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 29TH MARCH 2017
PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter/s	Attachment
3-1	To receive apologies for absence	Chair of the Trust Board	Verbal
3-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
3-3	Minutes of the Part 1 meeting of 22nd February 2017	Chair of the Trust Board	1
3-4	To note progress with previous actions	Chair of the Trust Board	2
3-5	Safety moment	Chief Nurse	Verbal
3-6	Chair's report	Chair of the Trust Board	Verbal
3-7	Chief Executive's report	Chief Executive	3
3-8	Integrated Performance Report for February 2017	Chief Executive	
	▪ Safe / Effectiveness / Caring	Chief Nurse	4
	▪ Safe / Effectiveness (incl. Mortality)	Medical Director	
	▪ Safe (infection control)	Dir. of Infect. Prev. & Control	
	▪ Well-Led (finance)	Director of Finance	
	▪ Effectiveness / Responsiveness (incl. DTOCs)	Chief Operating Officer	
	▪ Well-Led (workforce)	Director of Workforce	
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	Quality items		
3-10	Supplementary report on Quality and Patient Safety	Chief Nurse	6
3-11	Planned and actual Ward staffing for February 2017	Chief Nurse	7
3-12	Approval of updated declaration of compliance with eliminating Mixed Sex Accommodation	Chief Nurse	8
	Planning and strategy		
3-13	To support the case for change for the Kent & Medway Sustainability and Transformation Plan (STP)	Medical Director	9
	Assurance and policy		
3-14	Update from the Senior Information Risk Owner (SIRO) (incl. approval of the IG Toolkit submission for 2016/17)	Chief Nurse	10
	Reports from Board sub-committees (and the Trust Management Executive)		
3-15	Charitable Funds Committee, 20/02/17	Committee Chair	11
3-16	Patient Experience Committee, 08/03/17 (incl. revised Terms of Reference)	Committee Chair	12
3-17	Workforce Committee, 09/03/17 (incl. the findings of the national NHS staff survey 2016; and quarterly report from Guardian of Safe Working Hours)	Committee Chair	13
3-18	Quality Committee, 15/03/17	Committee Chair	14
3-19	Trust Management Executive, 22/03/17	Committee Chair	15
3-20	Finance Committee, 27/03/17	Committee Chair	16 (to follow)
	Other matters		
3-21	Update on the development of an overall communications approach	Deputy Chief Executive	Verbal
3-22	Review of Terms of Reference for the Trust Board	Chair of the Trust Board	17
3-23	**To consider any other business**		
3-24	**To receive any questions from members of the public**		
3-25	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 meeting: 26th April 2017, 10.30am, Education Centre, Tunbridge Wells Hospital		

Kevin Tallett,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 22ND FEBRUARY 2017, 10.30A.M AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Alex King	Non-Executive Director	(AK)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Acting Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Daniel Gaughan	General Manager, Critical Care (for item 2-8)	(DG)
	Lynn Gray	Director of Operations, Urgent Care Division	(LG)
	Richard Hayden	Director of Workforce	(RH)
	Greg Lawton	Clinical Director, Critical Care (for item 2-8)	(GL)
	Jim Lusby	Deputy Chief Executive	(JL)
	Kevin Rowan	Trust Secretary	(KR)
	Jacqui Slingsby	Lead Matron, Critical Care (for item 2-8)	(JS)
Observing:	Ian Courtney	EMIS Health	(IC)
	Annemieke Koper	Staff Side representative	(AKo)
	Aranghan Lingham	Core Surgical Trainee	(AL)
	Lindsey Shorter	Senior Programme Manager, East Kent Hospitals University NHS Foundation Trust	(LS)
	Darren Yates	Head of Communications	(DY)

2-1 To receive apologies for absence

Apologies were received from Angela Gallagher (AG), Chief Operating Officer, but it was noted that LG was attending in AG's place. It was also noted that Sara Mumford (SM), Director of Infection Prevention & Control, would not be in attendance.

2-2 To declare interests relevant to agenda items

KT declared that he remained engaged (via his company, Discidium Ltd) by Medway NHS Foundation Trust to deliver Programme Management Office (PMO) Services, including the Financial Recovery Programme.

2-3 Minutes of the Part 1 meeting of 25th January 2017

The minutes were agreed as a true and accurate record of the meeting, subject to the following amendment:

- Item 1-7 (page 3 of 10): Replace "GD then then continued, and highlighted that Sue Chapman, Discharge Lounge Nurse…" with "GD then continued, and highlighted that Sue Chapman, Discharge Lounge Nurse…"

2-4 To note progress with previous actions

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

- **1-9 ("Arrange for a detailed report on the Trust's 62-day Cancer waiting time target performance to be submitted to the Trust Board")**. It was noted that a detailed update would be given at the Trust Board in March 2017.

AJ then welcomed PM and COB to their first formal Trust Board meetings since starting as Medical Director and Chief Nurse respectively.

2-5 Safety moment

COB reported the following points:

- The focus of the month was Venous Thromboembolism (VTE), and each week the opportunity had been taken to raise the profile of the issue, and ensure all patients were assessed against the risk of acquiring a VTE. The Trust was meeting the national target of 95% for risk assessing patients, but the month had been used to continue to ensure this standard was met
- Patient education had also been a key aspect, to ensure that patients understood VTE and its impact

AJ asked why 100% compliance with risk assessment was not being achieved. COB replied that the main reason was likely to be related to patients' condition on arrival. SD asked whether the outcome of the 5% of patients that had not been assessed had been reviewed, to assess the occurrence of VTE. COB replied that the incidence of VTE was very low at the Trust, and there was no evidence to suggest that the aforementioned 5% were at increased risk. PM added that any patient experiencing a VTE would be subject to a full Root Cause Analysis (RCA), and the first aspect to be reviewed would be whether a risk assessment had been undertaken. SD queried whether further action was required. PM stated that the focus needed to be on increasing the level of completed risk assessments to above 95%. PM continued that this was a multidisciplinary team responsibility, but acknowledged that more work was required. SDu proposed that the outcomes of the 4.7% of patients that did not receive a VTE risk assessment be reviewed, but also proposed that a scoping exercise be undertaken in the first instance, to determine the level of work required. This was agreed. SDu also proposed that PM report the findings of this to the 'main' Quality Committee. This was also agreed.

Action: Undertake a scoping exercise to determine the work required in reviewing the clinical outcome of the 4.7% of inpatients that did not receive a VTE risk assessment, and reporting the findings to the 'main' Quality Committee (Medical Director, February 2017 onwards)

2-6 Chairman's report

AJ reported that this was his last Trust Board meeting, and was also SD's last Trust Board meeting, as her term of office expired on 28/02/17. AJ stated that SD had been Chair of both the Quality & Safety and Patient Experience Committees, and had contributed much to the Trust during the last 9 years. AJ continued that much of SD's work was undertaken 'behind the scenes', particularly in supporting the last 2 substantive Chief Nurses. AJ added that SD brought medical experience to the Trust Board, and had been exceptionally valuable to the Trust. AJ thanked SD on behalf of the Board, and stated that he would formally write to SD before he left.

AJ then reported that a new Chair of the Trust Board would be appointed in May, and KT would preside over the Board until that time. AJ added that the public announcement of the individual who had been appointed would be made shortly. AJ concluded by noting that he had known many of the existing Trust Board Members for a long time, and then thanked the Trust's staff, and the Board, noting that he would likely write to the Trust staff before he left.

2-7 Chief Executive's report

GD firstly acknowledged the contribution that SD had made, and particularly noted the support she had given to GD, which he valued very much. GD added that AJ had also been very supportive, and thanked AJ for what he had done for the Trust, and for GD personally.

GD then referred to the circulated report and stated that the content showed that the Trust was, along with the rest of the NHS, under significant pressure, but continued to develop and improve, despite this. GD elaborated that A&E staff had started to use Basic Sign Language, in the latest of a series of initiatives to engage with certain parts of the population.

AJ suggested that GD may wish to give further thanks to the Trust's staff, in his next weekly update, for their response to the immense pressure faced during the year. GD agreed, & appealed for all Trust Board Members to take the opportunity to thank staff whenever they visited the Trust.

Presentation from a Clinical Directorate

2-8 Critical Care

AJ welcomed DG, GL and JS, to the meeting. GL then gave a presentation highlighting the following points:

- The Critical Care Directorate currently managed the following services:
  - Anaesthetics, which comprised Generalists, Intensivists and Pain
  - Critical Care, which comprised 2 Intensive Care Units (ICUs), at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH)), and a 24/7 Critical Care Outreach service
  - Theatres, which comprised 22 Theatres across MH & TWH; & an admissions lounge at MH
  - Endoscopy, which comprised 2 Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited Units, with 6 Endoscopy rooms across both sites
  - Pain management, which included Chronic and Acute services; a Chronic Pain Unit (CPU) Hub at MH; and Outpatients at TWH and Sevenoaks Hospital
  - Resuscitation, which included training Trust staff in both Basic and Advanced Life Support
  - Pre-operative Assessment (POA), which included clinics at MH and TWH
  - Vascular access and
  - Acute Kidney Injury (AKI) and Sepsis
- The 2017/18 departmental resource limit was £31.7m, whilst the workforce consisted of 478 WTEs. This included Medical, Nursing, Scientific and Technical, and Administrative and Clerical staff, but predominantly consisted of Nursing staff
- In terms of current performance, there had been 4 Never Events in Theatres in the recent past, but all CQUIN targets were being achieved for Quarter 3, including inpatient Sepsis
- There was a current shortfall, of £56k, against the 2016/17 finance control target. Income generation was £360k adverse to plan, due to a recurrent budget in month 1. The 2017/18 Cost Improvement Plan (CIP) target was £3.26m, which was a major challenge
- In terms of workforce, the vacancy rates in Theatres were 18% at TWH and 16% at MH. There were 3 WTE Consultant Intensivist vacancies, but 1 fixed term Locum started in February 2017; and advertisements had been issued for substantive Intensivists. There were also positive signs in relation to Consultant appointments, in that there was a higher level of interest from prospective candidates than had been the case in recent years
- GL was keen to introduce Consultant delivered CEPOD/Trauma lists.
- The Directorate's risks included Theatre and Consultant Intensivist staffing; the escalation of Critical Care areas; capacity in Endoscopy; the aforementioned Never Events in Theatres; and the 2017/18 CIP target (although a Planned Care category procurement specialist was being recruited)
- Other risks included Theatre staffing (for which rolling advertising was in place) and Intensivist recruitment. High level prioritisation of capital funds also needed to be undertaken
- GL was particularly concerned at the capacity among Consultant Anaesthetists, given the increasing demand for the services Anaesthetists were required to deliver, such as lumbar punctures, vascular access, and other interventions
- GL had concerns regarding the sustainability of operating 5 out-of-hours Junior / Specialty and Associate Specialist (SAS) on-call rotas across the two hospital sites. This was likely to become increasingly challenging as the SAS Doctors were approaching retirement and were difficult to replace
- Challenges included bed capacity for elective surgery at TWH; and Endoscopy capacity (where a review was to be undertaken by the Programme Management Office (PMO))
- Opportunities included improved access to Endoscopy with Nurse Endoscopists and the commissioning of a fourth Endoscopy room at TWH. There was also an opportunity for further Chronic Pain activity, increasing musculoskeletal (MSK) provision, and widening the geographical borders of current service provision
- Future improvements included improved financial controls; a new Theatre build at MH (in accordance with the Sustainability and Transformation Plan (STP), and improved elective activity access); the potential expansion of Endoscopy capacity and Nurse Endoscopist investment; the centralisation of POA for a consistent improved quality service; MSK Chronic

Pain implementation and delivery; the development of a Pelvic pain service; a 7 day service; and Medical and Theatre staff recruitment and retention

SD commended the service she had experienced via the Chronic Pain Team, but asked how many Clinical Nurse Specialists (CNS) were in the Team. JS replied that the Chronic and Acute Pain Teams were combined, and there was 3.6 WTE, plus a lead CNS i.e. 4.6 WTE of CNS in total. SD made a plea for the Pain service to be given priority.

SD also asked why Anaesthetists were performing lumbar punctures. GL replied that this was one of many examples where Anaesthetists had become the 'go to' persons for clinical tasks that were unable to be performed by other specialities, and which had added pressure to the Team. PM added that this was, in part, a reflection of the super sub-specialisation that had occurred within medicine over the recent past. GL and PM acknowledged that this was beneficial for patients but had an impact on resources. KT opined that the situation warranted a re-balancing of the allocation of such resources. PM accepted the merit of KT's point, and noted that there would be a discussion at the forthcoming Clinical Directors' Committee meeting.

SDu noted the scale of the Directorate's CIP, and asked whether there was any form of financial recognition for undertaking part of a task that was, hitherto, included within the procedural tariff allocated to other Directorates. GL confirmed that there was no such financial recognition, and illustrated the situation in relation to the insertion of Peripherally Inserted Central Catheter (PICC) lines. GL added that if the CEPOD (emergency) and trauma Theatre lists were however funded properly, from the Division as a whole, the issue would be resolved, and all of the additional tasks currently undertaken could be managed effectively. SDu asked whether the solution referred to by GL was being considered. PM replied that the issue applied to several specialities, but acknowledged that GL had a strong case. SO commented that if the situation was planned properly, it would be able to be undertaken more efficiently and effectively than the current ad-hoc arrangement, and agreed that this was one of the key issues that needed to be considered.

AJ then asked about staff turnover within Theatres, and also asked whether enough was being done, internally, to train individuals to become Theatre staff. JS replied that staff left Theatres for many reasons, including personal reasons, but acknowledged that staff satisfaction had been adversely affected during periods of winter escalation, when Theatre staff were unable to treat the patients for which they had been trained. JS continued that turnover was continual, and there were continuous efforts to recruit, with 11 WTE staff currently appointed and waiting to start in post, but other staff may have left before these 11 started.

AJ asked about the process involved in training non-Theatre Nurses for Theatre Nursing roles. JS replied that there was an intensive training period. DG added that the training took circa 6 months, and explained the various training packages that were adopted. AJ asked whether the packages offered were similar to those used at other hospitals. DG confirmed this was the case for NHS hospitals, but pointed out that the Trust was unable to compete with local Independent Sector providers. RH then asked whether the Directorate had a presence at the next Trust Recruitment Fair, and DG and JS confirmed this was the case.

AJ thanked GL, DG and JS for their presentation, and remarked that despite the challenges raised, the Trust Board was confident in the team's ability to manage.

2-9 Review of the Board Assurance Framework, 2016/17

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

- The Board Assurance Framework (BAF) had already been reviewed at the February 2017 meetings of the Audit and Governance Committee, Trust Management Executive (TME) and Finance Committee (objectives 4.a and 4.b only)
- At the Finance Committee, SO had rightly identified that only 1 (not 3) of the 7 actions from NHS Improvement (NHSI) was incomplete (which was reported in the "Are the actions that had been planned for this point been taken?" section of the BAF for objectives 4.a and 4.b)

AJ queried whether the vacancy rate was higher than 8.5%. RH confirmed that the rate was 7.7%.

KT then referred to the discussion of the BAF that was held at the Audit and Governance Committee in February, and stated that the summary table on page 1 usefully demonstrated that there was too many 'red' rated areas. KT also stated that the Committee had felt that winter pressures were not necessarily an acceptable reason for the 2 'amber/red' rated objectives (i.e. 2.a and 2.b). KR replied that the Committee's views were acknowledged, and a discussion was required as to whether the achievement of objectives should just be considered from a binary perspective i.e. they were either met or not met, regardless of the wider circumstances. KT gave his support for the application of such an approach.

AJ then referred to the wording of key risk 2, "The Trust is unable to manage (either clinically or financially) during the winter period", and suggested this may need to be re-worded as the Trust had managed. KR explained that the wording of the risk was not intended to indicate whether or not the Trust had not managed, but to describe the risk that had existed at the start of the year.

AJ then stated that the 'green rating of "Are the actions that had been planned for this point been taken?" for objectives 2.a and 2.b may need to be reconsidered, given the 'amber/red' rating for "How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?". KR agreed that the relationship between the 2 ratings needed to be reconsidered, as there was currently no rules preventing such a difference in ratings. KR went on to query whether it was in fact confusing to ask the question "Are the actions that had been planned for this point been taken?", and stated that it may be beneficial better to remove that question from the BAF, and just rely on the "How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?" question. AJ agreed this was worthy of consideration.

2-10 Integrated Performance Report for January 2017 (including an update on the "Trauma & Orthopaedics 2020" programme)

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

- The pressure on capacity continued, nationally, but there was higher degree of pressure in Kent and Medway when compared to the rest of the country, for access to Social Care. In that context, the Trust was performing better than peer Trusts within Kent and Medway, although GD did not wish to give false assurance, as the situation was very challenging
- There was a significant and sustained increase in activity, but the effect on each hospital in the region was sporadic, in that one particular hospital may perform the best in the region on a certain week, but perform the worst in the region in the following week

AK asked whether the summer period was expected to see an improvement in the situation. GD replied that this was a reasonable assumption, but there was no guarantee. AK asked what the Trust, or all the Trusts in the region, could do to raise attention, and achieve financial support. GD noted that there had recently been an opportunity to bid for some funding to assist with the remainder of 2016/17, but although there were some areas, such as East Kent, in which money could make a difference, as it could be used to purchase domiciliary care packages, this was not possible in West Kent, due to the lack of domiciliary care capacity. GD added that the bid for the aforementioned funding that had been made for Kent as a whole had not been accepted, but he would not be surprised if additional funding was allocated for Social Care in the forthcoming national budget. GD also noted that a number of other issues were likely to have an adverse impact on the Trust's finances, including increases in business rates, which for TWH were circa £1m for 2017/18. GD pointed out that the increase would however be challenged.

AJ asked what the business rate value was for MH. SO explained this was low, and added that the rate increase for TWH had been included within the Trust's plans, so if the aforementioned challenge was successful, this would have a beneficial effect for the Trust.

SD highlighted the current national shortage of Physiotherapists and Occupational Therapists, noted that such staff often helped increase the level of patient discharges, and stated that funding was not therefore likely to be able to address the issues described. GD replied that he did not disagree, but he believed the key issue over the coming years for Kent and Medway was the lack of staff willing to undertake domiciliary care, which was often paid at minimum wage. KT asked

whether the Trust had considered reviewing the roles of its domestic/cleaning staff. GD answered that alternative solutions were being considered instead.

GD then invited colleagues to highlight any issues arising from the Integrated Performance Report.

[N.B. The order of the following domains within the Integrated Performance Report reflects the order they were discussed at the meeting, which differs from the order listed on the agenda]

Effectiveness / Responsiveness (incl. DTOCs)

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

- A&E 4-hour waiting time target performance had been poor, as a result of an increase in attendances (there had been a 16% increase for January over the previous 2 years)
- More elderly patients, who had a higher likelihood of being admitted, and who often stayed in hospital for longer, were also being seen
- There had been one 12-hour trolley breach ("Emergency A&E >12hr to Admission") in January, and therefore two for the year to date. The RCA was underway, but the initial findings showed that the action taken had been clinically appropriate, to enable the patient to receive treatment for their cardiac condition
- There had been some Ambulance handover delays, but the Trust was working with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to validate the data, as this was formally recorded by SECAMb, and the Trust's data was different
- The 'Home First' initiative was continuing to be implemented, and some signs of progress were being seen. Continuing Healthcare liaison also continued, and the focus was on ensuring that Palliative Care patients were able to be transferred to a more appropriate location, to avoid dying in hospital

AJ referred to the latter issue, and asked whether hospices had a role to play, noting that he understood the Maidstone hospice was reducing its staff. GD commented that only a small number of beds were available at the hospice, but accepted that any beds would be beneficial.

LG then continued, and highlighted the following points:

- Length of Stay (LOS) had increased, as a result of the increased patient acuity, whilst elective and Day Case activity had been low due to capacity in Theatres
- Aggregate performance on the 18-week Referral to Treatment (RTT) targets was non-compliant, due to an increase in non-elective demand, and the cancellation of elective procedures. The non-compliance was however only present for certain specialties, following improvements in a number of Medical specialities
- The Trust's was behind its agreed RTT trajectory, but diagnostic waiting times had improved for 2016/17, and were now in accordance with plan

KT asked whether the Maidstone Orthopaedic Unit (MOU) was operating at full capacity. LG confirmed that the Unit was almost at full capacity. KT also asked how much outsourcing was being undertaken. LG & GD confirmed no outsourcing was taking place, as this had been stopped.

AJ asked how many non-Trauma & Orthopaedic (T&O) patients were being treated in the MOU. JL answered that at that date, the MOU was almost exclusively treating T&O patients, although some Surgical patients had been treated in the early period after the MOU opened. JL added that the Unit was at, or very close to, 100% capacity every day, and the introduction of weekend operating was being considered.

LG then continued, and highlighted the following points:

- Performance on 62-day Cancer waiting times was still below target, and the overall backlog had increased, but the backlog of "MTW"- only patients had not changed. The issues affecting performance included reduction in diagnostic capacity, and the introduction of a new lung diagnostic test
- Performance against the Cancer 2 week wait target had been sustained for the third consecutive month & was expected to continue. A Cancer Summit was scheduled for 23/02/17

AJ emphasised that the Trust Board had been unhappy about the performance on the 62-day Cancer waiting time target for some time, so a message needed to be given to the Cancer Summit that performance needed to be delivered, notwithstanding the complexity of the issues. SD agreed, and pointed out the difference between current performance and the required target. SD also emphasised the impact on patients of the target not being met, noting that Cancer primarily affected elderly patients. SD asked when the 85% target would be met. LG confirmed she would relay the Board's concerns to the Cancer Summit, and noted that a detailed report would be submitted to the Board in March 2017. JL highlighted that the Breast pathway had demonstrated what could be achieved with concerted efforts, and acknowledged that such efforts needed to continue. JL added that a detailed action plan would be expected to be produced following the Cancer Summit, although he acknowledged that this would not be first action plan that had been produced in relation to the matter. GD stated that although the NHS was not achieving the 62-day target as a whole, there was no doubt that the Trust was able to do better, and needed to depart from providing excuses for the performance. JL agreed, but noted that the Trust's performance was closer to the best performing Trusts than the worst.

AG then continued, and highlighted the following points:

- Access to a Stroke Unit within 4 hours was below target, due to capacity issues i.e. the number of Stroke patients admitted was often higher than the number of 'ring-fenced' beds
- The Sentinel Stroke National Audit Programme (SSNAP) now rated MH at Level B, whilst TWH had achieved a Level B for the first time

AJ asked how other local hospitals had performed on the SSNAP. LG confirmed that these were rated lower than MH and TWH. AJ commended the achievement.

Safe / Effectiveness / Caring

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

- Pressure Ulcers had increased in January, but reduced in February. The Pressure Ulcers had primarily occurred on patients' heels, so efforts were focused on this aspect
- Falls had increased in January, but had also reduced in February. A significant amount of work was taking place, some of which was noted within the BAF, under item 2-9. It was acknowledged that the increases may be related to changes in Ward configuration, but COB was however confident that the plan, of a rate of 6.2, could be achieved at year end
- The complaints response rate was below target, but improvement was expected
- The response rate for the Friends and Family Test (FFT) in Maternity had increased dramatically, but caution should be exercised regarding the size of the increase, as this related to the addressing of a previous issue regarding the availability of the FFT survey forms

KT asked about falls at TWH. COB acknowledged this had increased, and was possibly related to the increased capacity pressures during January.

Safe / Effectiveness (incl. HSMR)

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

- Mortality rates remained the same, but a large number of actions had been undertaken, and a Quality Committee 'deep dive' had been held in January
- The focus of action was on fractured neck of femur patients, and a review of the 40 relevant deaths had been commissioned, to understand the reasons for the different mortality rates reported from Dr Foster and the National Hip Fracture Database (NHFD). It was however now known that the NHFD excluded patients who did not receive an operation, whilst Dr Foster included such patients. The NHFD also excluded post-operative deaths beyond 30 days, whilst Dr Foster included patients until discharge or death. Therefore the Dr Foster system, not the NHFD, would be the focus in the future
- PM had received the preliminary report into the aforementioned 40 patients, and had asked for some further actions in response. 20 of the deaths were related to aspiration pneumonia (which was one of the most common causes of inpatient mortality), but there was no analysis at present as to whether the care provided to such patients was as expected. 4 out of 15 patients were operated on after 36 hours, which did not meet the required standard. The potential

reasons for not operating until within 36 hours included delays in Theatres, but these had now been addressed. Another potential reason could be the need to ensure patients were medically stable before operating, and this aspect would continue to be focused on, and would be included in the clinical action plan that would be developed
- Further generic work on mortality was being undertaken, and the completion of Mortality Reviews had reduced recently. However this had improved following concerted efforts by the relevant Directorates

AJ asked what the correct percentage was for the completion of Mortality Reviews. PM initially replied that 100% was correct, but then clarified that was important that every unexplained and unexpected death was reviewed, and he would consider the appropriate level to be achieved for other deaths.

PM concluded by noting that a gap analysis was being undertaken against the “Learning, candour and accountability” report" by the Care Quality Commission, and this would be reported to the Quality Committee.

AJ stated that he was encouraged by PM’s report.

Safe (infection control)

COB then referred to the circulated report and highlighted the following points:
- MRSA screening was rated as ‘amber’, and the problem appeared to be related to Trauma patients. However, a solution had been identified and improvement was expected
- The Clostridium difficile position was being held, and there were 25 cases against a limit of 27

AJ asked whether any form of improvement was expected in MRSA screening. COB referred to her earlier comments, but acknowledged that the reported forecast was worthy of reconsideration.

Well-Led (finance)

SO referred to the circulated report and highlighted the following points:
- A surplus of £300k was delivered in month 10, though this was lower than the planned surplus for the month. For the year to date, the deficit was £14.1m, which was £4.2m adverse to plan
- The impact on elective and Day Case escalation had been less, in cost terms, than in previous years, and although income had reduced, costs had remained stable
- There had been a £1.1m loss of income relating to elective activity, and a £600k loss of Day Case income. Activity through the MOU had increased, particularly in elective inpatients, and without the MOU, elective Orthopaedic activity would be non-existent
- The cost base remained good, and therefore had been a significant reduction in Nursing Agency usage, with some reduction in Medical Agency usage. Non-pay remained well controlled
- If the Trust had received the monies from the Sustainability and Transformation Fund (STF), the plan would have been achieved
- The Trust had reviewed the asset lives of equipment (particularly that being used beyond its current life), and had re-set the lifespan appropriately. This had reduced charges, but could have a long-term adverse impact on capital
- Capital expenditure had reduced recently, but some expenditure expected in February and March, which included the replacement Linear Accelerator (LinAc), which would be purchased in March 2017

AJ referred to “Nurse Agency Spend” indicator on page 6, and commended the reduction, but noted that the ‘combined Locum and Agency spend’ had increased. SO clarified that the “Medical Locum & Agency Spend” indicator to which AJ had referred related solely to Medical staff.

