust Board Meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-19	Summary report from Finance and Performance Committee, 17/07	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 17th July 2017. This was the first meeting since the title of the Committee changed from "the Finance Committee".

1. The key matters considered at the meeting were as follows:

- The actions from previous meetings were reviewed
- Under the "Safety Moment", the Trust Secretary reported that July's theme was Safeguarding Children
- The Medical Director gave the latest monthly update on the Workforce Transformation programme. Later in the meeting, it was agreed that liaison should occur with Non-Executive Directors to obtain their views as to whether it remained necessary to continue to receive an update report on the Programme at each meeting
- The month 4 financial performance, including that on the Cost Improvement Plan (CIP), was discussed in detail, which included the presentation intended to be given at the Financial Special Measures "Checkpoint" meeting with NHS Improvement (NHSI) scheduled for later the same day
- A report on the expenditure relating to the Kent and Medway Sustainability and Transformation Plan (STP) was reviewed, which followed an action agreed at the June Finance Committee meeting
- An explanation of the adverse variance between "Budget" and "Actual" for the Ante-Natal, Delivery Suite and Post-Natal areas at Tunbridge Wells Hospital was received (which related to an action agreed at the Trust Board meeting held on 28/06/17)
- The month 4 non-finance, non-quality, related performance was considered for the first time, following the Trust Board's approval of the Committee's expanded role, and the Chief Operating Officer reported the latest position in relation to the A&E 4-hour, 62-day Cancer waiting time and Referral to Treatment (RTT) waiting time targets
- A Memorandum of Understanding (MoU) relating to genetics testing re-procurement was considered, following the Trust being invited by Guy's and St Thomas' NHS Foundation Trust (GSTT) to join a consortium to help develop a bid for a Genetic Laboratory Hub. The MoU was approved for signing (subject to the document having the inaccurate representation of the Trust's name and registered office corrected)
- The latest quarterly updates on service tender submissions, Service Line Reporting, and analysis of Consultancy use were reviewed, as was the usual monthly update on the Lord Carter efficiency review
- The financial aspects of the Board Assurance Framework (BAF) and Risk Register were considered
- The usual monthly report on breaches of the external cap on the Agency staff pay rate was noted

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

- The Chief Operating Officer should arrange for the Executive Team to consider the impact of the latest letter from the National Urgent and Emergency Care Director, and submit a response to the Finance and Performance Committee in August 2017

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

- An MoU relating to genetics testing re-procurement was approved for signing (which would restrict the Trust's ability to work with other partners)

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board meeting – July 2017

NHS Maidstone and Tunbridge Wells NHS Trust

7-20 Trust Board Members' hospital visits (19/04/17 – 12/07/17) 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 19th April and 12th July 2017.

The report includes Ward/Department visits; 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, Trust Board Members may have undertaken visits but not registered these with the Trust Management office and/or Programme Management Office (PMO), who oversee the new framework (see below) (Board Members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Trust 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, to encourage Board members to continue to undertake visits

[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, 19th April and 12th July 2017

Trust Board Member	Areas registered as being visited (MH: Maidstone Hospital; TWH: Tunbridge Wells Hospital)	Formal feedback provided?
Chief Executive (GD)	▪ Site visits with DH ▪ Attendance at Workforce Race Equality event	-
Chief Nurse (CO'B)	-	-
Chief Operating Officer (AG)	▪ Endoscopy (MH) ▪ Site visits with DH	-
Deputy Chief Executive (JL)	▪ Junior Doctors' visit with DH ▪ Hedgehog Ward (TWH) ▪ Accident and Emergency (TWH) ▪ LiA walkabouts ▪ Meeting with Colorectal Surgical Team	-
Director of Finance (SO)	▪ Academic Centre (Maidstone) ▪ Education Centre (Tunbridge Wells)	-
Director of Workforce (RH)	-	-
Medical Director (PM)	-	-
Chair of Trust Board (DH)	Various site visits as part of induction; Junior Doctors' visit	-
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SDu)	Radiology x 4 (TWH) A&E x 2 (TWH) Urology OPD (TWH) Ward 32 (TWH - as daily visitor)	-