Well-led (workforce)

RH referred to the circulated report and highlighted that there had been a 0.4% increase in sickness absence, which was primarily due to cold//flu symptoms, and work was underway with Departmental teams. RH added that a similar situation was however being seen at other Trusts.

Quality Items

2-11 Planned and actual ward staffing for January 2017

COB referred to the circulated report and pointed out that 5 areas had been rated as 'amber', compared to 3 such areas for the previous month. COB explained that this increase reflected vacancies, as had been discussed earlier in the meeting, and performance on a number of clinical indicators, which had been discussed with clinical areas.

Questions were invited. None were received.

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

21 Audit and Governance Committee, 02/02/17

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

- The BAF was reviewed, but this had already been discussed under item 2-9
- The Risk Register had been reviewed and a particular risk had been noted that related to a lack of functional computer screens in Cancer, which KT hoped had since been addressed, as this appeared to be easy to resolve

2-13 Quality Committee, 06/02/17

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

- The Committee had undertaken a very useful review of Surgery, which had been robust in discussing some issues which were yet to be completely resolved, but for which plans were in place. AJ concurred.
- Mortality rates were also discussed, & SDu had been encouraged by a new & far more vigorous approach to addressing the issues. SDu was therefore assured that the plan and approach was correct, but the issue now needed to be resolved as it had been present for too long

AJ referred to the latter issue, and stated that the only comfort he took was that the crude mortality rate remained stable. PM agreed, but noted that the Trust's Charlson index was very low, which meant that the Trust was not coding co-morbidities. AJ acknowledged the point, but pointed out that this had been known for some time.

SDu concluded by noting a new mortality dashboard was being developed and Directorates were expected to 'own', and report on, the data within such dashboards.

2-14 Trust Management Executive, 15/02/17 (incl. review of Hospital Pharmacy Transformational Programme (HPTP) Plan)

JL referred to the circulated report and highlighted that the new Chief Pharmacist had presented the HPTP Plan, and it had been encouraging that progress was being made, as the Trust had not had a substantive Chief Pharmacist for some time. JL added that the Plan had been supported by the TME, and the Trust Board was now asked to approve the Plan.

The Hospital Pharmacy Transformational Programme (HPTP) Plan was approved, as circulated, prior to its submission to NHSI.

2-15 Finance Committee, 20/02/17 (incl. quarterly progress update on Procurement Transformation Plan)

SDu referred to the circulated report (Attachment 10) and highlighted that the adverse position against plan for month 10 was largely related to the non-receipt of STF monies, which related to non-achievement of access targets. SDu noted that the situation was disappointing, but there was an appeals process. SO added that the appeal had been lodged with NHSI, and the process was based on whether there had been significant change from the assumptions within the original plan that had been submitted. SO pointed out that if the Trust's appeal was successful, £1m of income and cash would be received.

SDu added that there was now a far clearer understanding of the Trust's financial issues, and the issues that needed to be addressed, and commended SO and his team for this achievement. AJ agreed, and repeated the comments he made at the Finance Committee that the situation was far better understood than before SO and his colleagues had arrived. AK agreed, and stated that he believed the last Finance Committee had been one of the Committee's better meetings.

SO then referred to the quarterly progress update on the Procurement Transformation Plan (Attachment 11) and stated that this was the first update report. AJ noted that all of the actions were intended to be completed by September 2018. SO confirmed this was the intention.

Other matters

2-16 Charitable Funds Committee, 20/02/17

SDu reported that the 2016/17 Accounts would be subject to an Independent Review rather than a full audit. SDu also reported that the Committee had agreed to the establishment of a fundraiser post, linked to strategic appeals, and the decision had been affected by the fact that income for the year to date was only £83k, which was far lower than had been received previously (which had been primarily based on legacies). SDu added that it had been agreed to submit the proposal to establish the fundraiser post to the Trust Board in March 2017, but views were welcome now.

AJ stated that given the level of donations, the endeavour was worthy of being tried SO pointed out that that other local NHS Trusts achieved far more donations, and the Trust was lowest in the region. AK commented that another organisation, at which he was a Trustee, had applied a similar approach, and he had been amazed at the amounts raised.

KR asked whether, given the support expressed at the meeting, and the absence of any objections, the Trust Board wished to therefore approve the establishment of the fundraiser post, rather than wait to consider the matter at the Trust Board meeting in March 2017. It was duly agreed that the establishment of the fundraising post should proceed, and there was therefore no need for the Trust Board to be formally asked to approve this in March 2017.

2-17 To approve revised Terms of Reference for the Remuneration & Appointments Committee

AJ referred to the proposed amendments and invited questions or comment. None were received.

The proposed revisions to the Terms of Reference of the Remuneration and Appointments Committee were approved as circulated.

2-18 To consider any other business

There was no other business.

2-19 To receive any questions from members of the public

LS asked whether a presentation was received by a Directorate each month. KR explained the frequency of the scheduling of Directorate presentations and 'patient stories'.

2-20 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 – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
N/A	N/A	N/A	N/A	
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-4 (Jan 17)	Submit a report to the Trust Board, in March 2017, on the progress being made in relation to Medical productivity / Workforce Transformation Programme	Deputy Chief Executive	March 2017	A report has been submitted to the March 2017 Board
1-9 (Jan 17)	Arrange for a detailed report on the Trust's 62-day Cancer waiting time target performance to be submitted to the Trust Board	Chief Operating Officer	March 2017	A report has been submitted to the March 2017 Board
2-5 (Feb 17)	Undertake a scoping exercise to determine the work required in reviewing the clinical outcome of the 4.7% of inpatients that did not receive a VTE risk assessment, and reporting the findings to the 'main' Quality Committee	Medical Director	March 2017	A scoping exercise has been undertaken, and it is not considered feasible to accurately assess the outcome of the 4.7% of inpatients that had not received a VTE risk assessment (which equates to circa 420 patients per month). However, the case of every patient that is harmed by Thromboembolic disease is full investigated by the Serious Incident (SI) process, regardless of whether (or not) they had a VTE risk assessment undertaken

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
12-8iii (Dec 16)	Arrange for the next Trust Board 'Away Day' to discuss the 'new normal' levels of clinical activity seen at the Trust	Trust Secretary	spring 2016	
				The issue will be added to the agenda of the next 'Away Day', when the scheduling is confirmed

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

Trust Board meeting – March 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

3-7 Chief Executive's Report **Chief Executive**

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

1. MTW continues to focus on the provision of safe, high quality care for its patients. We are closely monitoring the effectiveness of our services and are proactively seeking opportunities for change to further improve and enhance our outcomes and overall patient experience.

   We are seeking new ways to empower our staff this year and achieve both their and our full potential. We will provide great care by supporting our healthcare professionals to lead more of the improvements they want to see.

   As a learning organisation, we have achieved a great deal in 2016/17, and while we have further to go, we are making steady progress at a time of significant national challenge for the NHS and social care as a whole.

   We are sighted on the national mandate, and its goals and objectives for NHS trusts in 2017. It is important that we continue to work individually and collectively - within our own organisation, and externally with our partners - to deliver these important patient standards.

   We welcome the recent announcement on additional funding for adult social care and will be working closely with our partners in Kent, Medway, and East Sussex, to reduce delayed transfers of care in our hospitals, which remain among the highest in the country. It is right that Kent has received one of the largest additional funding packages in the country and this bodes well for both our patients and out-of-hospital care. At the same time, we will continue to focus on addressing the challenges we continue to face with patients who are medically fit for discharge, but remain for too long in our care.

   Our Integrated Discharge Team (IDT) has been working towards the safe and timely discharge of patients across our sites as part of wider Trust plans to improve patient flow and reduce length of stay. As part of these initiatives, a new joined up approach to patient discharge is now set to be introduced by the IDT team, which will see them work collaboratively with staff from two other providers – Kent Community Health Trust and Social Services.

   As a learning organisation, we are continuing to look both inwardly to learn from our own practice, and outwardly to learn from others who have shown exemplary practice in the care of patients. I include examples in my report to the Board of areas in which we have recently excelled through individual and collective excellence, endeavour and empathy.

2. Since our last Board meeting we have announced the appointment of our new Chair of the Trust Board, David Highton. David, who starts in the role on 8 May, succeeds Tony Jones, who retired as Chairman on 28 February, after serving two full terms of office. Kevin Tallett, Non-Executive Director and Vice-Chair, will preside over the Board until 7 May, and David will Chair his first Board meeting on 24 May. I would like to publicly thank Tony for the significant contribution he has made to the Trust since he joined the Board in March 2008, and welcome David to the Trust.

3. Maternity staff from our `Better Births' team were runners-up at the Royal College of Midwives (RCM) Annual Midwifery Awards earlier this month. They were among the cream of midwifery teams to be nationally recognised for their outstanding work in maximising continuity of care, increasing normal birth and normality and reducing inequalities and disadvantage.

We were honoured to have Baroness Cumberlege, Chair of the National Maternity Review and Cathy Warwick, Chief Executive, RCM, as guest speakers at our fifth midwifery conference at the beginning of March. The event was attended by 120 delegates and showcased the strong maternity care provided within our Trust with presentations from both senior and student midwives.

4. The results of the 2016 NHS National Staff Survey have been published and It's clear that our staff are working extremely hard to meet increasing demand for our services and their time to care.

   Despite some considerable challenges, we've maintained many of the improvements we saw in 2015. Importantly, as many of our staff thought patient care was our top priority in 2016, as did in 2015. And we're above the national average yet again as a place to work or receive treatment. At the same time, it's clear that by working closer together in 2017, we can do more to make our trust an even better place for everyone to work at, and care for patients in.

5. I would like to highlight and commend to the Board the thoughtfulness displayed by Vicki Belton, a Health Play Specialist at Maidstone Hospital. Vicki eased the fears and anxiety of an 11-year-old boy who required an MRI scan by arranging for his autism therapy dog Daisy to stay nearby during his appointment. The boy's parents told us: "The fact that we could bring Daisy to his MRI scan made a world of difference and we are so grateful to the staff who made it happen. We have been through a huge number of hospital visits, locally and in London, but this was the first time the whole family came away saying what an amazing hospital this is. At Maidstone, the staff's focus on Benedict and his experience was better than anywhere we have ever been before."

6. More than 180 students from 18 different schools have attended a careers event at our Trust as part of our on-going commitment to encourage and support young people in our local communities. We were able to showcase the diverse range of careers within the NHS and opportunities for traineeships all the way through to higher and degree apprenticeships.

   It's important that we maintain and nurture our links to the community and within local education to allow future generations to understand and support what we do. I hope that some of these young people will be inspired by what they saw and heard and decide to come and work with us in the future. The event was held by our Learning and Development team in partnership with HEE KSS and Education Business Partnership Kent,

7. The Trust has exceeded its annual research recruitment target for 2016/17, with 1,300 people already consenting to take part in clinical trials this year – surpassing the 1,250 goal we were set. This fantastic achievement has seen more of our patients than ever before offered innovative treatments. Meeting the target also helps MTW secure future research funding. I would like to say well done to everyone involved, in particular the research department, for all their support and hard work over the past 12 months.

8. Kent Oncology Centre has had another successful CHKS inspection. Overall comments on the findings concluded, 'The Kent Oncology Centre remains an outstanding centre and it is recommended that they continue to be in receipt of their ISO certification.' This is testament to the ongoing hard work and commitment from all KOC staff.

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 – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-8 Integrated performance report for February 2017 — Chief Executive

The enclosed report includes:

- The 'story of the month' for February 2017
- A Mortality update
- A Quality Exception Report
- A Workforce update
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 22/03/17 (performance dashboard)

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

Discussion and scrutiny

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

‘Story of the month’ for February 2017

Responsiveness

At the end of month 11 the Trust is underperforming against the constitutional standards for emergency 4 hour standard, RTT and cancer 62 day first definitive treatment.

1. Four-hour standard, non-elective activity and LOS

Performance for the Trust for February (calendar) improved to 85.1% which although remains below the Trust recovery plan of 92.4% was much improved from the previous 2 months, with the greater level of improvement at Maidstone. We have set an internal target of at least 91% in the last week of March and 86% for the month.

- A&E Attendances remain high, conforming very closely to the MTW model. YTD attendances are 5.0% higher than last year, and A&E admissions 16.9% higher.
- Non-Elective Activity was 15.9% higher than plan for Feb and 7.8% higher than Feb last year. YTD activity is 11.8% higher than plan. More non-elective admissions are coming in through A&E than last year.
- There were 1,505 bed-days lost – 7.11% of occupied beds in Feb due to delayed transfers of care.
- Non-elective LOS dropped to 7.68 days for February discharges after spiking at 8.68 in Jan and the average occupied bed days dropped slightly to 754 in Feb, down from January’s record 776

As reported previously the Urgent Care Division remain focused on improving the flow at the front door, ambulatory & acute assessment pathways as well as LOS improvement across all specialities. Implementation of Home First is a key initiative for the Trust to manage complex discharges, particularly for patients requiring further care in a nursing home. The Trust continues to work with the CCG, the community Trust and KCC to deliver Home First in West Kent.

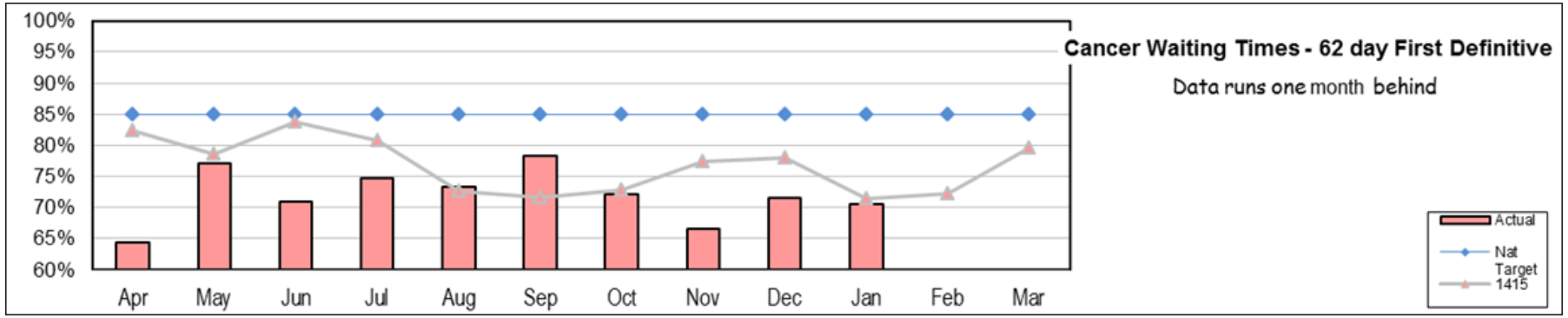
1.1 Delayed Transfers of Care

Row Labels	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Grand Total
A : Awaiting Assessment	17	17	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	368
B : Awaiting Public Funding	3	2	2		1	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	145
C : Awaiting Further Non-Acute NHS Care	18	28	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	766
Di : Awaiting Residential Home	3	6	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	589
Dii : Awaiting Nursing Home	12	30	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	1616
E : Awaiting Care Package	18	10	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	958
F : Awaiting Community Adoptions	1	8	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	236
G : Patient of Family Choice	47	60	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	1062
H : Disputes			2	1			1	3	1	1		1				3	1	1				1			1	18
I : Housing		1	3	4	3	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	107
Grand Total	119	162	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	5865

Trust delayed transfers of care	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.3%	8.1%	6.7%	7.1%

2. Cancer 62 day FDT

- Performance for 62 day First Definitive Treatment (data runs a month behind) - Jan-17: 70.6% 62 FDT for January: 28.5 breaches 21 of these were MTW only patients. 13 patients from Other Trusts to MTW and 3 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 2 patients from Medway, 1 patient from Darent Valley and 10 patients from East Kent (Patients shared across Trusts = 0.5 of a breach).
- Lower GI contributed the largest number of breaches in January (7.5 breaches [new breach allocation] – 7 MTW only patients). A delay in diagnostic pathways was the largest contributory factor in breaches.
- Urology contributed the second largest number of breaches in January (4.5 breaches [new breach allocation] – 3 MTW only patients). Surgical capacity and patients not being fit to proceed with treatment were the primary reasons for breaches.



Progress continues to be made with the individual MDT leads for each tumour site with a clear focus on the reasons for breaches and the actions necessary to address these. The clinical teams are aware of the issues in their respective areas to be addressed and the remedial actions are monitored on a regular basis. The actions related to improving the diagnostic phase and engaging with other units re timely referral for all patients on a cancer pathway.

3. RTT and elective activity.

Performance: February performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 89.2% against our trajectory of 94%. This is due to a continued increase in non-elective demand, restricting access to day surgery and elective beds.

The Trust continues to be non-compliant at a speciality level for T&O, Gynae, Neurology and ENT and the majority of the backlog is concentrated in these four-all of which are being carefully monitored against action plans put in place to reduce their longest waiters.

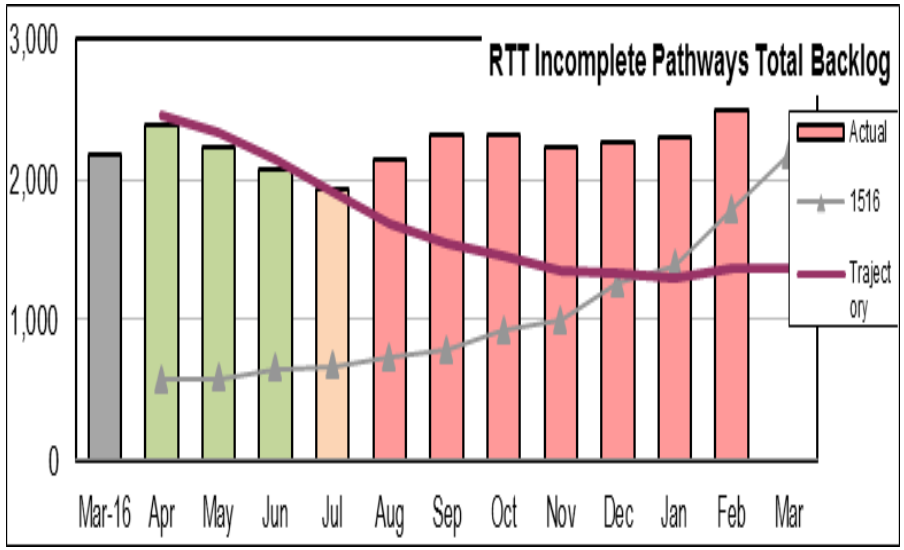
- ENT, T&O & Gynae are trying to continue to reduce their backlogs despite cancellations by moving lists to Maidstone and focusing capacity on patients within the backlog. Extra Saturday sessions are being planned when current escalation reduces. The criteria for the case-mix going through the Maidstone Orthopaedic Unit has been reviewed to maximise utilisation and reduce the need for outsourcing

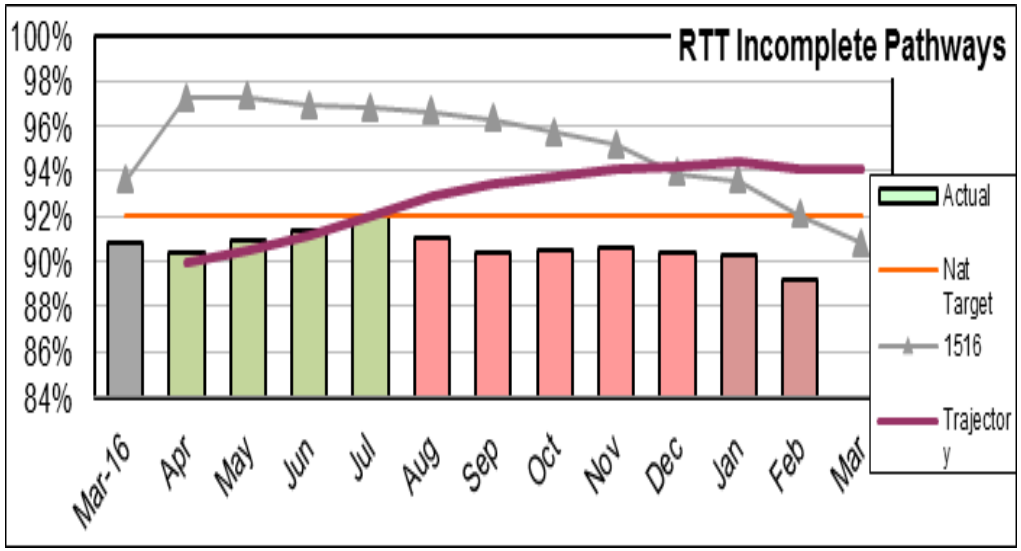
- Neurology continues to work on their recovery plan to address their outpatient backlogs by the end of Feb. This includes validation, running extra clinics and ensuring clinics are fully booked.

Operational teams have focused their recovery plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further. The organisation remains behind the RTT performance trajectory submitted for 16/17.

	Feb-17	Feb-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	2,493	1,375	+1,118
RTT Waiting List	23,360	23,425	+65
RTT Incomplete performance %	89.3%	94.1%	-4.8%

Cancellations: 214 cancellations on the day of which 43 were reportable. **Diagnostics:** The overall Trust performance is within tolerance so has achieved the 6 week Diagnostic standard for January. **Outsourcing:** The total outsourced activity was 62, which is a greatly reduced number compared to previous months.





Mortality

Work is continuing in relation to understanding the reasons for the increase in the Trust's Hospital Standardised Mortality Ratio (HSMR), and a verbal update on the latest position will be given at the Board meeting on 29/03/17.

Quality Exception Report

Any matters not included within the "Quality and Patient Safety Report" will be raised by exception in the meeting.

Workforce

As at the end of February 2017, the Trust employed 5,083.2 whole time equivalent substantive staff. Overall temporary staffing increased from January 2017, although this was primarily as a result of bank rather than agency use. Further work will continue to reduce dependence on temporary staff.
Sickness absence in the month (January) remained at 4.6% primarily as a result of staff reporting cold/flu illnesses within the month. Sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance has reduced slightly by 0.6% but remains consistently above the target percentage. Actions are in place to improve compliance further.

Work is currently underway to review the workforce metrics within the trust dashboard.

TRUST PERFORMANCE DASHBOARD **Position as at:** **28 February 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		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
1-01	*Rate C-Diff (Hospital only)	0.00	0.0	7.7	10.3	2.5	-	11.5	11.5	
1-02	Number of cases C.Difficile (Hospital)	0	0	17	25	8	-	27	27	
1-03	Number of cases MRSA (Hospital)	0	1	1	2	1	2	0	2	
1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%		1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	98.0%	96.0%	98.0%	96.0%		1.0%	95.0%	96.0%	
1-06	**Rate of Hospital Pressure Ulcers	3.9	2.4	2.8	2.7	- 0.0	- 0.3	*3.0*	2.7	3.0
1-07	***Rate of Total Patient Falls	6.2	6.1	6.7	6.1	- 0.7	- 0.1	*6.20*	6.20	
1-08	***Rate of Total Patient Falls Maidstone	6.0	4.6	6.1	5.4	- 0.8			5.3	
1-09	***Rate of Total Patient Falls TWells	6.8	7.1	7.2	6.6	- 0.6			7.6	
1-10	Falls - SIs in month	0	4	41	34	- 7				
1-11	Number of Never Events	0	1	2	3	1	3	*0*	3	
1-12	Total No of SIs Open with MTW	34	35			1				
1-13	Number of New SIs in month	6	13	95	104	9	- 6			
1-14	**Serious Incidents rate	0.28	0.61	0.43	0.43	- 0.01	0.37	*0.0584 - 0.6978*	0.43	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.48	1.12	1.13	0.76	- 0.37	- 0.47	*0 - 1.23*	0.76	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.1%	95.7%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.1%	97.5%	96.7%	96.6%	-0.1%	1.6%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.06%	2.39%	2.48%	3.17%	0.69%	0.2%	*3.00%*	3.17%	
1-20	C-Section Rate (non-elective)	13.3%	12.8%	13.3%	13.0%	-0.25%	-2.0%	*15.0%*	13.0%	

	Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.0	110.0	7.0	10.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		105.0	108.0	3.0	8.0			100.0
2-03	Crude Mortality	1.2%	1.3%	1.2%	1.3%	0.1%				
2-04	****Readmissions <30 days: Emergency	10.5%	10.5%	11.4%	11.7%	0.2%	-1.9%	*13.6%*	11.7%	14.1%
2-05	****Readmissions <30 days: All	10.2%	10.1%	10.7%	10.9%	0.2%	-3.8%	*14.7%*	10.9%	14.7%
2-06	Average LOS Elective	3.54	3.00	3.17	3.30	0.13	0.10	*3.20*	3.20	
2-07	Average LOS Non-Elective	7.73	7.71	7.33	7.73	0.40	0.89	*6.84*	7.73	
2-08	******FollowUp : New Ratio	1.26	1.63	1.27	1.59	0.32	0.07	*1.52*	1.59	
2-09	Day Case Rates	86.5%	86.6%	84.4%	85.6%	1.1%	5.6%	80.0%	85.6%	82.2%
2-10	Primary Referrals	9,144	8,098	96,402	98,187	1.9%	2.6%	104,825	108,006	
2-11	Cons to Cons Referrals	3,275	3,263	38,222	39,449	3.2%	4.5%	40,698	43,394	
2-12	First OP Activity	11,464	12,230	128,098	137,920	7.7%	1.2%	150,356	151,427	
2-13	Subsequent OP Activity	22,343	24,420	249,937	265,196	6.1%	0.5%	291,660	290,078	
2-14	Elective IP Activity	487	475	6,912	6,732	-2.6%	-11.8%	8,139	7,539	
2-15	Elective DC Activity	2,990	2,872	35,655	36,806	3.2%	-1.4%	40,746	40,883	
2-16	Non-Elective Activity	3,749	4,044	41,378	45,681	10.4%	0.4%	49,709	49,664	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	12,996	11,647	142,005	145,732	2.6%	-0.7%	164,376	159,938	
2-18	Oncology Fractions	5,509	5,564	63,416	64,562	1.8%	-3.6%	73,613	71,078	
2-19	No of Births (Mothers Delivered)	475	452	5,282	5,481	3.8%	1.6%	5,888	5,979	
2-20	% Mothers initiating breastfeeding	74.3%	77.6%	77.6%	81.8%	4.3%	3.8%	78.0%	81.8%	
2-21	% Stillbirths Rate	0.4%	0.22%	0.41%	0.32%	*-0.1%*	*-0.1%*	*0.47%*	0.32%	0.47%

	Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Single Sex Accommodation Breaches	0	0	6	12	6	12	0	12	
3-02	*****Rate of New Complaints	2.80	1.37	1.69	1.22	-0.5	- 0.10	*1.318-3.92*	1.22	
3-03	% complaints responded to within target	54.8%	76.7%	71.9%	69.0%	-2.8%	-6.0%	75.0%	72.5%	
3-04	****Staff Friends & Family (FFT) % rec care	82.2%	82.7%	82.2%	82.7%	0.5%	3.7%	79.0%	82.7%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	95.6%	95.8%	96.4%	95.5%	-0.8%	0.5%	95.0%	95.5%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	85.8%	92.6%	88.6%	90.4%	1.8%	3.4%	87.0%	90.4%	85.5%
3-07	Maternity Combined FFT % Positive	93.2%	93.4%	95.0%	93.8%	-1.3%	-1.2%	95.0%	93.8%	95.6%
3-08	OP Friends & Family (FFT) % Positive	81.7%	83.9%	80.0%	82.9%	2.9%			82.9%	

	Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
4-01	******Emergency A&E 4hr Wait	84.8%	85.1%	89.7%	86.9%	-2.8%	-3.8%	95.0%	87.1%	82.7%
4-02	Emergency A&E >12hr to Admission	0	0	0	2	2	2	*0*	2	
4-03	Ambulance Handover Delays >30mins	New	369	New						
4-04	Ambulance Handover Delays >60mins	New	28	New						
4-05	RTT Incomplete Admitted Backlog	942	1870	942	1870	928	954	916	1265	
4-06	RTT Incomplete Non-Admitted Backlog	444	623	444	623	179	164	459	635	
4-07	RTT Incomplete Pathway	93.6%	89.3%	93.6%	89.3%	-4.2%	-4.8%	92%	92.3%	
4-08	RTT 52 Week Waiters	0	1	5	6	1	6	*0*	6	
4-09	RTT Incomplete Total Backlog	1,386	2493	1,386	2493	1,107	1,118	1,375	1900	
4-10	% Diagnostics Tests WTimes <6wks	95.04%	99.6%	98.8%	99.6%	0.9%	0.6%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	1	3	3	2	- 1	- 7	9	3	
4-12	*Cancer two week wait	90.3%	95.3%	92.0%	95.3%	3.3%	2.3%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.9%	84.3%	85.6%	84.3%	-1.4%	-8.7%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	94.8%	92.7%	96.4%	92.7%	-3.7%	-3.3%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	71.4%	70.6%	74.3%	70.6%	-3.7%	-10.4%	85.2%	81.9%	
4-16	*Cancer 62 day wait - First Definitive - MTW	77.5%	75.9%	79.5%	75.9%	-3.6%		85.0%		
4-17	*Cancer 104 Day wait Accountable	6.5	10.5	43.5	90.0	46.5	90.0	*0*	90.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	New	79	New	79					
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	New	54	New	54					
4-20	Delayed Transfers of Care	5.1%	7.1%	6.2%	6.7%	0.5%	3.2%	3.5%	6.7%	
4-21	% TIA with high risk treated <24hrs	66.7%	90.9%	69.8%	83.7%	13.9%	23.7%	60%	83.7%	
4-22	*******% spending 90% time on Stroke Ward	70.2%	93.3%	81.3%	93.3%	12.1%	13.3%	80%	93.3%	
4-23	*******Stroke:% to Stroke Unit <4hrs	33.3%	62.5%	33.3%	52.6%	19.3%	-7.4%	60.0%	52.6%	
4-24	*******Stroke: % scanned <1hr of arrival	53.8%	55.2%	55.1%	56.5%	1.3%	8.5%	48.0%	56.5%	
4-25	*******Stroke:% assessed by Cons <24hrs	70.1%	72.4%	72.6%	67.0%	-5.6%	-13.0%	80.0%	67.0%	
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	0	1	0	29	29	29	*0*	29	

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		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
5-01	Income	32,952	33,504	364,489	389,041	6.7%	-1.8%	440,817	437,811	
5-02	EBITDA	197	340	6,296	11,174	77.5%	-51.9%	37,717	34,509	
5-03	Surplus (Deficit) against B/E Duty	(2,786)	(2,045)	(24,751)	(16,168)			4,675	2,435	
5-04	CIP Savings	1,472	2,591	18,967	20,613	8.7%	-22.2%	32,065	32,065	
5-05	Cash Balance	20,371	13,632	20,371	13,632	-33.1%	552%	1,000	1,000	
5-06	Capital Expenditure	1,294	486	11,274	4,022	-64.3%	-68.9%	*15,188*	8,646	
5-07	Establishment (Budget WTE)	5,702.5	5,605.4	5,702.5	5,605.4	-1.7%	0.0%	5,837.3	5,837.3	
5-08	Contracted WTE	5,153.3	5,083.2	5,153.3	5,083.2	-1.4%	-0.7%	5,427.1	5,427.1	
5-09	***Contracted not worked WTE	(114.1)	(89.9)	(114.1)	(89.9)	-21.2%		(100.0)	(100.0)	
5-11	Bank Staff (WTE)	331.4	321.5	331.4	321.5	-3.0%	-3.5%	254.8	254.8	
5-12	Agency & Locum Staff (WTE)	297.0	201.7	316.5	201.7	-36.3%		155.3	155.3	
5-13	Overtime (WTE)	46.0	33.7	46.0	33.7	-26.7%		50.0	64.4	
5-14	Worked Staff WTE	5,713.6	5,550.2	5,713.6	5,550.2	-2.9%	-1.0%	5,801.7	5,801.7	
5-15	Vacancies WTE	549.2	446.2	549.2	446.2	-18.8%	8.1%	408.6	408.6	
5-16	Vacancy %	9.6%	8.0%	9.6%	8.0%	-1.7%	-8.7%	8.5%	8.5%	
5-17	Nurse Agency Spend	(990)	(638)	(9,379)	(7,634)	-18.6%				
5-18	Medical Locum & Agency Spend	(939)	(942)	(11,297)	(13,374)	18.4%				
5-19	Temp costs & overtime as % of total pay bill		13.3%		13.3%					
5-20	Staff Turnover Rate	10.4%	10.7%	9.8%	10.4%	0.3%	0.2%	*10.5%*	10.4%	11.05%
5-21	Sickness Absence	4.1%	4.6%	3.9%	4.2%	0.6%	1.3%	*3.3%*	4.2%	4.3%
5-22	Statutory and Mandatory Training	90.4%	90.2%	90.4%	90.2%	-0.2%	5.2%	85.0%	90.2%	
5-23	Appraisal Completeness	80.5%	87.7%	62.9%	87.7%	7.2%	-2.3%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	101.7%	97.9%	101.6%	98.8%	-3.8%		93.5%	98.8%	
5-25	****Staff FFT % recommended work	56.9%	62%	56.9%	62%	5.4%	0.3%	62.0%	62%	62.9%
5-26	***Staff Friends & Family -Number Responses	253	422	253	422	169				
5-27	*****IP Resp Rate Recmd to Friends & Family	13.6%	25.6%	25.1%	23.1%	-2.0%	-1.9%	25.0%	23.1%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	6.0%	15.6%	13.0%	14.4%	1.4%	-0.6%	15.0%	14.4%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	13.5%	35.9%	20.3%	26.5%	6.3%	1.5%	25.0%	26.5%	24.0%

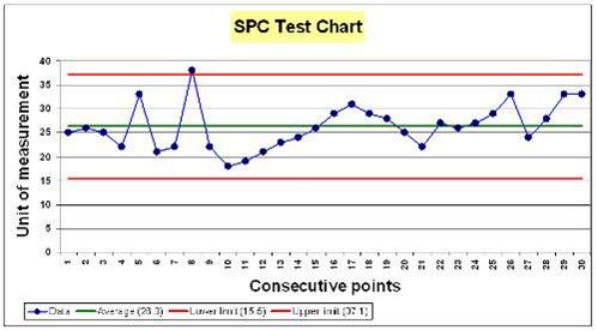
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

***** 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 within confidence limit*

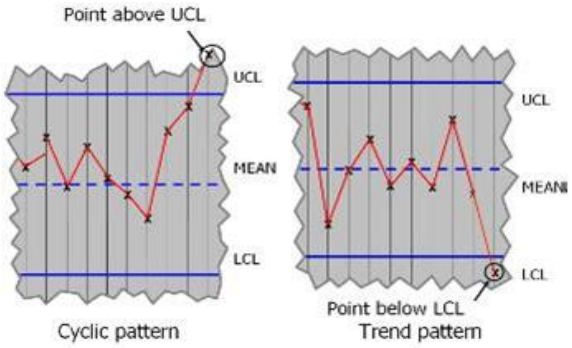
Explanation of Statistical Process Control (SPC) Charts

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:

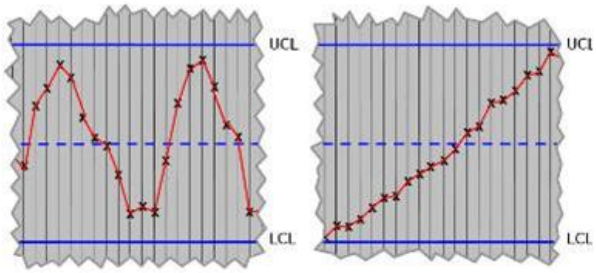


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

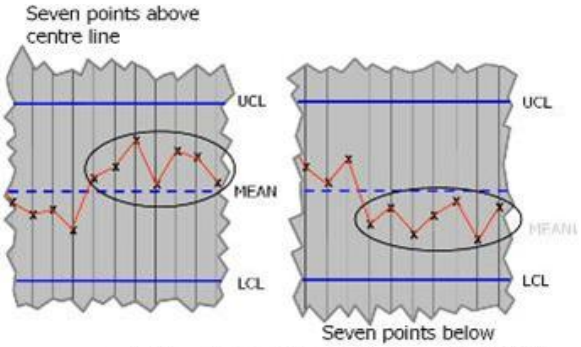


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

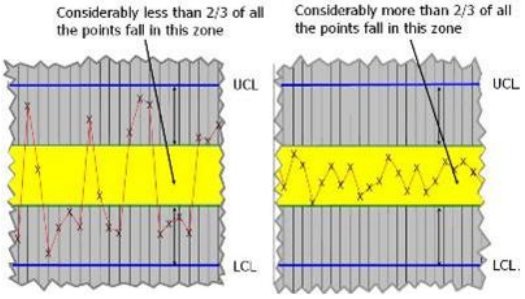


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

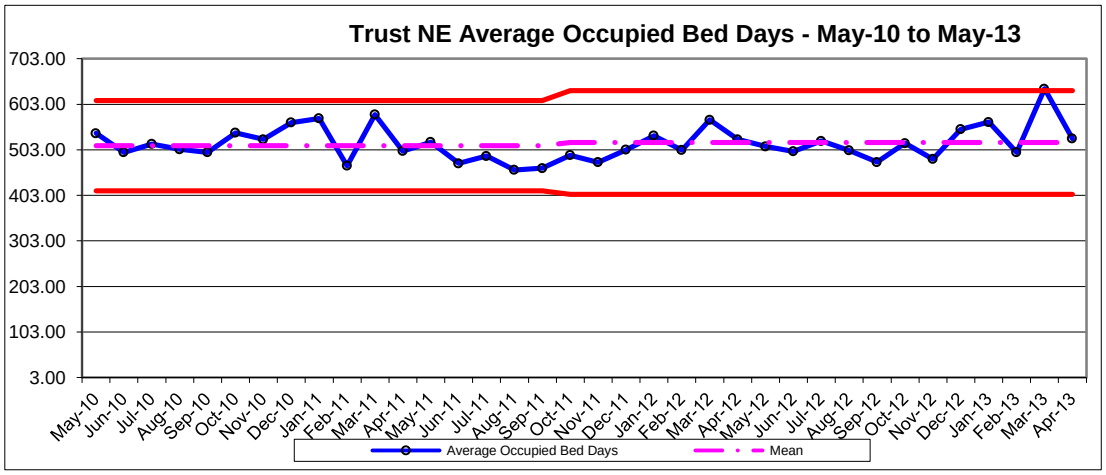


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

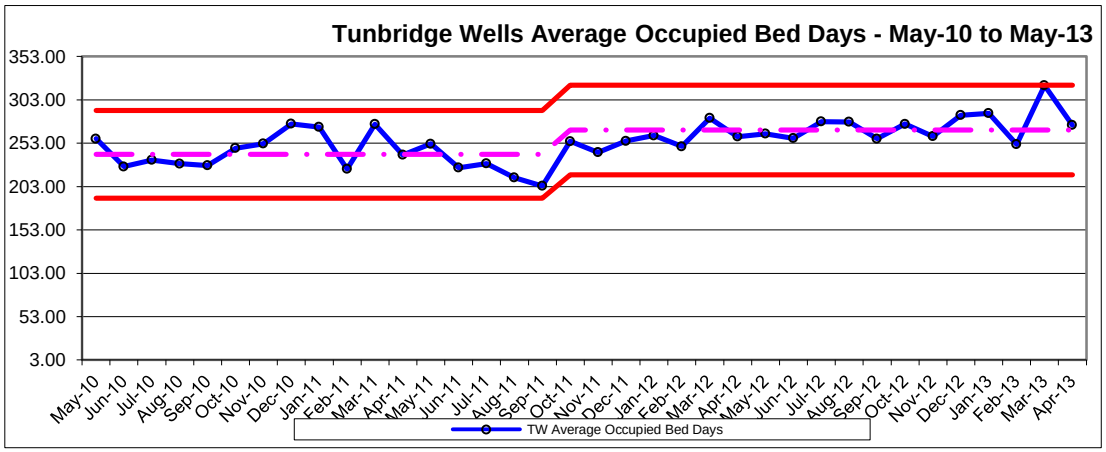


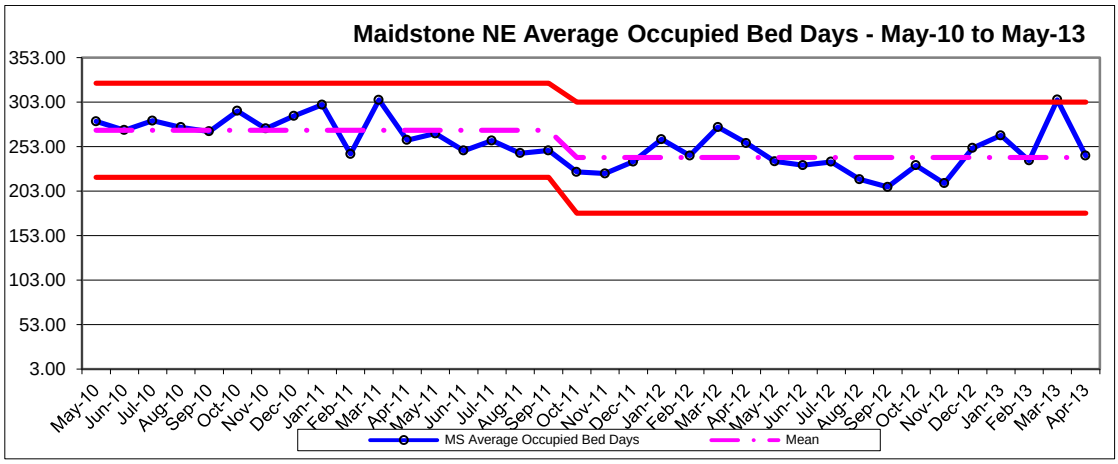
Changes to Control Lines

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:

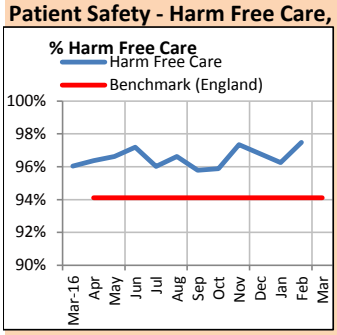


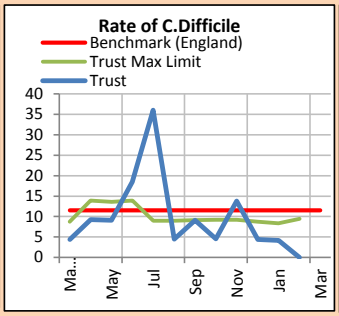


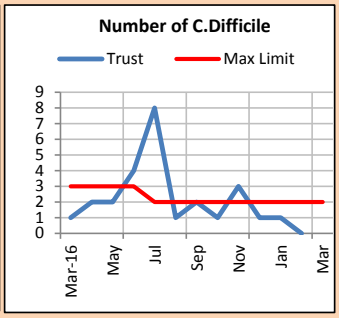
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

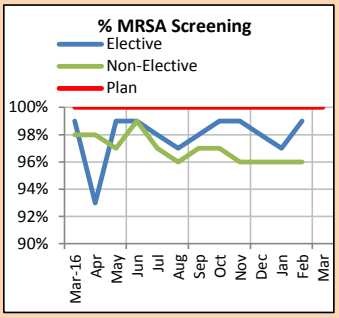
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

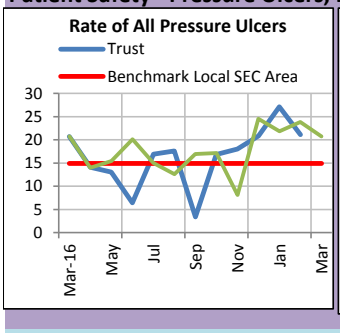


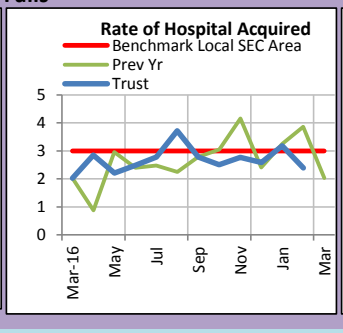


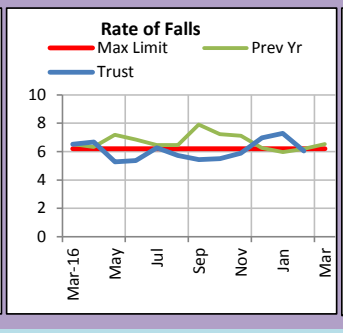


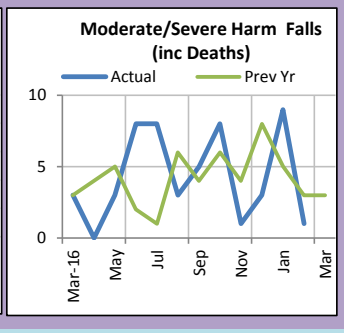


Patient Safety - Pressure Ulcers, Falls

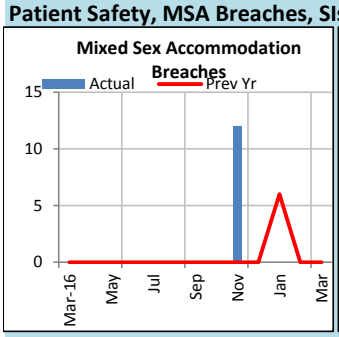


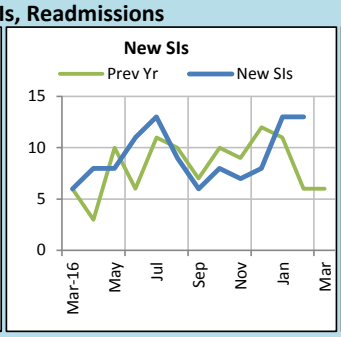


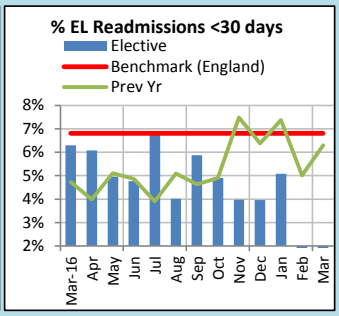


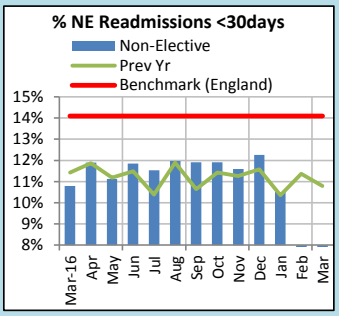


Patient Safety, MSA Breaches, SIs, Readmissions

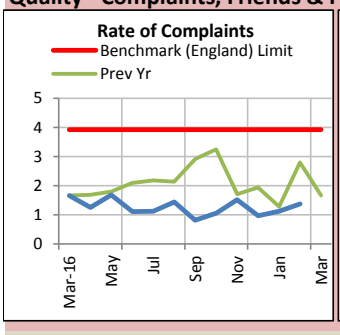


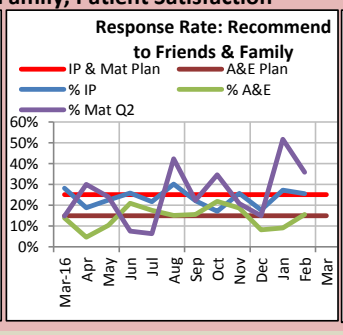


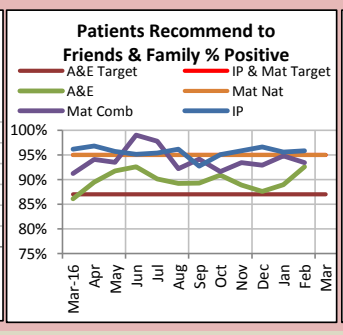


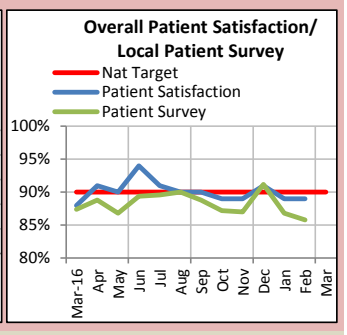


Quality - Complaints, Friends & Family, Patient Satisfaction

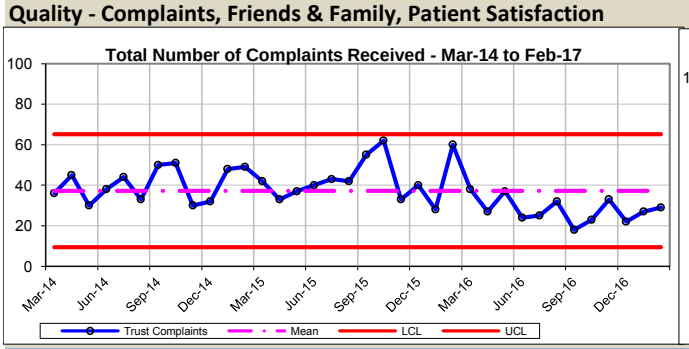


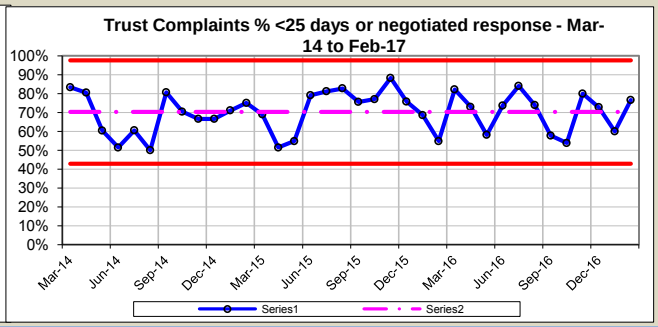




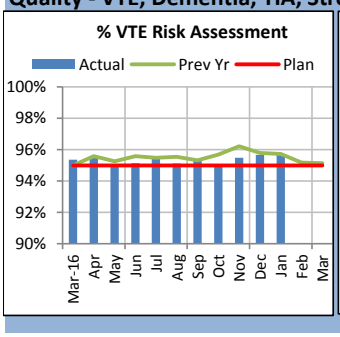


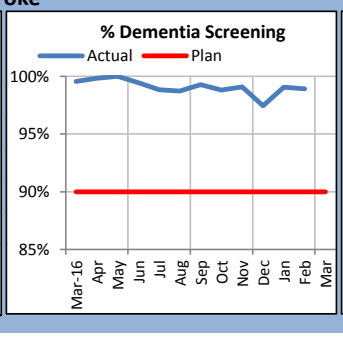
Quality - Complaints, Friends & Family, Patient Satisfaction

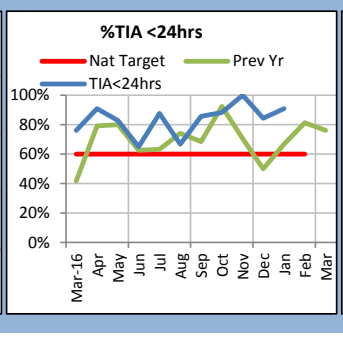


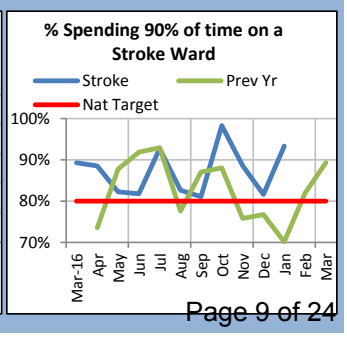


Quality - VTE, Dementia, TIA, Stroke



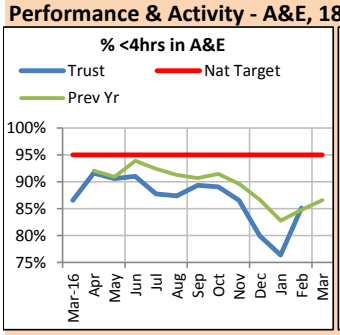


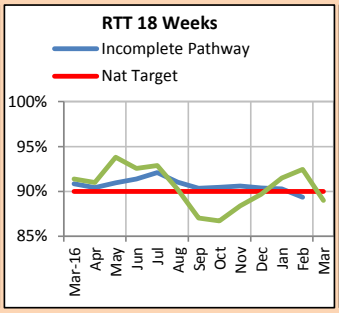


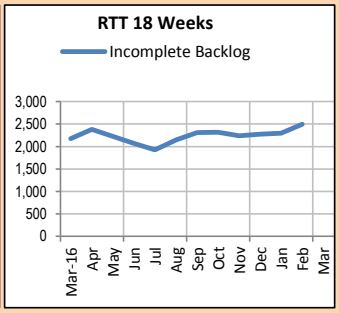


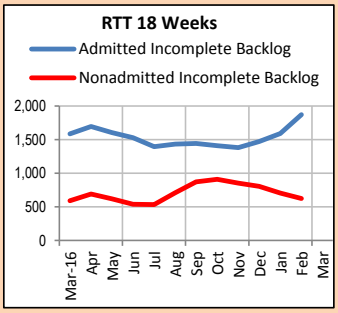
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

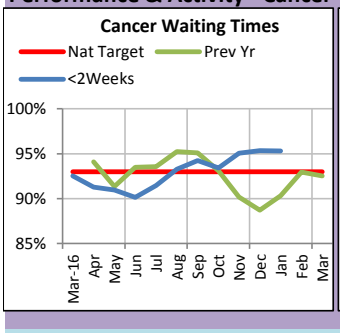


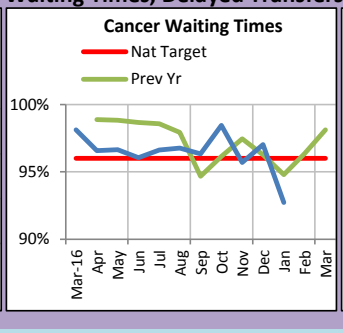


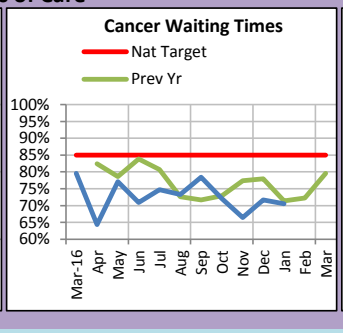


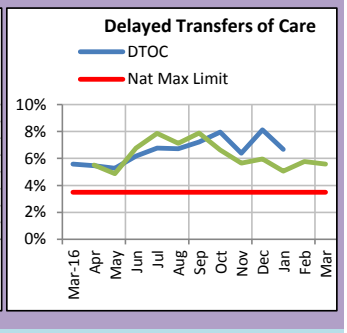


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

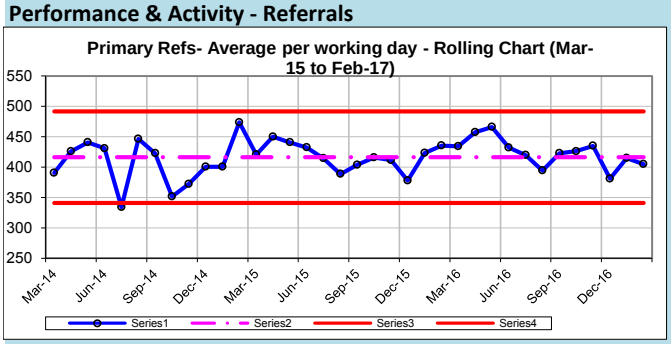


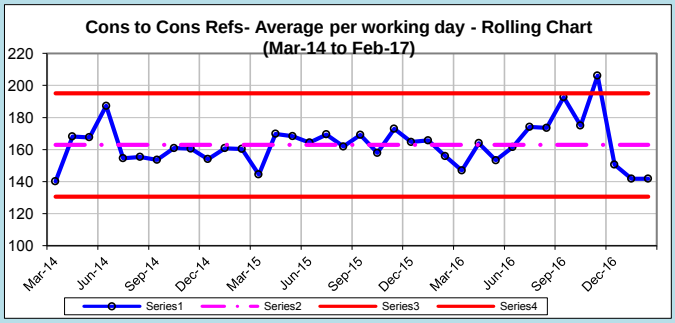




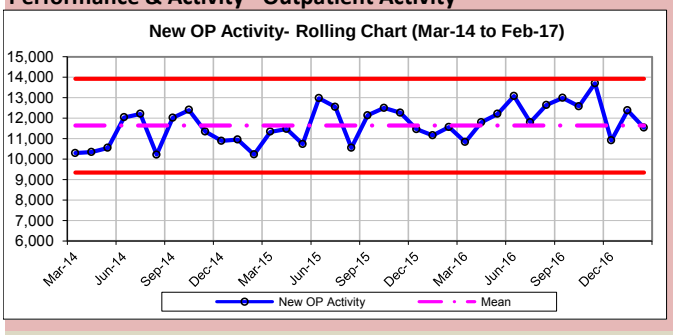


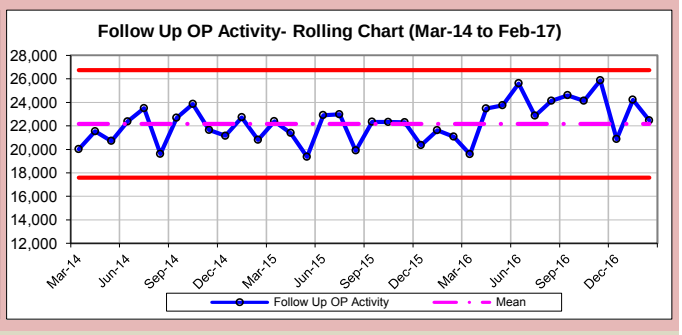
Performance & Activity - Referrals



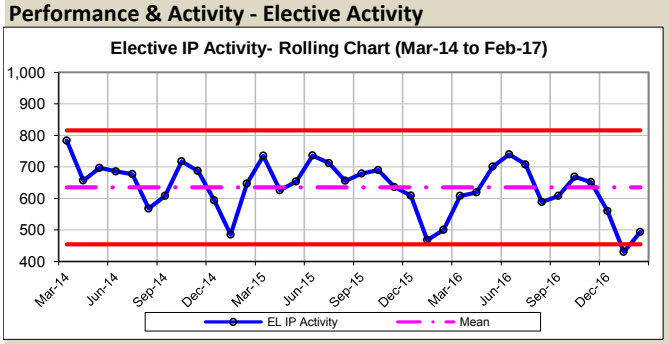


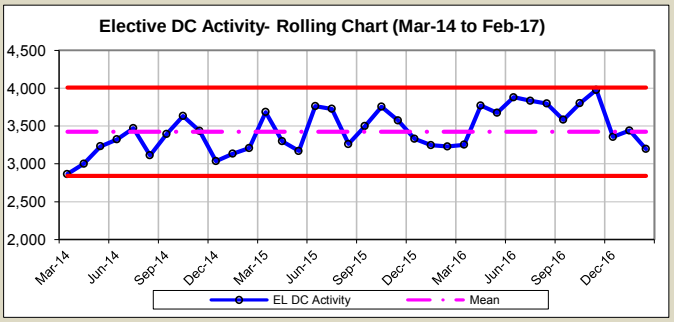
Performance & Activity - Outpatient Activity



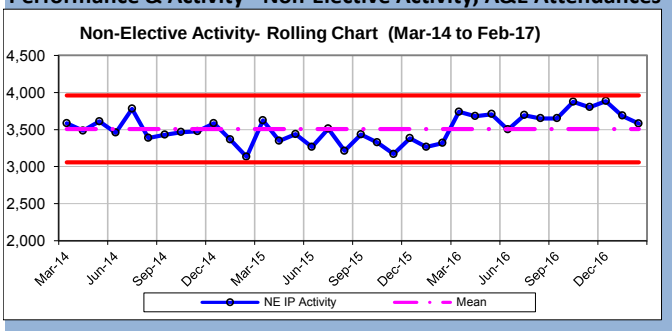


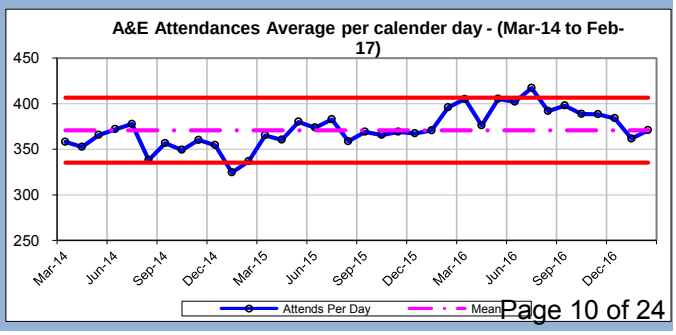
Performance & Activity - Elective Activity





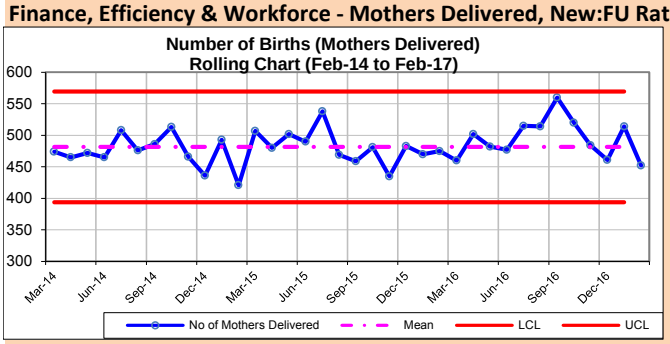
Performance & Activity - Non-Elective Activity, A&E Attendances

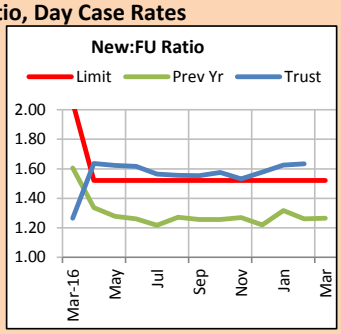


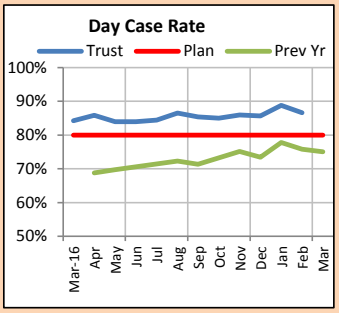


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

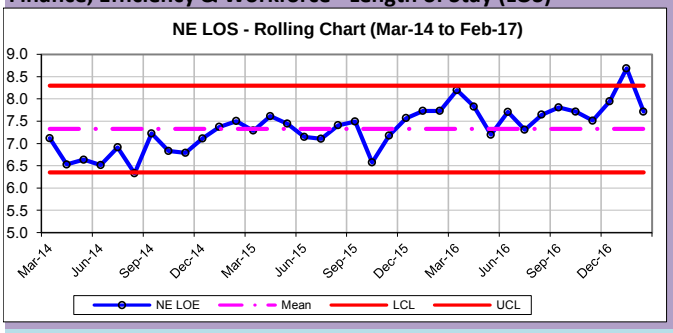
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

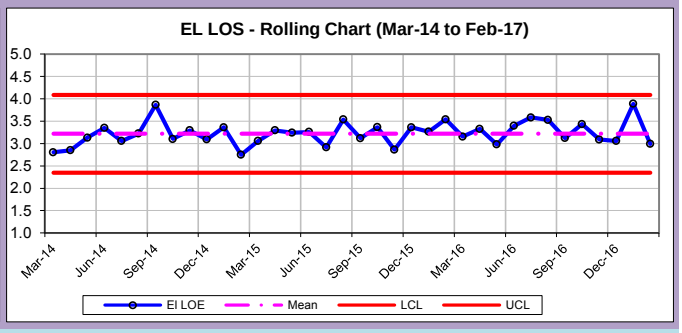




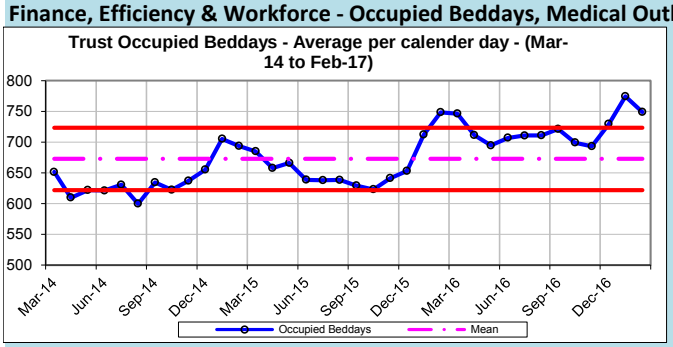


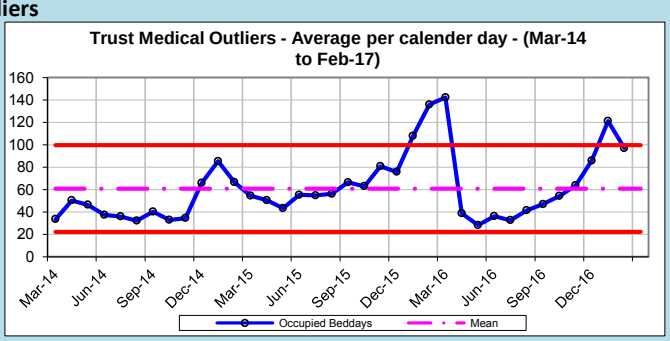
Finance, Efficiency & Workforce - Length of Stay (LOS)



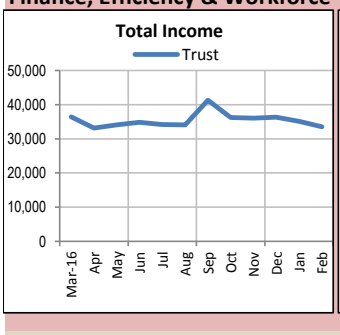


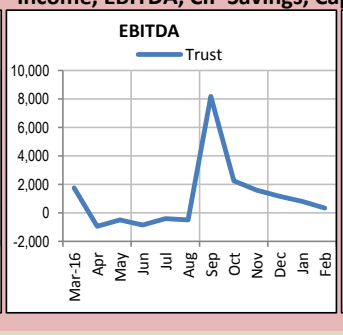
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

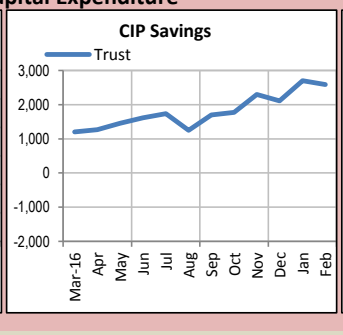


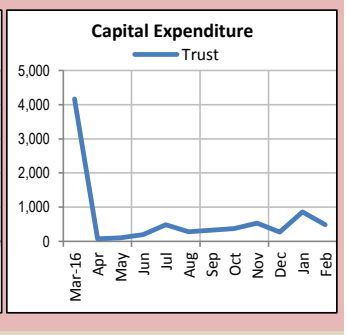


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

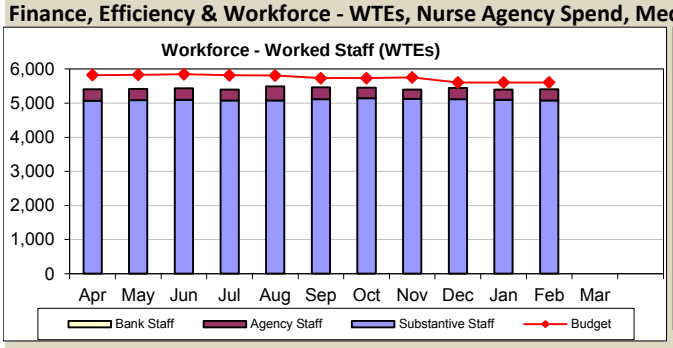


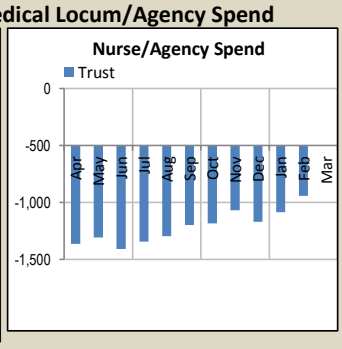


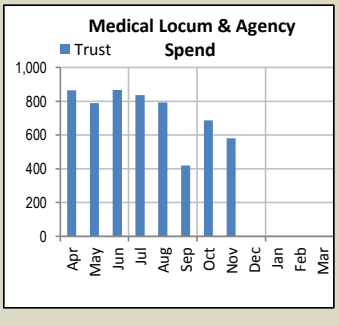




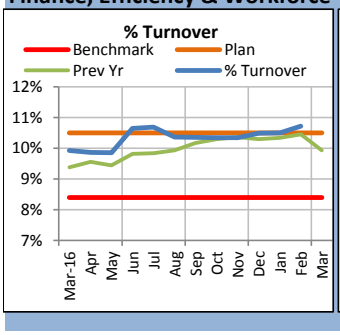
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

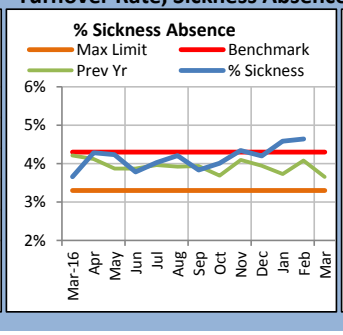


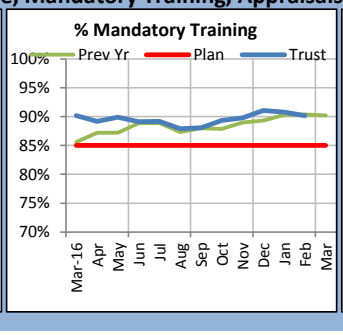


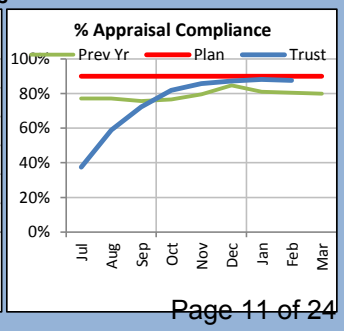


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-8 Review of Latest Financial Performance — Director of Finance

Summary / Key points

- The Trust had an adverse variance against plan in February 2017 of £5.5m including STF. The in month deficit was £2.0m.
- The Trust's net deficit to date (including technical adjustments) is £16.2m against a planned deficit of £6.4m, therefore £9.7m adverse to plan. The driver of the adversity to plan is the Trust has only achieved 59% of the STF YTD. The Trust fully achieved quarter 2 and 3 of the element relating to financial performance but has missed quarter 3 A&E performance, RTT and Cancer performance trajectories. The Trust has missed January and February STF targets but has appealed quarter 3 access targets and is awaiting an outcome from this appeal.
- In February the Trust operated with an EBITDA surplus of £0.3m, £5.6m adverse to plan.
- The key variances in the month are as follows:
  - Total income was £3.8m adverse in the month, Clinical income was £3.1m adverse in the month, Elective IP activity was £0.7 adverse, Daycase activity was £0.5m adverse, A&E £0.5m and Out Patients £0.3m adverse. STF funding was £1m adverse in the month due to failure to meet the Financial, A&E, RTT and Cancer trajectories for the month. Other operating income was £0.3m favourable to plan which related to STP.
  - Pay was £0.9m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs reduced by £0.3m between months, Nursing costs reduced by £0.1m with Nurse Agency hours reducing by 8% (1,400 hours). Medical costs reduced by £0.3m mainly within T&O (agency costs reduced by £0.1m).
  - Non Pay was overspent by £0.9m in the month which included £1m unidentified savings. Purchase of healthcare from non NHS was £0.2m favourable in the month and reduced between months by £0.3m which was arisen by T&O and Gynae reducing outsourcing.
  - PDC and Impairments reflect FRP adjustments for MEA and impairments with corresponding offset within technical adjustments.

The Trust normalised position for February was £2.2m deficit which was a reduction of £0.25m between months.

- The CIP and FRP performance in February delivered efficiencies of £2.6m which was £2.7m adverse to plan, £3.2m relates to unidentified savings phased in February.
- The Trust held £13.6m of cash at the end of February. This higher than normal month end cash balance is to ensure the Trust has sufficient cash to pay key statutory commitments which are due in March. Currently NHS England are not able to confirm when the Trust will be receiving the Qtr 3 STF funding, this is forecast to be used to repay the uncommitted loan balance of £2.458m. Therefore the Trust has moved both the repayment of the loan and the receipt of STF funding to April.
- The Trusts plan has been set to deliver the Control total for 2016/17 of a £4.7m surplus including STF, £4.7m deficit excluding STF.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 27/03/17

Reason for submission to the Board (decision, discussion, information, assurance etc.) 0F[1]

To note the financial position for February

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

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 11
2016/17

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for February 2017

1.Executive Summary

Maidstone and Tunbridge Wells NHS Trust

1a. Executive Summary February 2017

Key Variances £m

	February	YTD		Headlines
Total Surplus (+) / Deficit (-)	**(5.5)**	**(9.7)**	**Adverse**	The reported Trust position for February is a deficit of £2m which is £5.5m adverse to plan. The main drivers were: Clinical Income (Excluding STF) was £3.1m adverse to plan in month (£7.8m adverse YTD), the key variances were, Elective IP activity £0.7m adverse to plan, Daycase £0.5m adverse to plan, elective income increased by £0.2m between months. A&E £0.5m adverse to plan (£0.1m reduction between months), and out patient income was £0.3m adverse to plan (£0.2m reduction between months). The Trust did not meet the Financial plan or the access trajectories for February resulting in no STF funding.
Pay	**(0.9)**	**(0.3)**	**Adverse**	Pay was £0.9m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs reduced by £0.3m between months, Nursing costs reduced by £0.1m between months which was due to a reduction in bank costs (£0.2m) due to one less week in February. Nurse Agency costs increased between months by £0.1m however this was due to a non recurrent benefit in January. The number of nursing agency hours reduced between months by 8% (1,400 hours). Medical costs reduced by £0.2m this was mainly within T&O, £0.1m reduction in locum agency costs and £40k reduction in Cancer.
Non Pay	**(0.9)**	**(4.5)**	**Adverse**	Non Pay was overspent by £0.9m in the month which included £1m unidentified savings. Purchase of healthcare from non NHS (outsourcing) was £0.2m favourable in the month and reduced between months by £0.3m which was mainly within T&O and Gynae due to outsourcing reduction. Other non pay costs in February includes £0.5m STP costs which are offset by additional income.
Elective IP	**(0.7)**	**(2.6)**	**Adverse**	Elective Income increased by £0.2m between months (69 cases) but was the second lowest level this financial year.
Sustainability and Transformation Fund	**(1.0)**	**(3.4)**	**Adverse**	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards access targets (12.5% A&E, 12.5% RTT and 5% Cancer). The Trust did not achieve the financial and access targets in February
CIP / FRP	**(2.7)**	**(5.9)**	**Adverse**	The FRP plan in February included £3.2m unidentified cost reduction savings

Financial Forecast

Risks:
Unidentified cost reduction FRP/ CIP of £7.6m

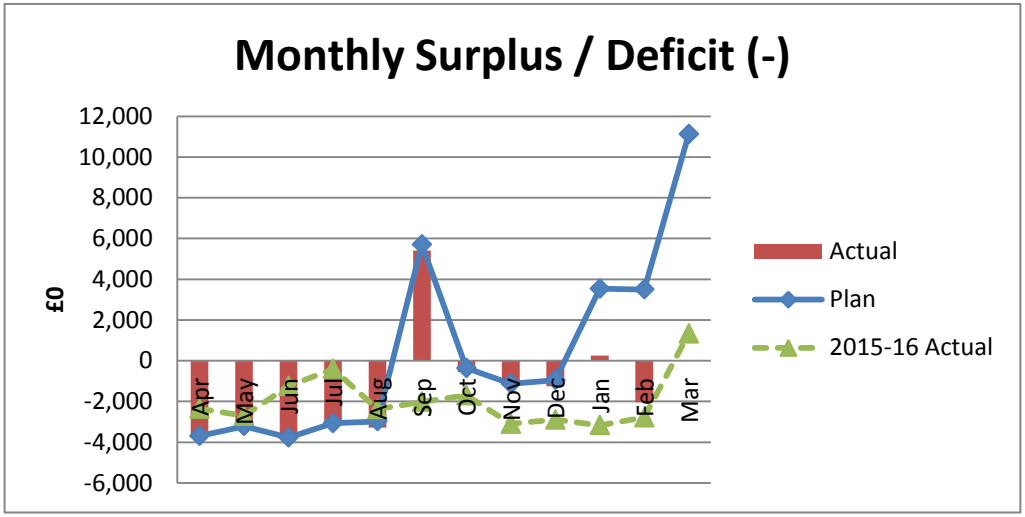
Ability to deliver elective activity due to non elective activity levels

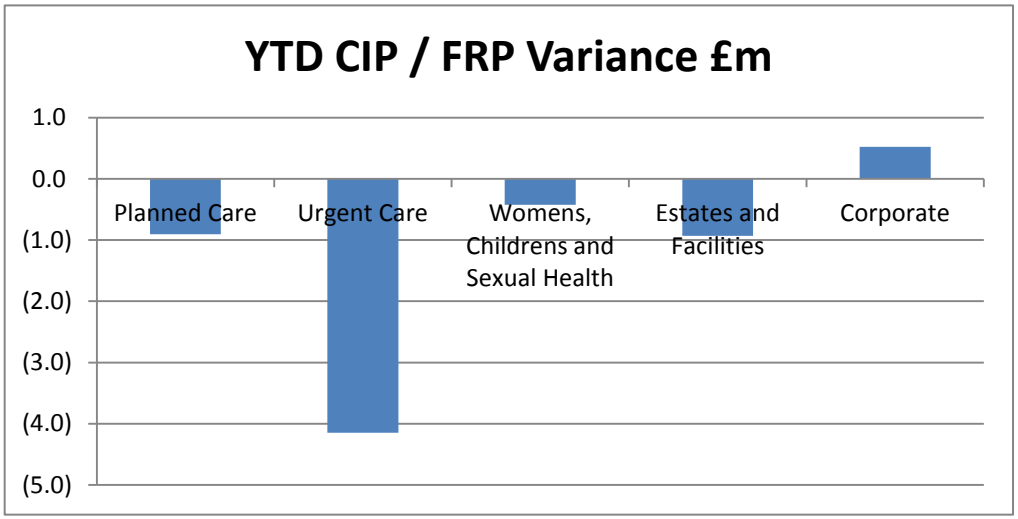
CQUINs are finalised with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing. CQUIN performance is forecasted to achieve 92% for the year for CCG and 100% for NHSE

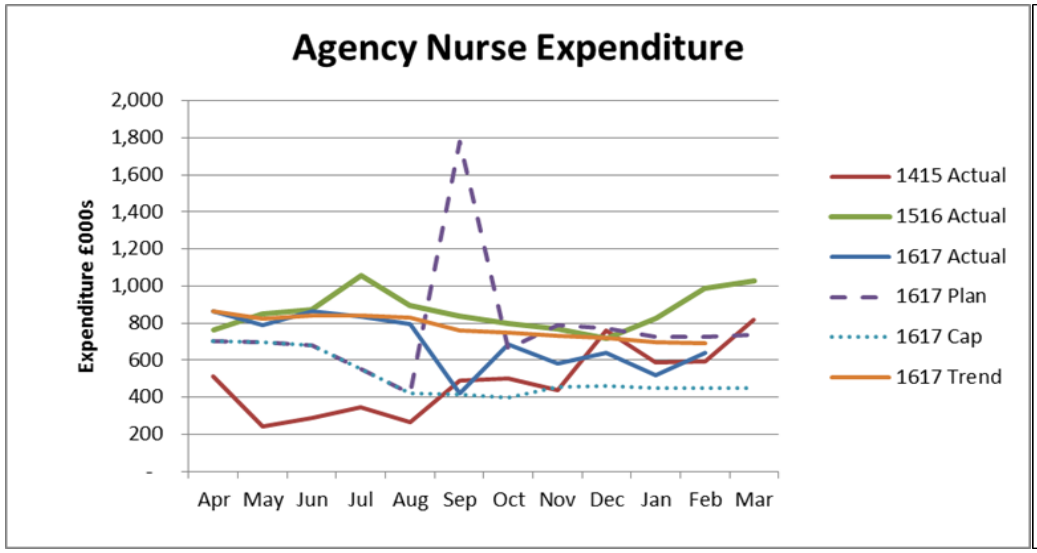
Opportunities:
The Trust is appealing quarter 3 missed access targets linked to STF.

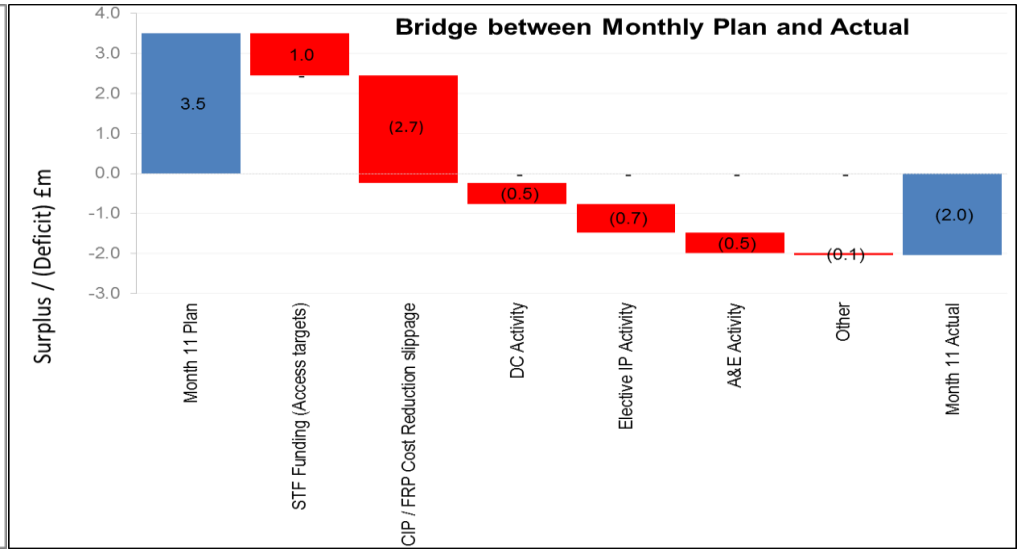
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's February 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure February 2016/17

		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	27.0	30.0	(3.1)	309.7	317.5	(7.8)	344.2	349.2	(5.0)
	STF	0.0	1.0	(1.0)	4.9	8.3	(3.4)	4.9	8.5	(3.6)
	High Cost Drugs	2.7	2.7	(0.0)	31.8	29.9	1.9	32.6	32.6	0
	Other Operating Income	3.9	3.5	0.3	42.6	40.6	2.0	50.5	50.5	0.0
	Total Revenue	33.5	37.3	(3.8)	389.0	396.3	(7.3)	432.3	440.8	(8.6)
Expenditure										
	Substantive	(17.8)	(17.1)	(0.8)	(197.3)	(197.2)	(0.1)	(218.2)	(214.3)	(3.9)
	Bank	(0.8)	(0.7)	(0.1)	(9.3)	(8.2)	(1.1)	(9.1)	(8.9)	(0.3)
	Locum	(0.9)	(0.7)	(0.3)	(11.5)	(10.1)	(1.4)	(11.3)	(10.8)	(0.5)
	Agency	(0.9)	(1.1)	0.2	(13.4)	(15.4)	2.0	(17.1)	(16.4)	(0.7)
	Pay Reserves	0.0	(0.0)	0.0	0	(0.3)	0.3	0	0	0
	Total Pay	(20.5)	(19.5)	(0.9)	(231.4)	(231.1)	(0.3)	(255.7)	(250.4)	(5.4)
	Drugs & Medical Gases	(4.0)	(3.7)	(0.3)	(46.6)	(44.6)	(2.0)	(49.3)	(48.3)	(1.0)
	Blood	(0.2)	(0.2)	(0.0)	(2.3)	(2.2)	(0.0)	(2.4)	(2.4)	0.0
	Supplies & Services - Clinical	(2.5)	(2.3)	(0.2)	(29.2)	(28.1)	(1.1)	(30.9)	(30.5)	(0.4)
	Supplies & Services - General	(0.4)	(0.5)	0.0	(5.0)	(5.0)	0.0	(5.4)	(5.5)	0.1
	Services from Other NHS Bodies	(0.7)	(0.7)	0.0	(7.2)	(7.9)	0.7	(8.8)	(8.6)	(0.1)
	Purchase of Healthcare from Non-NHS	(0.5)	(0.7)	0.2	(8.1)	(8.7)	0.6	(9.0)	(9.5)	0.5
	Clinical Negligence	(1.5)	(1.5)	0.0	(16.7)	(16.8)	0.1	(18.3)	(18.3)	0
	Establishment	(0.3)	(0.2)	(0.1)	(3.5)	(3.1)	(0.4)	(3.1)	(3.3)	0.2
	Premises	(1.7)	(1.6)	(0.2)	(18.7)	(19.0)	0.3	(20.5)	(20.5)	(0.0)
	Transport	(0.1)	(0.1)	(0.0)	(1.5)	(1.2)	(0.3)	(1.3)	(1.3)	(0.1)
	Other Non-Pay Costs	(0.7)	(0.3)	(0.4)	(6.4)	(4.0)	(2.4)	(4.3)	(4.2)	(0.2)
	Non-Pay Reserves	0.0	(0.0)	0.0	(1.3)	(1.3)	0.0	(0.3)	(0.3)	0
	Total Non Pay	(12.7)	(11.9)	(0.9)	(146.5)	(141.9)	(4.5)	(153.8)	(152.7)	(1.1)
	Total Expenditure	(33.2)	(31.4)	(1.8)	(377.9)	(373.1)	(4.8)	(409.5)	(403.1)	(6.4)
EBITDA	**EBITDA**	0.3	6.0	(5.6)	11.2	23.2	(12.1)	22.7	37.7	(15.0)
		0.0	*0.0*	*0.0*	*2.9%*	*5.9%*	*165.8%*	*5.3%*	*8.6%*	*175%*
Other Finance Costs										
	Depreciation	(1.0)	(1.1)	0.1	(12.0)	(14.2)	2.1	(14.6)	(15.7)	1.1
	Interest	(0.2)	(0.1)	(0.1)	(1.0)	(1.0)	(0.0)	(1.3)	(1.1)	(0.2)
	Dividend	0.7	(0.3)	1.0	(1.9)	(3.0)	1.1	(3.3)	(3.4)	0.1
	PFI and Impairments	(42.3)	(1.1)	(41.2)	(53.6)	(12.4)	(41.2)	(27.0)	(27.0)	(0.0)
	Total Finance Costs	(42.7)	(2.6)	(40.1)	(68.6)	(30.6)	(38.1)	(46.3)	(47.2)	1.0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(42.4)	3.4	(45.7)	(57.4)	(7.3)	(50.1)	(23.5)	(9.5)	(14.0)
Technical Adjustments	**Technical Adjustments**	40.3	0.1	40.2	41.3	0.9	40.4	14.2	14.2	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(2.0)	3.5	(5.5)	(16.2)	(6.4)	(9.7)	(9.3)	4.7	(14.0)
	Surplus/ Deficit (-) to B/E Duty Excl STF	(2.0)	2.5	(4.5)	(21.1)	(14.8)	(6.3)	(14.3)	(4.7)	(9.6)

Commentary

The Trusts deficit including STF was £2m in February which was £5.5m adverse to plan with a pre STF adverse variance of £4.5m.

Clinical Income (Excluding STF) was £3.1m adverse to plan in month (£7.8m adverse YTD), clinical income in February was £126k less than January which was mainly due to £0.1m PFI indexation income adjustment and £60k winter resilience income adjustment relating to the IDT service. The key variances were, Elective IP activity £0.7m adverse to plan, Daycase £0.5m adverse to plan, elective income increased by £0.2m between months. A&E £0.5m adverse to plan (£0.1m reduction between months), and out patient income was £0.3m adverse to plan (£0.2m reduction between months).

Other Operating Income includes £0.5m STP funding offsetting expenditure incurred in the month (£2.9m YTD). and £75k income relating to RIS compensation.

Pay was £0.9m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs reduced by £0.3m between months, Nursing costs reduced by £0.1m between months which saw a reduction in bank costs (£0.2m) due to one less week in February. Nurse Agency costs increased between months by £0.1m however this was due to a non recurrent benefit in January, the number of nursing agency hours reduced between months by 8% (1,400 hours). Medical costs reduced by £0.2m this was mainly within T&O, £0.1m reduction in locum agency costs and £40k reduction in Cancer.

Non Pay was overspent by £0.9m in the month which included £1m unidentified savings. Purchase of healthcare from non NHS was £0.2m favourable in the month and reduced between months by £0.3m which was mainly within T&O and Gynae due to a reduction in outsourcing. Other non pay costs in February includes £0.5m STP costs which are offset by other operating income.

Other Finance Costs relating to PDC and Impairments reflect the FRP adjustments for MEA and Impairments with a corresponding offset within technical adjustments.

The Trust normalised position for February was £2.2m deficit which was £0.2m improvement to January.

The Trust is forecasting a year end deficit of £9.3m (including STF) with mitigating actions of £11.8m to deliver a £2.5m forecast surplus.

Maidstone and Tunbridge Wells NHS Trust

3. Expenditure Analysis

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

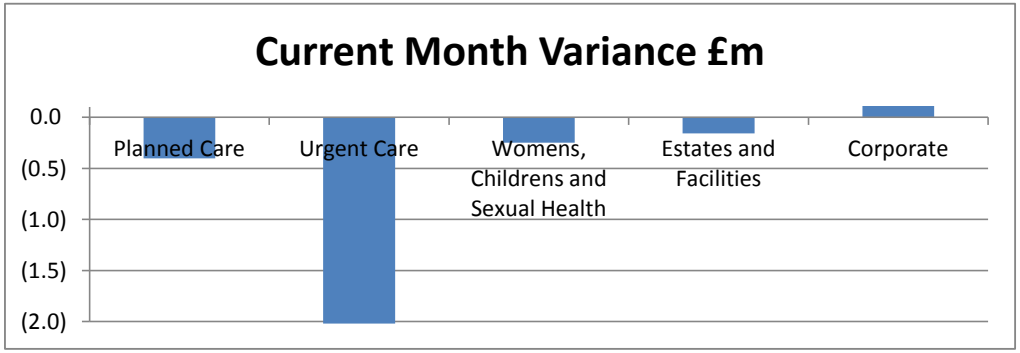
		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Change between Months
Revenue	Clinical Income	25.7	26.9	26.6	27.7	28.4	27.6	27.8	32.0	28.5	28.6	28.1	27.5	27.0	(0.5)
	STF	0	0	0	0	0	0	0	2.7	0.9	0.7	0.6	(0.0)	0.0	0.0
	High Cost Drugs	2.6	3.1	2.8	2.6	2.8	2.6	2.7	2.9	2.9	2.8	3.8	3.1	2.7	(0.4)
	Other Operating Income	4.6	6.5	3.8	3.8	3.6	4.0	3.6	3.7	4.0	3.9	3.9	4.5	3.9	(0.7)
	Total Revenue	**33.0**	**36.4**	**33.2**	**34.1**	**34.8**	**34.2**	**34.1**	**41.3**	**36.2**	**36.1**	**36.3**	**35.1**	**33.5**	**(1.6)**
Expenditure	Substantive	(17.7)	(18.1)	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(0.3)
	Bank	(0.9)	(1.1)	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	0.3
	Locum	(0.7)	(0.6)	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	0.1
	Agency	(1.7)	(1.9)	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(0.1)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(21.0)	(21.8)	(21.2)	(21.2)	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	0.0
Non-Pay	Drugs & Medical Gases	(3.9)	(4.0)	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	0.2
	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	(2.3)	(2.3)	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	0.2
	Supplies & Services - General	(0.4)	(0.7)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.0)
	Services from Other NHS Bodies	(0.6)	(0.7)	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.1)
	Purchase of Healthcare from Non-NHS	(0.7)	(1.1)	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	0.3
	Clinical Negligence	(1.4)	(1.4)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0
	Establishment	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(1.0)	(1.1)	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	0.0
	Transport	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.8)	(0.8)	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	0.5
	Non-Pay Reserves	0	0	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	0	0	0	0	0
	Total Non Pay	(11.8)	(12.9)	(12.9)	(13.4)	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	1.1
	Total Expenditure	(32.8)	(34.7)	(34.1)	(34.6)	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	1.1
EBITDA	EBITDA	0.2	1.8	(1.0)	(0.5)	(0.8)	(0.4)	(0.5)	8.2	2.2	1.6	1.2	0.8	0.3	(0.5)
		1%	*5%*	*-3%*	*-1%*	*-2%*	*-1%*	*-1%*	*20%*	*6%*	*4%*	*3%*	*2%*	*1%*	
Other Finance Costs	Depreciation	(1.4)	0.9	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.8)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)
	Dividend	(0.4)	0.1	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	1.0
	PFI and Impairments	(1.4)	(14.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(41.2)
		(3.2)	**(13.3)**	**(2.9)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(42.0)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(3.0)	(11.5)	(3.8)	(3.3)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(1.3)	(1.2)	0.1	(42.4)	(42.5)
Technical Adjustments	Technical Adjustments	0.2	12.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	40.2
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(2.8)	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	5.4	(0.5)	(1.2)	(1.3)	0.3	(2.0)	(2.3)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.8)	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	2.7	(1.4)	(1.9)	(1.9)	0.3	(2.0)	(2.3)

4. Cost Improvement Programme and Financial Recovery Plan

Maidstone and Tunbridge Wells NHS Trust

4a. Curent month savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	0.1	0.1	0.0	0.1	(0.0)	0.1	0.2	0.1	0.1
Critical Care	0.1	0.1	(0.0)	0.1	0.1	(0.0)	0.1	0.2	(0.0)
Diagnostics	0.1	0.1	0.0	0.1	0.3	(0.2)	0.3	0.5	(0.2)
Head and Neck	0.0	0.1	(0.0)	0.1	0.1	(0.1)	0.1	0.2	(0.1)
Surgery	0.1	0.1	0.0	0.1	0.3	(0.1)	0.2	0.3	(0.1)
Trauma and Orthopaedics	0.0	0.0	0.0	0.3	0.4	(0.1)	0.4	0.4	(0.1)
Patient Admin	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Private Patients Unit	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Total Planned Care	**0.5**	**0.5**	**(0.0)**	**0.8**	**1.2**	**(0.4)**	**1.3**	**1.7**	**(0.4)**
Urgent Care	**0.3**	**0.3**	**(0.0)**	0.4	2.4	(2.0)	0.7	2.7	(2.0)
Womens, Childrens and Sexual Health	**0.1**	**0.1**	**(0.0)**	0.1	0.4	(0.2)	0.2	0.5	(0.3)
Estates and Facilities	**0.1**	**0.1**	**(0.0)**	0.1	0.3	(0.1)	0.2	0.4	(0.2)
Corporate	**0.1**	**0.1**	**(0.0)**	0.1	(0.0)	0.2	0.2	0.0	0.1
Total	**1.0**	**1.1**	**(0.1)**	**1.6**	**4.2**	**(2.6)**	**2.6**	**5.3**	**(2.7)**



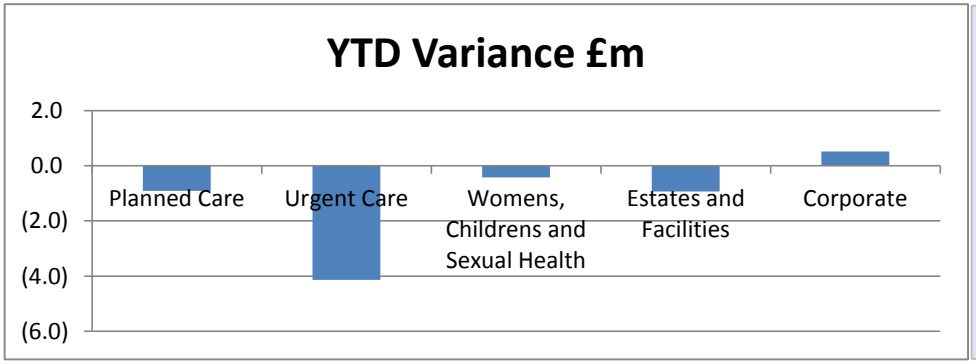
Savings of £2.6m were delivered in February, £0.1m less than January and savings were £2.7m adverse to plan. The majority of the underperformance was within Urgent care.

The FRP plan includes £3.2m unidentified savings in February, the Trust has therefore identified / over performed against existing schemes by £0.6m, the main schemes relate to:
- MOU Activity £250k
- Surgery Waiting List Reduction £50k
- Reduction in Gynae Outsourcing = £40k

Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date Savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	2.1	2.1	0.0	0.4	0.2	0.2	2.5	2.3	0.2
Critical Care	1.0	1.0	(0.0)	0.2	0.3	(0.0)	1.2	1.3	(0.1)
Diagnostics	1.3	1.3	0.0	0.9	1.1	(0.2)	2.2	2.4	(0.2)
Head and Neck	0.7	0.8	(0.1)	0.2	0.3	(0.1)	1.0	1.1	(0.2)
Surgery	1.1	1.1	0.0	0.4	0.7	(0.3)	1.5	1.8	(0.3)
Trauma and Orthopaedics	0.9	1.0	(0.1)	0.6	0.9	(0.3)	1.5	1.8	(0.4)
Patient Admin	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Private Patients Unit	0.2	0.2	0.0	0.0	0.0	0.0	0.2	0.2	0.0
Total Planned Care	**7.4**	**7.5**	**(0.1)**	**2.7**	**3.5**	**(0.8)**	**10.1**	**11.0**	**(0.9)**
Urgent Care	**3.3**	**3.4**	**(0.1)**	**1.7**	**5.7**	**(4.0)**	**5.0**	**9.1**	**(4.1)**
Womens, Childrens and Sexual Health	**1.0**	**1.0**	**0.0**	**0.5**	**0.9**	**(0.4)**	**1.5**	**1.9**	**(0.4)**
Estates and Facilities	**1.1**	**1.9**	**(0.8)**	**0.8**	**0.9**	**(0.1)**	**2.0**	**2.9**	**(0.9)**
Corporate	**0.9**	**0.9**	**(0.1)**	**1.2**	**0.6**	**0.6**	**2.1**	**1.6**	**0.5**
Total	**13.6**	**14.8**	**(1.1)**	**7.0**	**11.7**	**(4.7)**	**20.6**	**26.5**	**(5.9)**



The YTD FRP plan includes £6.4m unidentified savings in February.

Planned Care: £0.8m YTD FRP adverse variance, includes £1.6m unidentified savings, offset by £0.8m over achievements of schemes which mainly relates to MOU activity and Surgery waiting list initiatives reduction.

Urgent Care: £4m YTD FRP adverse variance relates to £4.2m **u**nidentified savings.

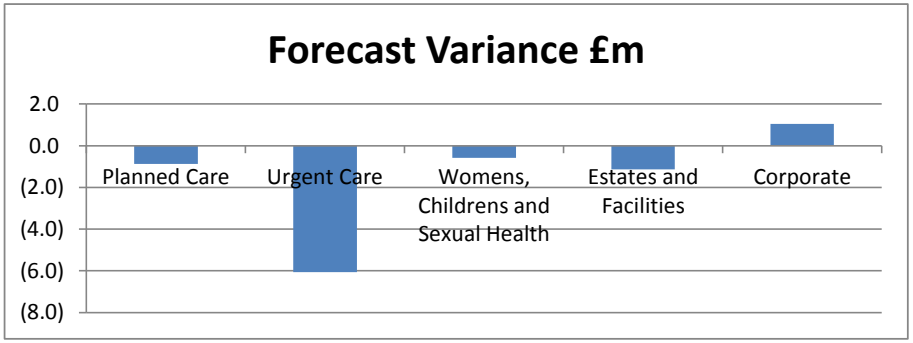
Womens, Children's and Sexual Health: £0.4m YTD FRP adverse variance, this includes £0.6m unidentified savings.

Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	2.2	2.2	0.0	1.1	0.5	0.6	3.3	2.7	0.6
Critical Care	1.0	1.1	(0.0)	0.3	0.4	(0.0)	1.4	1.5	(0.1)
Diagnostics	1.4	1.4	0.0	1.1	1.4	(0.4)	2.5	2.8	(0.3)
Head and Neck	0.8	0.9	(0.1)	0.3	0.5	(0.2)	1.1	1.3	(0.2)
Surgery	1.2	1.2	0.0	0.5	1.0	(0.5)	1.7	2.2	(0.5)
Trauma and Orthopaedics	0.9	1.0	(0.1)	0.9	1.2	(0.3)	1.8	2.2	(0.4)
Patient Admin	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Private Patients Unit	0.2	0.2	0.0	0.0	0.0	0.0	0.2	0.2	0.0
Total Planned Care	**7.8**	**8.0**	**(0.1)**	**4.3**	**5.0**	**(0.7)**	**12.1**	**13.0**	**(0.9)**
Urgent Care	**3.5**	**3.7**	**(0.2)**	**2.2**	**8.1**	**(5.9)**	**5.7**	**11.8**	**(6.1)**
Womens, Childrens and Sexual Health	**1.1**	**1.1**	**0.0**	**0.7**	**1.3**	**(0.6)**	**1.8**	**2.4**	**(0.6)**
Estates and Facilities	**1.2**	**2.1**	**(0.8)**	**0.9**	**1.2**	**(0.3)**	**2.1**	**3.3**	**(1.1)**
Corporate	**0.9**	**1.0**	**(0.1)**	**1.7**	**0.6**	**1.2**	**2.7**	**1.6**	**1.0**
Total	**14.6**	**15.9**	**(1.2)**	**9.8**	**16.2**	**(6.4)**	**24.5**	**32.1**	**(7.6)**



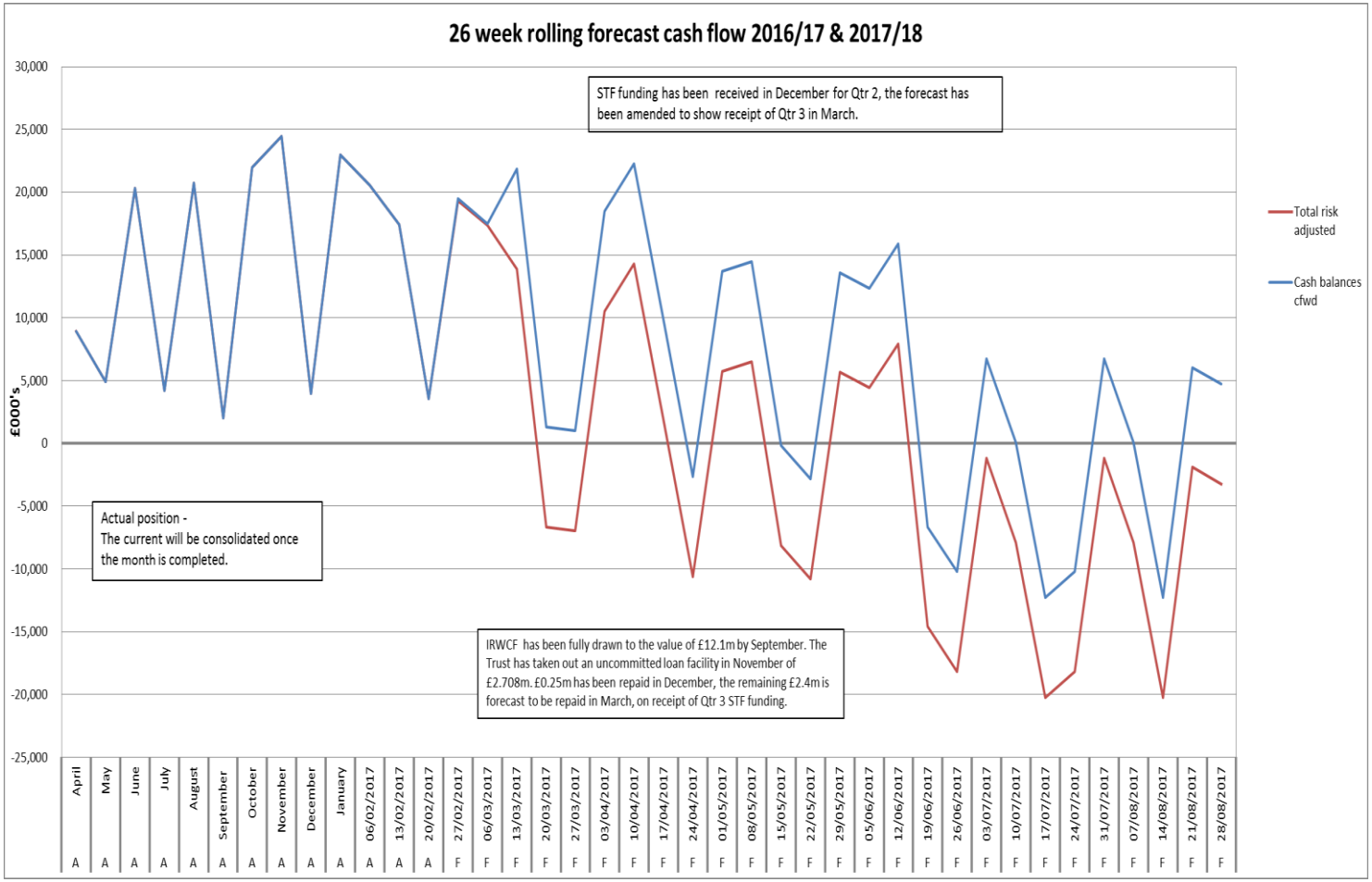
The annual savings plan for the Trust incorporating CIP and FRP equates to £32.1m for 2016/17.

The CIP forecast which was used for the resubmitted plan included savings for energy and rates. However this was not included in the I&E forecast therefore has no bottom line impact, this will be a £0.75m shortfall at the year end. Planned savings of £340k associated with the new Patient Transport contract have not delivered.

The current year end forecasted FRP gap is £6.4m, thr majority of this is within Urgent Care.

5. Balance Sheet and Liquidity

5a. I Cash Flow



Commentary

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

For 2016/17 the Trust has IRWCF of £12.132m to assist the cash position, with interest charged at 3.5%.

The Trust was originally forecasting to repay the remaining £2.5m of uncommitted loan in March, however the Trusts awaiting confirmation of when the Qtr. 3 STF funding will be recieved and this will be used to repay the loan. Both the receipt of STF and the repayment of loan have been moved into April. There is a risk that the Trust will receive £2.1m qtr. 3 STF funding leaving a balance of £0.4m. The £0.4m is currently being risk adjusted on the cash graph.

Cash receipts were primarily from the recovery of outstanding debts.

The cash forecast has been amended to reflect the I&E position after agreeing to the control totals. It assumes receiving the remaining over performance for 16/17 of c£7.3m in March and receipt of STF funding of £4.8m. The over performance value has been risk adjusted in full on the red line of the graph along with the element of STF funding of £0.5m which is at risk.

Maidstone and Tunbridge Wells NHS Trust

5b. Balance Sheet

February 2017

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

	February			January	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	276.7	348.2	(71.5)	341.8	335.3	330.2
Intangibles	2.7	1.0	1.6	2.8	1.5	2.0
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.2	1.2	1.2
Total Non-Current Assets	**280.6**	**350.4**	**(69.9)**	**345.7**	**338.0**	**333.4**
Current Assets						
Inventory (Stock)	8.3	8.3	(0.0)	7.7	8.3	8.3
Receivables (Debtors) - NHS	34.7	25.4	9.3	52.5	20.6	21.5
Receivables (Debtors) - Non-NHS	9.7	7.8	1.9	11.7	10.0	9.4
Cash	13.6	2.1	11.5	2.7	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**68.0**	**43.5**	**24.4**	**76.3**	**39.9**	**40.2**
Current Liabilities						
Payables (Creditors) - NHS	(4.1)	(5.0)	0.9	(4.1)	(5.0)	(5.0)
Payables (Creditors) - Non-NHS	(63.9)	(32.3)	(31.6)	(71.0)	(21.8)	(21.7)
Capital & Working Capital Loan	(2.2)	(2.3)	0.2	(2.2)	(2.2)	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.1)	(5.0)
Provisions for Liabilities and Charges	(1.8)	(2.2)	0.3	(1.8)	(1.1)	(1.0)
Total Current Liabilities	**(76.8)**	**(46.6)**	**(30.2)**	**(83.9)**	**(35.2)**	**(34.9)**
Net Current Assets	(8.8)	(3.0)	(5.8)	(7.6)	4.7	5.3
Finance Lease - Non- Current	(198.7)	(198.9)	0.2	(199.1)	(198.2)	(198.2)
Capital Loan - (interest Bearing Borrowings)	(13.4)	(17.5)	4.1	(13.4)	(16.4)	(12.4)
Interim Revolving Working Capital Facility	(31.5)	(29.0)	(2.5)	(31.5)	(29.0)	(29.0)
Provisions for Liabilities and Charges	(1.2)	(1.4)	0.2	(1.2)	(0.7)	(0.7)
Total Assets Employed	**27.0**	**100.6**	**(73.6)**	**92.8**	**98.4**	**98.4**
Financed By						
Capital & Reserves						
Public dividend capital	(203.3)	(203.3)	0.0	(203.3)	(203.3)	(203.3)
Revaluation reserve	(30.3)	(53.8)	23.5	(53.8)	(53.8)	(53.8)
Retained Earnings Reserve	206.4	156.5	49.9	164.2	158.7	158.7
Total Capital & Reserves	**(27.2)**	**(100.6)**	**73.4**	**(92.8)**	**(98.4)**	**(98.4)**

Commentary:
The balance sheet is less than plan. Key movements to January are in working capital where the stock and cash are decreasing and debtors and creditors balances are increasing from the December's position. The teams are focusing 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 continues to fall as depreciation is greater than the current capital spend, this is due to capital projects being prioritised. This is in line with plan and is not creating an unsustainable backlog of maintenance or required replacements. The Trust has been working with Montagu Evans the Trust valuers on the revaluation of Land, Build and Dwellings using the Modern Equivalent Asset Valuation method (MEA). This has been transacted through the Asset Register and the nominal ledger resulting in February which majority of the variance from January relates to.

Current Assets Inventory has increased slightly from the reported January position, mainly due to an increase in pharmacy stock from £3.3m to £3.9m. Other stocks have remained consistent with cardiology stocks £1m, materials management £1m and all other stock including theatres of £2.5m. Inventory reduction is a cash management.

NHS Receivables have decreased since January, remaining significantly higher than the plan value. Of the £34.9m balance, £14.4m relates to invoiced debt of which £3.8m is aged debt over 90 days. Debt over 90 days has decreased since January as a result of the receipts for PFI indexation, STP and high cost drugs. 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 by £2m from January's position, and is above plan by £1.9m. Included within this balance is trade invoiced debt of £1.4m and private patient invoiced debt of £0.7m (consistent with £0.8m in January).

Current Liabilities NHS trade payables has remained consistent with the January reported position and is below plan. Non-NHS trade payables has decreased by £7.1m, still remaining significantly above plan. Although the Trust has a policy to pay approved invoices within 30 days there are £8.2m of unapproved invoices, and £13.9m of approved invoices at month end.

Of the £63.9m trade creditor balances, £18.9m relates to invoices, £11.8m is deferred income primarily relating to the advance received Medway CCG's in April 2016. The remaining £33.2m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

The Revaluation reserve has reduced by £23.5m which is the result of the desktop revaluation carried out by the Trust valuers Montagu Evans on 30th September 2016 of Land, build and Dwellings as mentioned in PPE note. The £23.5m relates to a reduction in land of £4.3m and buildings of £19.2m.

6. Capital

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual Forecast			Committed
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*	
	£000	£000	£000	£000	£000	£m	£000
Estates	982	8,030	7,048	9,384	2,443	6,941	2,004
ICT	1,700	2,505	805	2,671	2,039	632	1,774
Equipment	1,146	2,381	1,235	2,581	3,612	-1,031	3,294
PFI Lifecycle (IFRIC 12)	195	0	-195	553	553	0	553
Donated Assets	127	500	373	800	800	0	376
Total	**4,150**	**13,416**	**9,266**	**15,989**	**9,446**	**6,542**	**8,001**
Less donated assets	-800	-800	0	-800	-800	0	-800
Contingency Against Non-Disposal	0	0	0	0	0	0	0
Adjusted Total	**3,350**	**12,616**	**9,266**	**15,189**	**8,646**	**6,542**	**7,201**

The Forecast Outturn remains £9.4m with the YTD Actual Spend at £4.1m. Significant spend is planned for the final month of the financial year, including backlog maintenance programme completion, several items of medical equipment and the delivery of the new linear accelerator to a warehouse in March. The total resource approved by the Trust board for the 2016/17 capital programme was £15.988m, including PFI lifecycle and donated assets. The Trust has proposed a Capital to Revenue transfer of £4.188m as part of its recovery plan. It also was unable to proceed at this point with the plans for the TWH radiotherapy satellite scheme as Specialist Commissioners want to further consider the proposal in the light of STP plans.

The forecast outturn therefore takes into account the reductions of £4.188m for the capital to revenue transfer and £4.056m for the TWH radiotherapy satellite scheme element. The Trust has been successful in a bid for PDC funding (£1.7m) to support the purchase of a Linac in 16/17, as part of the NHSE investment in radiotherapy modernisation and this is included in the year end spend forecast.

Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-9	UPDATE ON THE WORKFORCE TRANSFORMATION PROGRAMME	MEDICAL DIRECTOR

Summary / Key points

It was agreed at the Trust Board meeting on 25/01/17 that a report would be submitted to the Trust Board in March 2017 on the progress being made in relation to Medical productivity / the Workforce Transformation Programme.

A presentation was given at the Finance Committee on 20/02/17 to update it on the progress with the Programme. This presentation is enclosed and covers the following areas:

- Progress on Actions & Next Steps
- The launch of the Workforce Transformation Programme
- Progress with T&O Desktop Pilot
- Forward look to March 2017

The Programme was launched at the Trust Management Executive Meeting on 22/03/17. A verbal update will be given as required at the Trust Board Meeting.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 22/03/2017
- Finance Committee, 27/03/17 (verbal update)

Reason for submission to the Board (decision, discussion, information, assurance etc.) 0F[1]

Information

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Workforce Transformation Progress Update

Presentation to the Finance Committee

Monday, 20th February 2017

Maidstone and Tunbridge Wells NHS
NHS Trust

Content

- Progress on Actions & Next Steps *(From 23.1.17)*
- Launch of Workforce Transformation Programme
- Progress with T&O Pilot
- Forward look to March 2017

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NHS Trust

Urgent Actions (from 23.1.17)

Job Planning Training (6/7 Feb) ✓

* Further sessions to be run to secure all CDs, GMs and AGMs

Revise and refresh job-planning and associated workforce policies ✓

* Discussion at CD meeting (1 Mar)
* TME discussion (15 Mar)
* Agreement with JMCC *(next meeting 25 May)*

Review Job Planning Timetable in line with above (in discussion with Medical Director)

Central oversight & establishment of IT systems for: (in progress – for discussion with Steering Group – 2.3.17)

Job planning
All Leave
Rotas (DRS for Juniors Drs but no system for Consultant rotas)
Compliance with existing sickness system

Resource and support for the Medical Director (Senior support secured ✓ – further support in discussion)

Steering Group

Date of inaugural meeting: 02.03.17

Members

- Deputy Chief Executive - Chair
- Lead Non-Executive *(Sarah Dunnett)*
- Medical Director
- Deputy Medical Directors
- Clinical Director Representatives
- Chief Operating Officer
- Director of Workforce
- 3 x Directors of Operations
- Deputy Director of Finance
- Head of PMO
- Head of Delivery Development

Maidstone and Tunbridge Wells NHS
NHS Trust

Organisational Launch

Key Issues for discussion with Steering Group – 2.3.17:

- Outputs & actions from T&O Desktop Pilot & sign off of methodology
- Job Planning
- IT Systems and Systems Compliance
- Leave Audit

Trust Wide

- Roll out programme – First full pilot, early adopters and all Directorates

Maidstone and Tunbridge Wells NHS
NHS Trust

Organisational Launch

- T&O Desktop Pilot discussions with local Team - 15.02.17
- Confirmation of Pilot Methodology - 02.03.17
- Medical Director discussion with CDs - by 14.3.17
- Launch to TME by Medical Director - 15.03.17

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NHS Trust

T&O Carter Metrics (1)

Trauma & Orthopaedic Model Hospital 2014-15	
Cost Weighted Output (CWO)	£31,216,406
Adjusted Treatment Cost (ATC)	£1.04
Weighted Activity Units (WAU)	8,875
Cost per WAU	£3,670

Staff Group	Weighted Activity Units (WAU) per FTE					
	FTE (Template)	FTE (ESR)	Trust Actual	National Median	Upper Quartile	Peer Median
Medical & Dental	55	47	161	185	211	174

Staff Group	Estimated Total cost	Trust Actual	National Median	Upper Quartile	Peer Median
Medical & Dental	£4.9m	£558	£517	£460	£526

The tables show the performance of T&O in the Model Hospital. Lord Carter's team calculated that the specialty were 4% more expensive than the national median.

The team highlighted that productivity, expressed in WAUs, using the Carter metrics was low for Medical staff.

Consequently Medical cost per WAU was higher than the national median by £41.

Maidstone and Tunbridge Wells NHS Trust

T&O Carter Metrics (2)

Maidstone & Tunbridge Wells NHS Trust

KPIs - Medical Productivity

Annual Productivity measures per FTE

		Jan	Total
Productivity per Medical FTE per Month	Target National Median 2014-15 WAU	15.33	185
	Medical Staff	10.76*	
Income per FTE	Target per Income plan	£47,437	£566,234
	Medical Staff	£42,071	
Volume of Admitted Patients seen per FTE per month	Target per Income plan	12	141
	Medical Staff	8	
Volume of Outpatients seen per FTE per month	Target per Income plan	73	872
	Medical Staff	77	
Medical cost per WAU per month	Target National Median 2014-15 WAU	£517	£517
	Medical Cost per WAU	£821	
GIRFT target	Target	100%	100.00%
	% of Consultant staff with contemporaneous job plan	0%	
	% of sessions are DCC of identified Job plans	82%	

*The table reflects both cancelled lists at TWH in January and the increased available capacity due to the MOU being open at Maidstone. The net impact of these is calculated as a 3.35 WAU reduction per FTE in this month. **The resulting shortfall of approximately 1.2 WAUs per FTE equates to £2.5m per annum.**

Note: All outsourced activity is included in the activity figures.

Maidstone and Tunbridge Wells NHS
NHS Trust

T&O Pilot

Outputs from Testing the Desktop Pilot Methodology:

- £2.5m estimated shortfall (normalised) from Jan 17 medical productivity index data
- Initial local discussions held with Divisional Director and Clinical Director
  Next stage – full local deep dive with Team
- Estimated key areas emerging in respect of index identified shortfall:
  (yet to be confirmed by Division/Directorate)

  * Locum spend
  * Job planning (PA review)
  * Number of Consultants
    (STP Clinical Board Focus on Orthopaedics)

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NHS Trust

Actions and Next Steps

- **Confirm pilot methodology** - End Feb 2017

- **Finalise T&O pilot** - March 2017
  (report findings & agree actions
  with Workforce Transformation Steering Group)

- **Produce rollout timetable** - March 2017
  (Agree with Medical Director -
  First full pilot, early adopters and full rollout programme)

Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-10 Supplementary report on Quality and Patient Safety — Interim Chief Nurse

Summary / Key points

This report provides information on actions being taken to improve the Trust's position in regard to falls prevention, Friends & Family response rates and an overview on this month's topic for the Patient Safety Calendar. The key highlights are as follows:

- There is continued focus on supporting a reduction in patient falls which has resulted in ongoing improvements in overall falls rate for the last seven months with the YTD position below 6.05 per 1000 bed days.
- The response rate for FFT has improved for February following some inconsistent results in December 2016 and January 2017. The report identifies some of the key themes identified from recent internal assurance processes.
- The patient safety topic for the month as part of the Patient Safety Calendar is focussed on reducing the incidence of pressure ulcers. We have been successful in reducing our rate of pressure ulcers during 2016/17 (February 2.4 rate of pressure sores per 1000 admissions compared with data for 2015/16 which was 3.9 per 1000 admissions)

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) 0F[1]

Assurance

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

Quality Report – March 2017

The purpose of this report is to bring to the attention of the board any specific quality or patient safety issues that are either not covered within the integrated monthly performance report but require board oversight or are covered but require greater detail.

This report is intentionally brief, highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. The Board is asked to note the content of this report and make any recommendations as necessary.

Falls prevention:

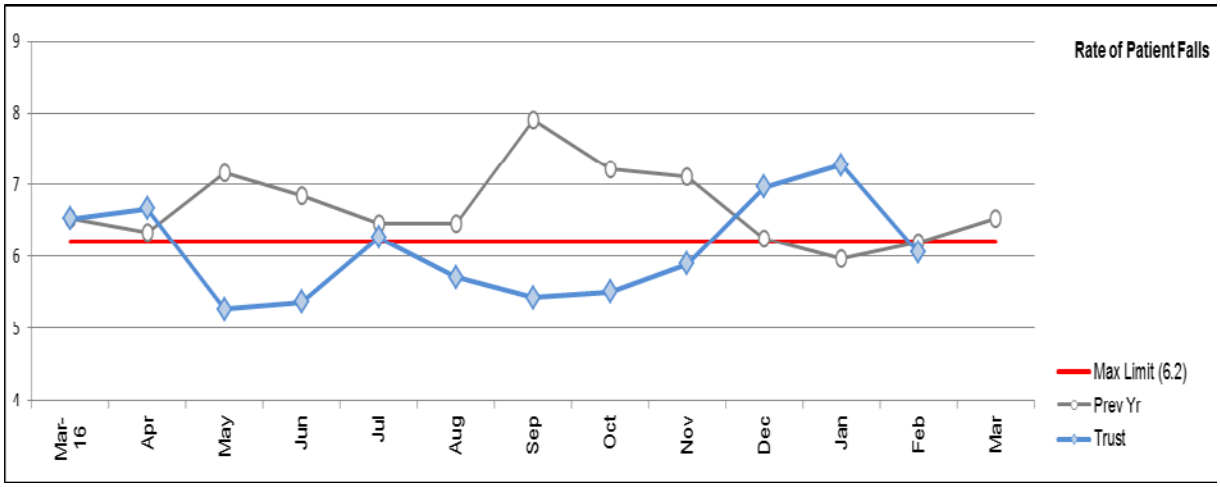
The falls rate threshold for 2016/17 has been set at 6.2 per 1,000 occupied bed days. The rate for the month of February was 6.05 per 1000 occupied bed days with the year to date rate currently at 6.05 also. This compares favourably to the same time last year which was recorded at 6.7.

The number of patient falls that resulted in serious harm and were declared as serious incidents (SI) for February is reported at 4. These comprised of 3 hip fractures and a fractured humerus. One of these occurred at Maidstone hospital and the other 3 at Tunbridge Wells.

Actions for 2016/17

- Task and Finish group was established to support reduction in falls chaired by the Chief Nurse
- Terms of reference for Slips, Trips and Falls group have been reviewed
- Revise the Period of increased Incidence (PII) monitoring framework for falls.
- Threshold for falls number on each ward/unit has been revised
- Nursing assessment documents for falls prevention have been reviewed
- Review Policy and procedure for management of falls.
- Screen saver with falls prevention message instigated
- National Falls Audit to be completed in May 2017
- Falls dashboard established.
- Monthly falls data by ward sent out to all ward managers.
- The falls prevention care plan has been revised and will be implemented in the next two months.
- ‘Take 5’ initiative used recently – further details below.
- Clinical Staff survey on lying and standing blood pressure measurement commenced 13/03/2017; the survey will gauge the skills of the workforce to undertake manual blood pressure measurements. The results will be reviewed by the task and finish group.

Comparison of Patient Falls 2015/2016 to 2016/2017



'Take Five'

To maintain the momentum in ensuring falls prevention is part of all our business and to engage every staff group in falls prevention at MTW the teams are being asked to 'take five'. This initiative aims to make sure that each patient is assessed to determine the most appropriate interventions that will reduce their risk of a fall. The following should be considered however there may be other alternatives that may also be appropriate:-

- Identification- patient at risk of falls is identified; ensure this is clearly communicated to all staff
- Comprehensive assessment to ascertain interventions that are required for the individual patient, for example;
  - Environmental factors
  - Intensity of monitoring required
  - Method to alert healthcare staff i.e. call bell or alarm mat etc.
  - Low level bed +/- crash mat.
  - Medication review
  - Lying and standing blood pressure.
  - Personal factors i.e. patient with cognitive impairment
  - Mental capacity, including assessment for DOL's.
  - Mobility deficit
- How do you know your interventions are appropriate and working?

At safety huddle ask:

- Which patients on the ward today are at risk of falling?
- Has the medication reviews for these patients been completed?.

Friends and Family (FFT)

The contract with the company I Want Great Care (IWGC) who support the Trust in the collation and reporting of our FFT response rates and feedback from patients has been in place since June 2016. As part of that contract a small project group meets on a monthly basis to monitor the implementation of the new contract and to monitor progress against actions required to address any non-compliance with targets. Membership of this project group includes Nursing and Midwifery staff and a patient Representative as well as representatives from the company.

In the past few months there has been some inconsistency in the FFT response rates each month with a notable reduction in the response rates for December 2016 and January 2017.

There has however been some improvement with the results for February as outlined below:

- The inpatient response rates for the last two months (including day case and children) have fallen slightly from 27.2% in January to 25.6% in February. No significant changes noted in positive response scores, achieving 95.8% in February compared to 95.6 in January.
- For A&E (including children) the response rates significantly improved with an increase from 9.1% in January to 15.6% in February. Positive responses also increased, with 92% positive responses which is the highest score to date.
- The maternity response rate for February reduced to 35% compared to the response rate of 51% in January. This reduction was expected as there had been a delay in the collection of cards from December which meant an extraordinary response rate for January. Positive responses decreased slightly to 93.4% compared to 94.8 in January.

The Trust target for the FFT responses in each area is as follows:

- 25% response rates in FFT in all adult inpatient and Maternity Services and

- 15% response rate for Accident and Emergency services

- Both inpatients and A&E will be challenged to meet the overall yearend target.
- A&E is potentially achievable but this would require considerable focus (would need 2000 responses equating to a performance of 21% for the month), likely to achieve 14.4 for the year. Both of the matrons in the A&E departments are completely focussed on increasing the response rates on both sites and to ensure greater consistency in overall processes.
- Inpatients are unlikely to achieve the target of 25% as this would require in excess of 2600 responses (equating to a performance of 46% for the month). We are likely to achieve 23% for the year.
- Maternity are on track to achieve the target of 25% response rate.

The project group has met since the February results have been published and have agreed the following key actions:

- Once a month there is a presentation from a selected ward manager on each site at the Nursing engagement and learning forums (NELF) detailing the results from the FFT for the month. A template has been developed which assists ward managers to highlight feedback received from patients, best practice and any key learning from the feedback.
- IWGC are supporting the trust in helping us to promote best practice which we hope will encourage others to replicate where possible. Working with the staff in A&E they have developed a case study which promotes the overall approaches taken by staff in each department to embed the FFT into practice. This is being finalised and will be shared with the NELF in April and also to staff in the Trust via the weekly communication
- We are finalising a new FFT card that has some additional 'quality focussed' questions for patients to complete. We are aiming for the revised card to be implemented in May 2017
- The children's services are going to use ipads to support children and families to provide feedback to the FFT question. This is currently being rolled out in the service.

Patient Safety Calendar

This month's Clinical Governance safety calendar focus has been focusing on the incidence of pressure damage. We have been successful in reducing our rate of pressure ulcers during 2016/17 (February 2.4 rate of pressure sores per 1,000 admissions, data for 2015/16 was 3.9) but our Tissue Viability team are striving to reduce this further and took the opportunity to raise awareness in regard to **SSKIN** – a simple five step checklist of key actions to help staff prevent pressure damage.

The prevalence of pressure ulcers is one of the four common harms recorded in the NHS Safety Thermometer. As a result, the occurrence of pressure ulcers is increasingly being used to assess

the quality of care delivered by a health system, or facility and the effectiveness of the prevention initiatives in place.

Data is currently being used to estimate the total number of patients with pressure ulcers within a particular population (i.e. prevalence) and the rate at which new pressure ulcers are occurring (incidence).

POINT PREVALENCE is the method used most commonly to indicate prevalence. It measures the proportion of a defined set of people who have a pressure ulcer at a particular moment in time. It therefore includes those admitted to a healthcare facility with a pressure ulcer and those who have developed one between admission and the time of the study.
INCIDENCE provides information on the rate of occurrence of cases of new pressure ulcers over time.
The prevalence and incidence audit of pressure damage is undertaken yearly and this is due to take place in April. The tissue viability CNSs will also use this audit to review documentation that is required for the initial assessment and prevention of pressure damage and moisture lesion.

Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-11 Planned and actual Ward staffing for February 2017 Interim Chief Nurse

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of February 2017. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day

CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for Maidstone Hospital has remained at 7.5, and for Tunbridge Wells it remained at 8.9, meaning no change in overall care hours between January and February.

Planned vs. Actual

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

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

Wards in this category during January were Maidstone Stroke, Edith Cavel, Ward 10, Ward 20, and Hedgehog (Hedgehog also had some additional requirements to cover escalation beds)

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Lord North Ward had additional clinical support requirement to support a high number of ward attenders during the month.

Escalation areas account for over-fill on Maidstone AMU (UMAU), and TWH AMU.
Short Stay Surgery Unit TWH were working to agreed numbers, however this does not reflect the need to provide support to escalated beds in recovery which required additional staff.

Ward 21 had a shift in skill mix to maintain sufficient numbers of staff to provide fundamental aspects of care. This was a considered decision based on acuity and skill mix with oversight by the directorate matron.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife.

Accident & Emergency (A&E) Departments had acceptable levels of Registered Nurse cover; however there were challenges in filling the Clinical Support Worker shifts at Tunbridge Wells Hospital. Whilst this is an attractive area for qualified staff, support workers often find the idea of working in this area stressful.

A number of wards will cross-cover each other. This enables a more efficient use of staff, and allows for safe redeployment of staff to escalated areas. For example Short Stay Surgery at Tunbridge Wells Hospital has provided support to the escalated beds in Recovery. The ITUs will move staff between sites according to the acuity levels on each site.

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

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

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

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

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

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

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

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.

	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) 0F[1]

Assurance

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

February '17		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	95.0%	98.2%	98.2%	116.1%	7.5	51.6%	100.0%	7	0		Enhanced care requirements for 6 nights.	118,484	110,487	7,997
MAIDSTONE	Foster Clark	96.9%	95.5%	100.0%	100.0%	6.3	35.0%	88.6%	2	1			98,543	88,069	10,474
MAIDSTONE	Cornwallis	100.0%	96.4%	95.2%	105.0%	6.4	42.4%	97.4%	1	1			62,108	77,719	-15,611
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	92.9%	100.0%	N/A	10.7	3.7%	100.0%	0	0			92,405	96,544	-4,139
MAIDSTONE	Culpepper	100.0%	100.0%	100.0%	100.0%	7.1	120.7%	100.0%	2	0					
MAIDSTONE	John Day	89.3%	102.4%	100.7%	96.5%	6.4	41.0%	100.0%	7	1		RN fill rate an accepted risk based on acuity and dependency	115,418	110,395	5,023
MAIDSTONE	Intensive Treatment Unit (ITU)	98.2%	N/A	98.6%	N/A	27.3	N/A	N/A	0	0			164,701	171,043	-6,342
MAIDSTONE	Pye Oliver	87.1%	92.9%	100.0%	100.0%	6.4	43.3%	88.5%	2	1		RN fill rate reflects 12 shifts not covered (of which 4 shifts were due to short notice sickness)	105,945	104,730	1,215
MAIDSTONE	Chaucer	98.2%	99.3%	98.8%	99.1%	6.1	23.1%	88.9%	2	0			110,172	111,206	-1,034
MAIDSTONE	Lord North	100.0%	125.0%	100.0%	107.1%	7.0	103.4%	100.0%	1	0		Additional CSW requirement during the day for ward attenders and 1 patient needing enhanced care over two days.	86,245	85,960	285
MAIDSTONE	Mercer	115.2%	97.3%	98.8%	100.0%	7.0	57.6%	89.5%	4	0		RN fill rate reflects rota and leave profiling. Support provided to Whatman Ward.	95,497	96,113	-616
MAIDSTONE	Edith Cavell (MOU)	91.6%	104.8%	98.8%	146.4%	6.4	135.5%	90.5%	7	0		Enhanced care requirements over 13 nights.	115,874	86,687	29,187
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	86.1%	95.2%	133.3%	182.1%	10.7	0.0%	0.0%	1	0		Escalated at night. Reduced fill rate during the day an accepted risk.	87,799	60,857	26,942
TWH	Stroke/W22	71.4%	108.6%	92.1%	100.0%	9.4	113.6%	92.0%	11	0		4 episodes of short notice sickness covered by CSW. Other gaps in rota either accepted risk or covered by neighbouring wards as required, particularly at night.	172,189	175,869	-3,680
TWH	Coronary Care Unit (CCU)	96.7%	85.7%	94.0%	N/A	12.1	80.5%	93.9%	0	0		CSW fill rate an accepted risk.	59,084	67,750	-8,666
TWH	Gynaecology/ Ward 33	89.9%	79.0%	100.0%	96.6%	7.2	6.9%	77.8%	3	0		13 shifts not covered by bank. Priority given to ensuring cover at night.	71,114	73,009	-1,895
TWH	Intensive Treatment Unit (ITU)	100.0%	100.0%	99.1%	100.0%	28.4	100.0%	100.0%	1	0			179,171	183,344	-4,173
TWH	Medical Assessment Unit	85.3%	115.2%	120.7%	102.4%	8.3	39.7%	92.9%	14	2		RN:CSW ratio during the day an accepted risk. Increased staffing at night to cover escalation beds.	147,018	220,213	-73,195
TWH	SAU	106.0%	81.5%	107.1%	100.0%	8.7	0.0%	0.0%	1	0		CSW fill rate an accepted risk. Able to provide support to SSSU and Ward 32 on 8 occasions in month.	86,565	63,886	22,679
TWH	Ward 32	97.6%	83.3%	96.4%	98.2%	7.6	13.4%	28.1%	6	0		CSW fill rate due to reduced availability of bank staff	118,549	108,131	10,418
TWH	Ward 10	93.8%	100.9%	75.0%	194.6%	8.3	23.5%	93.8%	2	0		Enhanced care needs throughout the month. Reviewed by matron. RN: CSW ratio therefore an accepted risk.	108,760	114,353	-5,593
TWH	Ward 11	94.4%	109.5%	100.0%	100.0%	6.7	36.7%	96.6%	1	0			109,498	120,552	-11,054
TWH	Ward 12	81.3%	92.0%	95.2%	92.9%	6.3	15.9%	92.3%	5	2		5 shifts where agency RN did not arrive. 10 shifts overall not covered.	119,125	116,883	2,242
TWH	Ward 20	95.2%	89.3%	100.0%	132.1%	4.5	20.0%	60.0%	13	0		Enhanced care cohort for 18 nights.	112,925	97,869	15,056
TWH	Ward 21	94.6%	100.0%	88.6%	116.1%	6.3	10.8%	100.0%	3	1		RN: CSW ratio at night an accepted risk.	126,492	126,319	173
TWH	Ward 2	89.3%	91.4%	104.8%	83.0%	6.3	91.4%	100.0%	6	1		RN fill rate reflect 12 shifts unfilled during the month.	81,865	119,871	-38,006
TWH	Ward 30	91.5%	93.3%	98.2%	103.6%	6.4	22.7%	100.0%	15	1			103,381	109,512	-6,131
TWH	Ward 31	91.1%	98.5%	101.8%	90.3%	6.8	13.5%	80.0%	3	0			103,146	154,311	-51,165
Crowborough	Birth Centre	92.9%	64.3%	100.0%	100.0%				0	0		CSW fill rate an accepted risk, as unit co-located with other out-patient services.	86,691	55,748	30,943
TWH	Ante-Natal	98.2%	89.3%	96.4%	96.4%		35.9%	93.4%	0	0		CSW fill rate an improved position compared to previous months.	596,712	651,287	-54,575
TWH	Delivery Suite	93.7%	96.4%	91.3%	94.6%				0	0					
TWH	Post-Natal	96.2%	85.7%	93.8%	88.1%				0	0					
TWH	Gynae Triage	98.2%	100.0%	100.0%	100.0%				0	0			12,405	19,321	-6,916
TWH	Hedgehog	107.7%	57.1%	128.6%	107.1%	11.4	21.0%	94.3%	0	0		HDU requirements over 24 days. Additional staff required to manage this at night. 1 child needing RMN support for 16 nights.	213,963	191,566	22,397
MAIDSTONE	Birth Centre	100.0%	100.0%	100.0%	100.0%				0	0			62,136	66,382	-4,246
TWH	Neonatal Unit	111.8%	85.7%	109.5%	92.9%	11.0			0	0		RN fill rate reflects recruitment with a new starters in supernumerary phase, but contributing to care.	162,269	167,290	-5,021
MAIDSTONE	MSSU	108.8%	72.7%	100.0%	N/A	13.6	0.0%	0.0%	0	0		CSW fill rate an accepted risk. Support provided from Peale when required.	39,206	42,860	-3,654
MAIDSTONE	Peale	120.2%	65.9%	107.1%	79.3%	6.8	1.6%	100.0%	0	0		Rota changes still in transition, 1 RN to orthopaedic unit. Cover provided to short stay when required.	61,123	73,256	-12,133
TWH	SSSU	100.0%	100.0%	100.0%	100.0%	2.8	0.0%	0.0%	3	0		Whilst fill rate is at agreed levels, staff were also providing support to Recovery during periods of escalation	22,981	214,593	-191,612
MAIDSTONE	Whatman	94.6%	93.8%	98.8%	100.0%	4.4	37.0%	90.0%	4	0			114,972	93,668	21,304
MAIDSTONE	A&E	97.8%	96.4%	99.5%	100.0%		6.3%	90.0%	2	0			202,542	168,105	34,437
TWH	A&E	90.5%	83.3%	97.7%	75.0%		25.0%	93.2%	3	0			294,411	290,862	3,549
												Total Establishment Wards	**4,821,484**	**5,086,621**	**(265,137)**
												Additional Capacity beds	40,897	52,502	-11,605
												Other associated nursing costs	2,427,801	2,434,414	-6,613
												Total	7,290,182	7,573,536	-283,354

RAG Key

Under fill

Over fill

Trust Board meeting – March 2017

Maidstone and Tunbridge Wells NHS Trust

3-12	**Approval of updated declaration of compliance with eliminating Mixed Sex Accommodation**	**Chief Nurse**

Since the introduction of the Eliminating Mixed Sex Accommodation declaration exercise in April 2011[1], Trust Boards have been required to make an annual declaration of compliance for delivering single sex accommodation (DSSA), and to publish this on their website.

The Trust Board last approved the DSSA declaration in March 2016, and is therefore asked to approve the statement below:

Declaration of compliance

Maidstone and Tunbridge Wells NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate Mixed-Sex Accommodation except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care (ICU), Coronary Care (CCU), or the Acute Stroke Unit, or when patients actively choose to share (for instance Chemotherapy Day Unit).

All in-patient care at Tunbridge Wells Hospital is provided in single rooms including Intensive Care, Coronary Care and Acute Stroke. All rooms (except Intensive Care) have en-suite toilet and shower facilities.

The Acute Medical Unit (AMU) at Tunbridge Wells Hospital provides in-patient care in 4 bedded bays. These bays are single sex, and have appropriate gender-specific toilets and washing facilities adjacent to them.

Patients admitted to the Surgical Assessment Unit (SAU) at Tunbridge Wells Hospital will be cared for in single occupancy cubicles. Provision is made to access appropriate gender specific toilet and washing facilities.

If our care should fall short of the required standard, we will report it through our governance structures to the Trust Board. We have an audit mechanism in place to make sure that we do not misclassify any of our reports.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval

[1] Gateway reference: 15552 (see www.gov.uk/government/uploads/system/uploads/attachment_data/file/215773/dh_124233.pdf)

[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

Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-13	To support the case for change for the Kent & Medway Sustainability and Transformation Plan (STP)	Medical Director

The case for change for the Kent and Medway Sustainability and Transformation Plan (STP) was published on 24/03/17.

The main case for change document ("Our case for change"), plus the more detailed technical document, are enclosed.

Both documents along with other information relating to the STP, can be accessed via the STP's website (http://kentandmedway.nhs.uk).

The Trust Board is asked to support the case for change.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

To support the case for change

[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

Transforming health and social care in Kent and Medway

Our case for change

What's this about?

We all want health and social care services that can meet our needs now and in the future. The NHS in Kent and Medway, Kent County Council and Medway Council do their best to offer safe, compassionate and high-quality care. However, we face new challenges that mean we need to change the way we work to improve care and get better value for the money we have available.

As our population grows, and more people live with long-term conditions, the demands on our services are changing and increasing. Services are not necessarily designed for today's or future needs, and it is becoming harder to keep up with rising costs. What's more we aren't making the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent.

This booklet – our case for change – describes the current situation and why change is necessary. We want you to get involved to help shape and influence good health and social care in your area.

Why do we need a case for change?

We are publishing this case for change to explain more about the thinking behind a draft plan called the Sustainability and Transformation Plan that was launched in November 2016.

What is the plan?

The draft plan explains our vision for the future. Our ambition is to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital. It sets out how we want to:

- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- make sure NHS and social care staff are not under so much pressure that they can't deliver the caring ethos of the NHS and social care
- better meet people's needs within the funding we have available
- build health and care services that are sustainable for years to come.

Local care

Our first priority is to develop more and better local care services, which bring together all the services you currently get from your GP, as well as a range of additional services such as:

- urgent care and care for non-life-threatening injuries
- diagnostic tests
- ante and post-natal maternity care
- community and district nursing
- mental health support
- social care eg. help with washing, dressing and using the toilet
- physiotherapy
- dementia care.

Bringing together primary, community, mental health and social care services will mean we can offer joined-up care in people's homes and local communities. We recognise we will need to increase our capacity in these areas in order to achieve this.

Having high-quality local care services with greater capacity will relieve some of the pressure on our hospitals. It will reduce the need for people to go to hospital for treatment and services that in the future could be provided more locally.

Hospital care

Some people will always need specialist and intensive care that can – and should – only be available in hospital. We need to make sure our hospitals can deliver the quality of care people need and that they can leave hospital as soon as possible, safely supported by local care services. This will improve medical outcomes for people and their experience of health services. Over time it will also reduce dependency on hospitals which then releases resources back into local care services.

How will the new way of delivering services benefit you?

You can expect to see:

- joined-up services to treat and care for you at home and support you to leave hospital
- as soon as you're medically fit to leave "your own bed, is the best bed" with the right care and support in place
- health and social care professionals coming together to work as a single team for your local area, able to access your records 24 hours a day (with your consent)
- a modern approach to health and social care services using the best technology, from booking your appointment online to virtual (but secure) consultations, online assessment and diagnostic systems, and advice on apps to monitor your health
- timely appointments with the right professional
- care for you as a whole, for both your physical and mental health
- regular monitoring if you have complex health conditions affecting your physical or mental health, or both
- more support from voluntary and charitable organisations who have great expertise and local knowledge and already play such an important part in our communities
- better access to health improvement advice and services to help you improve and manage your own health and so reduce your risk of serious illness
- "social prescribing" - information to help you access relevant support from voluntary, charitable and local community groups or services
- quality hospital care when you need it – and more care, treatment and support out of hospital when you don't.

Read the Kent and Medway vision for securing the future of our services at www.kentandmedway.nhs.uk/stp

There is already lots of good work happening in our area. Individual services are finding ways to work more effectively, to join up health and social care and to better design services around the needs of local people. You can find out more about this work on our website at www.kentandmedway.nhs.uk/casestudies. We need to build on this good work across the whole of Kent and Medway.

More detailed plans for changing the NHS and social care in Kent and Medway are now being drawn up by groups of local doctors, hospital chief executives, patient groups and councils. At the end of this booklet there is more information about how you can get involved and contribute to the more detailed plans.

About health and social care in Kent and Medway

Understanding the health and social care needs of local people, and how these are likely to change over time, helps us plan for the future and make better use of resources (that's technology, money, staff and buildings). We also need to have a clear picture of how current ways of working are getting in the way of our ambition to keep people well, independent and out of hospital, so we can see what needs to change.

All of us, the people who use services, are changing. The good news is we are living longer, but this means the way the NHS and social care work needs to change to meet the needs of an ageing population. We are living with more long-term conditions, such as diabetes, dementia and heart disease which increases demand for health and care services. But the type of services we need are not necessarily the same sorts of services we have always had.

Some of our services were designed to meet the needs of people in the 1960s, 70s, and 80s. We know there are better ways of organising how we care for people. For example, we offer a lot of tests, treatments and services in big hospitals which could be safely offered in people's homes, health centres or local communities.

We also don't have enough professionals working in local communities in a joined-up way. Our current ways of working mean it is harder to support people who have a number of health and care needs. People who are frail, or who have multiple health conditions, can quickly get unwell and end up in hospital. This is because we don't always spot when someone is at risk of getting worse early enough, and then put the right care in place in their home or community so they don't need to go into hospital.

While most of the contact people have with health and social care happens outside of hospital, we spend most of our budget on acute hospital care because big hospitals cost more to run than community services. We know we could safely deliver more services in local communities, more cost-effectively and more conveniently for local people.

Local services

In Kent and Medway we have:

249 GP practices

4 organisations providing community care

4 hospital trusts providing services across **7** acute hospitals

3 organisations providing mental health care

13 community hospitals

1 ambulance trust

2 local authorities providing social care

466 independently run social care providers

303 independently run residential and nursing care homes

394
dentist practices

157
optician practices

More than
335
pharmacies

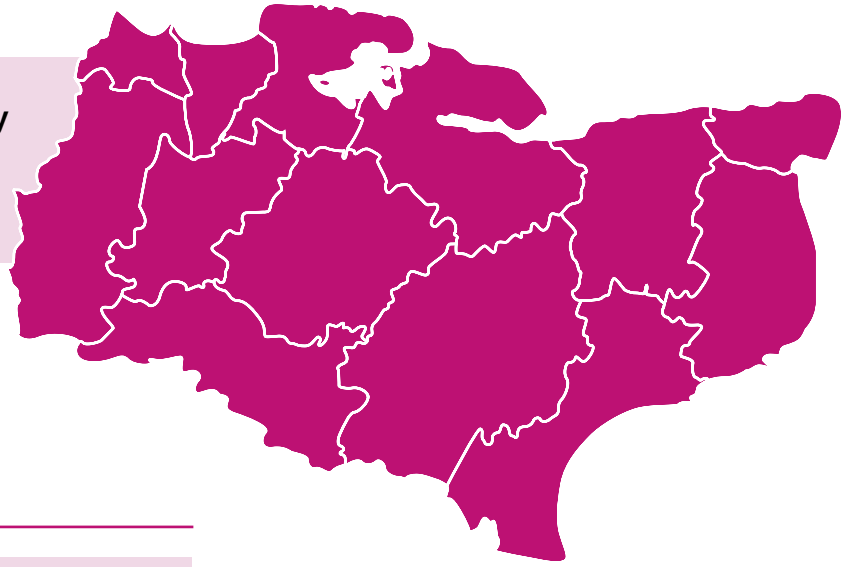
Health and social care budget

We have around
£3.6bn
to spend on health and social care each year

*70% of people who receive social care pay for it themselves, so the amount spent on social care in total is over £1 billion.

Local needs

There are approximately 1.8 million people living in Kent and Medway.



The local population is growing rapidly

The number of people living in Kent & Medway is predicted to rise by almost a quarter by 2031.

This increase is higher than the average across England. This is because local people are living for longer and because people are moving into the area.

Local people are living longer and older people tend to have additional health needs

While it's good news that people are living longer, an ageing population often means increasing demand for services to keep people well or help them when they are not. We need to change what we currently do to better support older people in our area.

Lots of people are living with long-term conditions

Over 528,000 - that's almost one in three - local people live with one or more significant long-term health conditions.

Many long-term conditions like diabetes, high blood pressure or breathing problems (such as COPD - chronic obstructive pulmonary disease) can be well managed, improved or even prevented if people can get the right support easily and quickly.

Too many people are living unhealthy lifestyles and are at risk of developing conditions that are preventable

In Kent and Medway, on average around one in five people smoke, but in some areas it is as high as 30%. Around ten per cent of adults are obese and more than a quarter don't get enough physical activity. All these lifestyle factors increase the risk of developing a serious illness.

There are unacceptable differences in health across Kent and Medway

Women in the most deprived areas of Thanet live on average 22 years less than those in the least deprived.

With the right help it can be possible to prevent the main causes of early death which are often linked to things like obesity, smoking and childhood poverty.

Many people (including children) have poor mental health, often alongside poor physical health

We know that mental health is as important as physical health.
The percentage of adults and children living with mental ill-health in Kent and Medway is roughly in line with the rest of England, but mental health problems are more common in people living in the most deprived areas. We want to better support everyone with mental health needs.

If we carry on working in the way we are, we cannot meet the current and future needs of local people with our existing budgets

We are very unlikely to see any more significant increases in health and social care budgets in the near future. Our budgets are not rising at the same pace as costs and demand. Our health budget is already overspent by £110m in 2016/17.

If we don't change how we work and spend our money for the greatest benefit, we will be overspent by £486m by 2020/21.

What you've told us you want from local services

We know from ongoing discussions with local communities, and research done by Healthwatch, that local people would like:

- more support to help people live healthy lives
- the NHS and social care working more efficiently and offering higher quality care
- the NHS and social care to work in a more joined-up way
- quick action when you become unwell or need extra help
- care to be as close to home as possible
- appointments that are easy to book and at convenient times.

Find out more about how your local NHS has listened to and acted on your views over recent years on our website.

The challenges we face

We are facing some big challenges in health and social care. We need to address these quickly to improve the health and wellbeing of local people, increase the quality of local services and work within our budget.

We need to focus more on supporting people so they don't get ill in the first place

Most people are currently healthy, but many are at risk of developing long-term health conditions such as diabetes and heart disease. Currently only two per cent of health and social care funding is spent on preventing people becoming ill.

This is about £86 million a year, but we spend around £3.4 billion on treating ill-health.

Between 2009 and 2013, around 1,600 early deaths each year could have been avoided with the right early help and support. For example, the lung condition chronic obstructive pulmonary disease (COPD) is a common cause of early death, however most cases (85%) are caused by smoking.

We need to focus ill-health prevention and public health work in areas of Kent and Medway with the greatest needs. We need to actively encourage and give practical support to people to help them find realistic ways to improve their long-term health and wellbeing.

GPs and their teams are understaffed and not able to deliver the quality of care they would like

If staffing in Kent and Medway were in line with the national average there would be 245 more GPs and 37 more practice nurses.

However, we can't recruit the doctors and nurses we need as there are not enough who want to live and work in Kent and Medway. This means we have a lot of staff vacancies. Primary care teams are doing their best in difficult circumstances but not being able to recruit enough staff means local people can't always get appointments quickly and sometimes have long waiting times once they are in the surgery. These types of problems in primary care can mean diseases are not detected early enough or existing conditions get worse. This isn't good enough for patients, or the staff who care for them, and puts increased pressure on hospital and mental health services.

Services and outcomes for people with long-term conditions are poor

Often people with long-term conditions do not get enough support to manage their health and wellbeing, and this can lead to unplanned time in hospital.

Evidence shows that as many as four in 10 emergency hospital admissions could be avoided if the right care was available outside hospital.

Carers are also not receiving enough support. Fewer than half of local carers are satisfied with their experience of care and support.

Many people in hospital could be better cared for elsewhere

Evidence shows that every day around 1,000 people in Kent and Medway are in a hospital bed when they no longer need to be.

This equates to about one in three people in hospital at any one time. These people may still need help and care, but it could be given more appropriately elsewhere if the right services were available.

People don't want to be in hospital if they don't need to be and staying in hospital longer than necessary can be harmful. For example, extended hospitals stays can increase the risk of infection, may lead to muscle wastage and could make it less likely for people to return to their previous level of independence. It is also expensive – it costs £220 a day to care for someone in an acute hospital bed when they are not actively receiving treatment, and this money could be better used elsewhere.

Having people stuck in hospital leads to knock-on delays that can cause, for example, long waits in A&E or cancelled operations because beds are not available for planned or emergency admissions.

Services for the most seriously ill patients need 24-hour access to specialist staff, tests and equipment

Some services for seriously ill people in Kent and Medway find it hard to offer a full service round-the-clock, and to meet expected standards of care. For example, all stroke patients who are medically suitable should get clot busting drugs within 60 minutes of arriving at hospital. They require specialist diagnostic tests and highly skilled expertise to deliver this. None of the hospitals in our area currently meet this standard for all patients.

Even if there was more funding available, there is a shortage of skilled staff, especially senior doctors, to cover rotas 24 hours a day, seven days a week.

Not having enough senior doctors on hand all the time can mean worse outcomes for patients. Essential support services that help people get discharged from hospital such as pharmacy, social care and mental health liaison are also not available at the weekend.

We know from evidence elsewhere that bringing services together to create larger specialist units, for example for stroke, would improve outcomes for patients and the quality of care available. We would have more specialists to cover the service all the time, and specialist staff would see enough patients with the same illness or condition to keep up their levels of expertise.

Planned care – such as going into hospital for a hip operation or having an x-ray – is not as efficient as it could be

There is variation across Kent and Medway in how often GPs refer people to see a hospital specialist. Once patients have been referred there is variation in the tests and treatments they get. This means some people get referrals, tests and treatments they don't need, and others don't get the care they should. Unnecessary referrals, tests and treatments also waste valuable resources. Planned care is often disrupted by emergency and unplanned hospital admissions, meaning appointments and operations get cancelled at the last minute.

Cancer care does not always meet national standards

Cancer is a major cause of death and survival rates could be much better. Most of Kent and Medway is below the England average when it comes to diagnosing cancer at its earliest stage. This is partly because of lack of awareness of the symptoms of cancer leading to delays in diagnosis, and because not enough people take up the offer to have screening for cancer. Once cancer is suspected, waiting times for diagnostic tests, to see a specialist and then for treatment, sometimes do not meet national standards.

People with mental ill-health have poor outcomes and access to services is not good enough

People with a serious mental illness die on average 15 to 20 years earlier than the general population.

There is a lot of evidence that links poor physical health with mental illness and vice versa. For example, having depression doubles the risk of developing heart disease and people with depression have significantly worse survival rates from cancer and heart disease. We know that a lot of people are not happy with mental health services, particularly for crisis care.

Services could be run more productively

The efficiency of our hospitals is broadly in line with other hospitals of a similar type across England in many of the ways they spend money, and some are among the most efficient. However, healthcare organisations in Kent and Medway know they could do more to reduce costs and run services more efficiently. For example, by working together they could have more buying power and get lower prices for commonly used goods and equipment.

It is estimated that approximately £190m of savings could be made if services were run as efficiently as top performing hospitals in England.

Putting the right foundations in place

In order to deliver our plan, there are three foundation areas that must be working well:

Being able to attract, recruit and retain the right staff

There are currently high levels of staff vacancies, turnover and temporary staff in most areas. There is also a shortage of skilled staff in some areas.

Having the right buildings

We are fortunate to generally have good quality buildings, however we don't use some of our buildings as effectively as we could, to deliver health and social care services.

Excellent information technology and information management systems

None of the organisations in Kent and Medway think they currently have the IT and information management systems they need to share information across organisations in a way that will better support the delivery of high-quality care.

There have never been better reasons to update the way services are organised in Kent and Medway. Our desire to make services better for patients and staff, and the challenges we face, combined with the financial pressure health and social care services are under, explain why things cannot stay as they are.

Our ambition for the future

Our ambition for the future is described in detail in our draft Sustainability and Transformation Plan. We have published this case for change to explain more about the reasons behind the ambition set out in the draft plan.

Our plan explains how we want to address the challenges described here, and take advantage of the opportunities, to make our local health and social care services sustainable for the future.

What will our plans mean for health and care in Kent and Medway?

Better health and wellbeing

- services which meet the needs of our changing population, as people age, and more people move into Kent and Medway
- reductions in health inequalities (unfair differences in health and life expectancy that people experience in some parts of the county) and death rates from preventable conditions
- more services to prevent and manage long-term health conditions such as diabetes and lung disease.

Better standards of care

- people cared for in the right place and able to get high-quality, accessible social care across Kent and Medway
- fewer attendances at accident and emergency departments, and fewer emergency admissions to hospital beds
- local providers of health and social care consistently delivering high-quality services, which meet nationally-recognised clinical quality standards.

Better use of staff and funds

- ability to attract, retain and grow a talented workforce – and use our staff to the best effect
- some of our specialist clinical staff and equipment consolidated so they can work more effectively across a wider population as expert teams
- a balanced budget for health and social care across Kent and Medway.

Get involved

We hope this case for change will help to get local people - patients, users of services, carers and health and social care staff - talking in more detail about what should happen next. We want you to get involved in shaping plans for health and social care in Kent and Medway.

During 2017 there will be lots of ways to influence what happens next, including public events and meetings, online surveys and joining your local patient participation group or health network. For more information visit www.kentandmedway.nhs.uk/getinvolved

Sign up now

Now you have read this booklet please subscribe to our newsletter at www.kentandmedway.nhs.uk/subscribe. By signing up you'll be kept up to date on all the opportunities to share your views and ideas with us as our plans develop.

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Kent & Medway

Case for Change

24th March 2017

Contents

Foreword

We have come together as health and social care partners across Kent & Medway to improve the services we provide and get the best possible health and social care outcomes for local people. It is important to understand where we are now, so that we can better understand where we can improve.

There is much to be proud of about health and social care services in Kent & Medway. Staff work very hard to provide high quality care and local people are relatively healthy compared with other parts of the country and local organisations have a track record of working together to meet the needs of local people. But we have been delivering services in the same way for many years and, increasingly, this way of delivering services no longer meets the needs of local people, especially frail, older people and those with long term health conditions.

There are, therefore, several issues that we need to tackle in Kent & Medway; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through self-management, ill health prevention and earlier diagnosis. This case for change sets out our key challenges and will make sure that we target our efforts and resources on meeting these challenges in the coming years. The case for change highlights many challenges but we would like to highlight some of the key facts and figures:

- 1,600 local people die early each year from causes considered amenable to healthcare, with people in deprived areas and those with severe mental illness more likely to be affected.
- There are health inequalities across Kent & Medway with, for example, a difference in life expectancy of 22 years between the most deprived and least deprived areas in Thanet.
- Only 2% of health and social care budgets are spent on public health care and lifestyle intervention services to reduce the risk of avoidable disease and disability. These budgets are expected to decline by 9% over the next 3 years (representing a decline of 3% per year).
- Over 1,000 (32%) people are in hospital beds that do not need hospital based medical care and could be helped elsewhere if services were available.
- People find it difficult to access GP services and there are a low number of GPs in Kent & Medway; there would be 245 more full-time GPs if we had the same numbers as the national average - and there are 136 vacant GP posts across Kent & Medway.
- For stroke patients who require thrombolysis, no hospital in Kent & Medway delivers this treatment to all patients within the national guideline recommended time of 60 minutes; in 2015/16, the worst performing trust thrombolysed just 16% of patients within 60 minutes.
- Local health and social care commissioners and providers are facing a £110m deficit in 2016/17 which will rise to £486m by 2020/21 if nothing changes.

We are committed to working together to make sure that local services are as high quality and as accessible as possible. We will make sure that we prevent disease where possible, that we meet the needs of all local people and that we provide high quality services for all.

This case for change describes the local context, the changing health and care needs of local people, and the key challenges facing health and care services in Kent & Medway. This document does not contain solutions but will be used to guide our understanding of where we need to transform local services over the next few years.

A group of senior doctors, nurses and care professionals have worked together to develop this document which we hope will show where we can improve health and well-being and make local

services better. We believe that every person in Kent & Medway should receive the same high quality standard of care. This will mean that we need to work more closely together to prevent ill health where we can and provide integrated, high quality services when people fall ill. We recognise thatwe will need to work together to achieve this.

Signed by

Dr Peter Maskell, Co-Chair Kent & Medway Clinical Board (and Medical Director, Maidstone & Tunbridge Wells NHS Trust)

Dr Sarah Phillips, Co-Chair Kent & Medway Clinical Board (and Clinical Chair, NHS Canterbury & Coastal CCG)

On behalf of the Kent & Medway Clinical Board

Dr Fiona Armstrong	Clinical Chair	Swale CCG
Dr Bob Bowes	Clinical Chair	West Kent CCG
Dr Jonathan Bryant	Clinical Chair	South Kent Coast CCG
Dr Andrew Burnett	Director of Public Health (interim), Prevention SRO	Medway Unitary Authority
Dr Simon Collins	Medical Director	Medway Community Healthcare
Vicky Ellis	Director of Quality	Medway Community Healthcare
Dr Steve Fenlon	Medical Director	Dartford and Gravesham NHS Trust
Dr Peter Green	Clinical Chair	Medway CCG
Dr Diana Hamilton-Fairley	Medical Director	Medway NHS Foundation Trust
Diane Hull	Director of Nursing	Sussex Partnership NHS Foundation Trust
Andrew Ireland	Director of Social Services	Kent County Council
Dr Catherine Kinane	Medical Director	Kent and Medway NHS and Social Care Partnership Trust
Dr Navin Kumta	Clinical Chair	Ashford CCG
Vikki Leivers-Carruth	Director of Nursing	Dartford and Gravesham NHS Trust
Dr Elizabeth Lunt	Clinical Chair	Dartford, Gravesham and Swanley CCG
Dr Tony Martin	Clinical Chair	Thanet CCG
Dr Rory McCrea	Medical Director	South East Coast Ambulance Service NHS Foundation Trust
Mary Mumvuri	Executive Director of Nursing & Governance	Kent and Medway NHS & Social Care Partnership Trust
Andrew Scott-Clark	Director of Public Health, Prevention SRO	Kent County Council
Dr Paul Sigston	Deputy Medical Director	Maidstone and Tunbridge Wells NHS Trust
Dr Paul Stevens	Medical Director	East Kent Hospitals University NHS Foundation Trust
Ali Strowman	Director of Nursing	Kent Community NHS Foundation Trust
Anne Tidmarsh	Director of Older People and Physical Disability	Kent County Council
Sarah Vaux	Chief Nurse	NHS Medway CCG
William Willson	Director of Pharmacy	East Kent Hospitals University NHS Foundation Trust

1. Executive summary

This case for change document describes the changing health and care needs of local people and the key issues facing health and care services in Kent & Medway (K&M). It will be used to guide the transformation of local services to improve care and quality over the next few years.

K&M comprises eight CCGs – Ashford, Canterbury & Coastal, Dartford Gravesham & Swanley, Medway, South Kent Coast, Swale, Thanet and West Kent – which cover the areas of Kent County Council and Medway Unitary Authority. There are around 1.8 million residents in K&M and the area spends £3.6bn on health and social care. There are seven acute hospitals, three providers of community services and three providers of mental health services, as well as 249 GP practices and around 466 social care providers.

The needs of local people drive local requirements for health and social care:

- **The local population is growing rapidly:** From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people in K&M in 188,200 new homes [1]; 10,000 of these new homes will be in the new town in Ebbsfleet[2]. This growth will be distributed unevenly across K&M, with most housing growth occurring in Medway, Dartford and Maidstone.
- **Local people are living longer and older people tend to have additional health needs:** the number of older people is growing quickly and older people tend to have higher levels of health and social care service use compared to other age groups. Growth in the number of over 65s is over 4 times greater than those under 65; an ageing population means increasing demand for health and social care. There are also around 12,000 people with dementia in K&M.
- **There are widespread inequalities across K&M:** there are stark health inequalities across K&M; for example, women living in the most deprived areas in Thanet live on average 22 years fewer than those in the least deprived. Evidence shows that poorer regions tend to have worse health and lower life expectancy. The main causes of early death are often amenable to public health and medical interventions.
- **People are living in poor health with preventable long term conditions:** over 528,000 local people (including 19,000 children under 16) live with one or more significant long-term health condition[1], many of which are preventable; and many of these people have multiple long-term health conditions, dementia or mental ill health. On average, total spend on a person in K&M with a long-term condition costs 6 times more than on a healthy person.
- **There are differing levels of health and social care needs:** the majority of local people are largely healthy, but there is high use of health and social care by those with long term conditions, severe mental illness, learning disabilities, severe physical disabilities, dementia and cancer.
- **Many people (including children) have poor mental health, often alongside poor physical health:** the prevalence of mental health disorders in K&M is generally in line with the rest of England, but mental health problems disproportionately affect people living in the most deprived areas in K&M. Approximately one in ten children aged 5 to 16 has a diagnosable mental health problem (this is similar to the national average), and there are many 'at risk' groups including children living in deprived households.

[1] Including severe mental illness, dementia, cancer, physical disability, learning disability, asthma, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, depression, diabetes, epilepsy, heart failure, hypertension and stroke.

- **There is a substantial financial challenge facing health and social care organisations in K&M**: commissioners and providers in K&M are already £110m in deficit in 2016/17 and, if nothing changes, will be £486m in deficit by 2020/21.

This suggests that the priority groups for focus are ill health prevention, older people, those living in the most deprived areas, those living with long term conditions and people with poor mental health. It is also important to make sure high quality services are available when required for the majority of local people who are generally healthy.

There are challenges in the delivery of care and quality:

1. **There is not enough focus on maintaining independence and ill health prevention across the whole K&M system (including physical health, mental health, social care and the wider public sector):** many people in K&M are healthy and well, but are at risk of developing long term health conditions such as diabetes and heart disease. Between 2009 and 2013, there were around 1,600 early deaths each year that could have been avoided if more effective public health and medical interventions had been in place. Many of the indicators of future poor health (for example, obesity and smoking) are worse than the national average in K&M, especially in more deprived areas. There is therefore an opportunity to focus on reducing the need for health and social care through the prevention of disease and ill-health and maintaining independence. However, only 2% of health and social care funding is spent on public health in K&M (of which at least half is spent on health care, such as genitourinary medicine and drug and alcohol treatment, the remainder being spent directly on lifestyle intervention services to reduce the risk of avoidable disease and disability).

2. **There are challenges in primary care provision, which is extremely fragile in some areas:** some local people are unhappy with existing GP services; in Medway, for example, almost 1 in 3 people would not recommend their GP surgery. This may be partly explained by poor access to GP services and long waiting times once patients are in the surgery. Poor access is partly driven by a lack of capacity in primary care – there would be 245 more GPs and 37 more practice nurses in K&M if the area had the same numbers as the national average - this lack of capacity is greatest in the most deprived areas. However, it is difficult to recruit new GPs; there were an estimated 136 open GP vacancies in September 2016 across K&M (12% of the total number of GPs) – this also means there are large numbers of locum GPs. The fragility of primary care provision can lead to disease not being detected early enough, increasing activity in hospitals and pressure on mental health services.

3. **There are gaps in service and poor outcomes for those with long term health conditions**: there are over 528,000 people in K&M with significant long term conditions; most of these people are older and many have multiple long-term conditions. Many local people do not get enough support to manage their conditions and there are high levels of hospitalisation for these people. Evidence from elsewhere suggests that 25-40% of emergency admissions could be avoided if alternative care was available outside hospital. Carers are also not receiving enough support; fewer than half of local carers are satisfied with their experience of care and support.

4. **Many people are in hospital who could be cared for elsewhere:** every day over 1,000 people are in local hospitals when they could be elsewhere. Longer stays are not always driven by medical need and can be harmful to health. Some of the main causes of delay are awaiting care home placement (14%) and awaiting a care package in their own home (14%). The majority of patients medically fit to leave hospital require basic essential care such as

feeding and washing. Quality is also an issue; 41% of residential social care organisations in K&M require improvement or are inadequate and there has been a significant reduction in nursing home places with 25 homes closing in the last two years.

5. **Some local hospitals find it difficult to deliver services for seriously ill people:** some services are vulnerable and potentially unsustainable. There are some services for seriously ill people in K&M that are small, and senior staff and specialist tests and equipment are not available 24 hours a day. There are also issues with services outside hospital, particularly at weekends, making it difficult for people to go home when they are able. This leads to delays along the patient pathway, including: waits to be seen by a senior doctor, for diagnostic tests, for a hospital bed, for treatment and to leave the hospital. There are particular issues in stroke, vascular and acute medicine. These challenges also result in poor access for patients; some hospitals in K&M have some of the worst patient satisfaction scores in the country for A&E. However, even if there were unlimited funds, there are simply not enough qualified and experienced staff to deliver services and some providers are having problems recruiting and retaining staff with vacancy rates of around 10% and turnover of medical staff is 16%.

6. **Planned care is not delivered as efficiently and effectively as it could be:** it should be possible to standardise planned care across K&M according to best practice and therefore deliver it as efficiently as possible. However, in K&M, the level of referrals from GPs to hospital specialists are higher than other places with a similar population; if the level of referrals were the same top performing CCGs in similar areas, outpatient activity would reduce by 9%. If planned activity within hospitals were the same as top performing CCGs in similar areas, it would reduce by 14%. There are also differences between hospitals in the delivery of planned care. On average over a third of patients having a hip replacement stay in hospital for longer than 3-days and there is a potential opportunity to reduce this. One potential cause of differences in the delivery of planned care is levels of emergency care. In K&M, emergency activity is increasing and so are occupancy rates (the numbers of beds that are full in the hospital) which may explain some of the issues in delivering planned care.

7. **There are particular challenges in the provision of cancer care:** there are many opportunities to save lives and deliver cancer services more efficiently. Cancer is a major cause of death in K&M and survival rates could be much better. Mortality from cancer in K&M is similar to other parts of England. However, compared to other countries such as Sweden, the UK has much lower survival rates, suggesting that improvements could be made. Late diagnosis of cancers is a particular issue in K&M, as is low take-up of screening for cancer. Once cancer is suspected, waiting times to see a specialist and then for treatment are long across K&M.

8. **People with mental ill health have poor outcomes and may not always be able to access services:** there is a lot of evidence that links poor physical health with mental illness. People with a serious mental illness are at risk of dying on average 15 to 20 years earlier than the general population. Nationally, years of low prioritisation have led to CCGs underinvesting in mental health services relative to physical health services. There is widespread dissatisfaction with services, particularly for crisis care and changes in who the person sees.

9. **Services could be run more productively across K&M.** Although local providers have comparable levels of efficiency to hospitals of a similar type in many areas of spend, and some are amongst the most efficient, all providers in K&M could do more to reduce costs

and run services more efficiently. It is estimated that approximately £190m of savings could be made if services were run as efficiently as top performing hospitals of a similar type.

There are a number of key enablers that will need to be in place to allow us to transform services and improve health and social services for local people. These include:

- The ability to recruit and retain a qualified and experienced workforce across health and social care. There are currently high levels of vacancies, high turnover and high numbers of temporary staff across some areas in K&M. There is also a shortage of some skilled staff in some areas and there will not be enough skilled staff to meet future demand.
- High quality, fit for purpose estates that are utilised as fully as possible. Whilst we generally have good quality estates in K&M, there are issues with under-utilisation of some hospitals, particularly in the community.
- The information technology and information management systems that will allow us to deliver care across organisational boundaries and support the delivery of high quality and efficient care. All organisations in K&M believe they do not have the IM&T capabilities required.

This case for change suggests several priority areas for focus, including:

- Health promotion and ill health prevention, particularly around those who are healthy and well but are at risk of developing long term health conditions. Investment in preventing ill health will be crucial to achieve this.
- Recruitment and retention of primary care staff, especially GPs.
- Avoiding hospital admissions for people with long-term conditions and supporting their carers.
- Reducing the length of stay in hospitals especially for older people, in partnership with social care.
- Specialised services which need to be configured so there is sufficient senior workforce to continue to provide high quality services. This needs to be balanced against the need to provide local access to services, where possible.
- Reducing differences in referrals into planned care, and the differences in the delivery of planned care within hospitals, including the relationship with emergency services.
- Improving efficiency, quality and access on the cancer pathway across primary and acute providers.
- Provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.
- Improving productivity across all providers in K&M.

This case for change has shown the significant scale of the challenges in K&M and the urgency with which they need to be addressed. Across K&M there are many examples of excellent work taking place to improve the way people are cared for. While these improvements are promising, they are only happening in some parts of K&M. The changes we need to make are greater than those already made, and so we must work together on a scale greater than we have before. Health and social care commissioners and providers across K&M have therefore come together to create a 5-year Sustainability and Transformation Plan (STP). As part of this plan, we are exploring and pursuing opportunities around four key themes: care transformation, productivity, enablers and system leadership. We will focus more on preventing ill-health and promoting good health and our local care will improve the health of people in K&M. We will work with local people to transform local care through the integration of primary, community, mental health and social care. Hospital care will need to change to improve patient experience and outcomes; make best use of the available workforce; and make best use of our buildings. With these plans, we are confident that we can

overcome the challenges which our health and care system faces and provide high quality services and outcomes for local people. This work will be overseen by the Clinical Board which includes GPs, hospital consultants, nurses, public health professionals, social care e leads, pha rmacists and other clinical experts. This is an ambitious plan of work and we are committed to progressing it for the benefit of local people.

2. Context

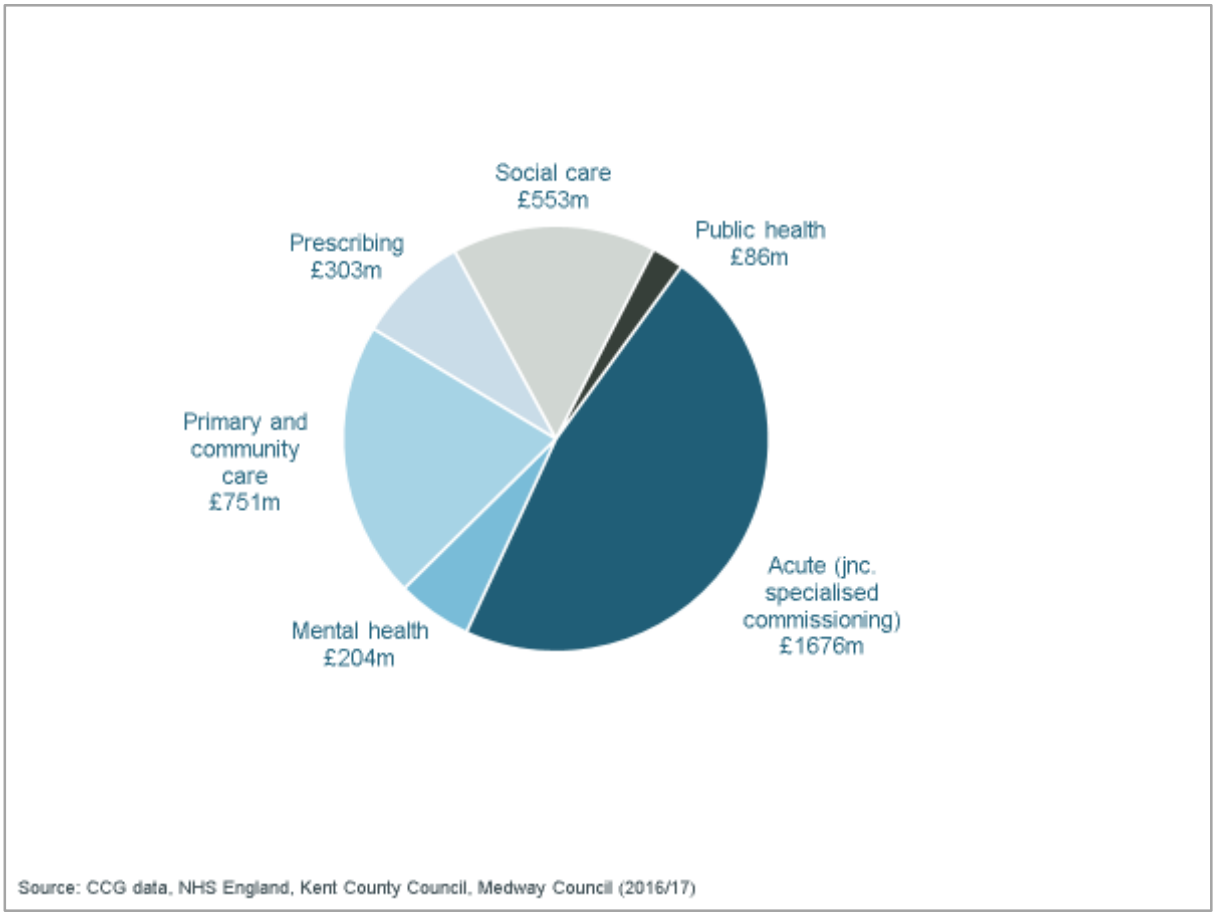
2.1 The local area

Kent & Medway (K&M) comprises eight CCGs – Ashford, Canterbury & Coastal, Dartford Gravesham & Swanley, Medway, South Kent Coast, Swale, Thanet and West Kent – which cover the areas of Kent County Council and Medway Unitary Authority. It includes the city of Canterbury (population c.160,000) in the east, the large market town of Maidstone (population c.165,000) in the west, and the large conurbation of Medway which includes Gillingham (c.105,000) and Chatham (c.77,000)[3] in the north. This large geographical area (1,368 square miles)[4] includes many smaller towns and villages and rural areas, and borders with London in the north west. K&M has a very long coastline which gives rise to challenges is providing accessible services. The number of people living in K&M is approximately 1.8 million[5].

2.2 Commissioners of services

Health and social care spending on the residents of K&M was £3.6bn in 2016/17. Of this, 47% was spent on hospital care including specialised commissioning, 15% on social care, 21% on primary and community services, 6% on mental health, 9% on prescriptions and 2% on public health[6].

Exhibit 1 – Total commissioner spend on health and social care across K&M (2016/17)



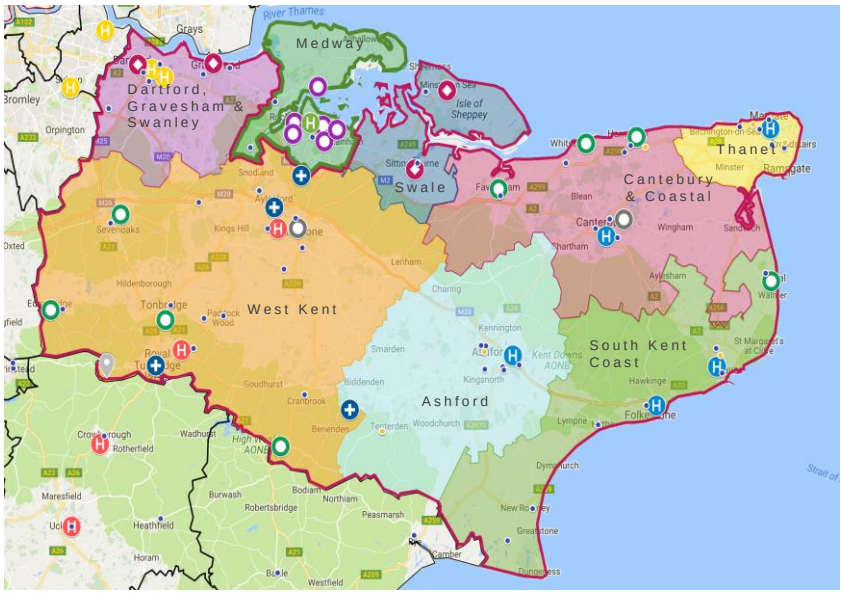
Health services in K&M are commissioned on behalf of local people by the eight local CCGs a nd NHS England. Social care services in K&M are commissioned by Kent County Council and Medway Unitary Authority. NHS England commissions specialist services such as major trauma, kidney transplants, eating disorders, plus primary care services (GP primary care services are co-commissioned with

CCGs in some areas) whilst the CCGs commission all other health services including mental health, hospital and community.

2.3 Providers of health and social care

In 2015/16, in K&M, there were 6.7m consultations at GP surgeries[7], over 1.4 million contacts with community staff, 487,000 attendances at A&E[8], 60,000 planned operations[9] and 170,000 emergencies that required hospitalisation[10]. There is a complex range of organisations providing these health and social care services in K&M, as shown in Exhibit 2.

Exhibit 2 – K&M overview



Source: Google Maps (2016); Carnall Farrar analysis

There are 249 GP practices, 394 dentists, 157 opticians and more than 335 pharmacies in primary care and around 466 social care providers. Out-of-hours primary care services are delivered by Primecare in East Kent, Integrated Care 24 (IC24) in West Kent and Medway on Call Care (MedOCC) in Medway.

There are several mental health providers which provide inpatient mental health facilities, community mental health teams, liaison psychiatry into hospitals and a range of specialist mental health services. These are:

- **Kent and Medway NHS and Social Care Partnership** which provides inpatient, outpatient and community mental health services, and other services including forensic mental health, learning disability, substance misuse and a range of specialist services[11].
- **Sussex Partnership NHS Foundation Trust** which provides children and young people's mental health services for children and young people who have emotional, behavioural or mental health problems. They also have a Children in Care (CIC) team dedicated to providing support for looked after children across K&M[12] and specialist inpatient beds for children and young people with mental health problems

- **South London and Maudsley NHS Foundation Trust** which provides CAMHS services and specialist inpatient beds for children and young people with mental health problems.

There are three community providers which deliver a range of services including inpatient community beds, stoke rehabilitation beds, intermediate care beds, urgent care, diagnostics, outpatients and minor surgery and community teams including community nurses, health visitors and a range of therapists. There are also 13 community hospitals in K&M providing 294 community inpatient beds[13]. The providers are:

- **Kent Community Health NHS Foundation Trust** which provides a range of community care services in Kent, East Sussex and Newham.
- **Medway Community Healthcare CIC** which provides a range of community health services in Medway and Kent.
- **Virgin Care** which provides community nursing, community hospital services, intermediate care, community falls service, speech and language therapy and podiatry in north Kent.

East Kent Hospitals University NHS Foundation Trust also provide community services at two hospitals. There are a range of social care services provided by local authorities, including home care, meals, transport and home modifications. There are 303 privately run residential and nursing care homes in Kent[14], who provide both health and social care.

There are four hospital trusts providing acute hospital services including A&E, emergency and elective (planned) surgery, acute stroke services, consultant-led maternity services and inpatient children's services plus a range of specialist services. The trusts are:

- **Dartford and Gravesham NHS Trust** which provides acute hospital services predominantly from one site in Dartford and a range of planned, urgent and community care services from four sites in north-west Kent[2].
- **East Kent Hospitals University NHS Foundation Trust** which provides acute hospital services from three sites in Ashford, Margate and Canterbury. They also offer a range of services throughout the local area in facilities owned by other organisations and runs renal (kidney) services in East Kent, Medway and Maidstone.
- **Medway NHS Foundation Trust** which provides acute hospital services predominantly from Medway Maritime Hospital in Gillingham, and offers a range of surgical specialities, such as the West Kent vascular service.
- **Maidstone and Tunbridge Wells NHS Trust** which provides acute hospital services predominantly from two sites in Maidstone and Tunbridge Wells, and a full range of general hospital services and specialist cancer care.

A number of people travel from outside K&M to use services in K&M hospitals. For example, over 20% of the people who are seen at Tunbridge Wells Hospital for planned care are from outside K&M[15].

Travel distances between acute hospitals in K&M are generally less than an hour, except for the Queen Elizabeth, The Queen Mother Hospital in Margate, which is more remote than other hospitals[16]. People living in K&M also go outside the area for some routine care and also some specialist treatments, for example, burns care in East Grinstead and liver transplants in London. These specialist treatments are not covered by this case for change.

[2] These four sites are not included in the Sustainability & Transformation Plan footprint.

2.4 Local successes

There are many services in K&M that provide high quality services every day and will continue to do so. The NHS and social services in K&M have also already had a number of successes making changes to local services to deliver the needs of the local population. There are many examples of how local services are starting to implement new ways of delivering care. Some of these are listed below.

Example 1: Therapeutic staffing in mental health
As a result of national nursing staff shortages, high levels of agency usage, and being committed to the parity of esteem agenda, KMPT have reviewed staff and skill mix on inpatient wards. The purpose of this is to ensure a therapeutic environment is achieved and maintained, giving maximum opportunity for timely acute recovery through available occupational, psychological, nursing and medical care. This has included the development of a hybrid B and 3 role with the aim to release "Time to Care", extending access to the therapeutic programme (beyond 9-5 Mon-Fri) and ensuring staffing reflects peak demands such as late afternoon/early evening when there is an increase of admissions. Physical health nurses are included in the staffing complement, with career progression opportunities enhanced with the newer development of not only Band 5, but also Band 6 physical health nurses. The quality impact assessment completed in East Kent's pilot demonstrated a positive impact on multi-disciplinary working, patient experience and an improved range of therapeutic activities being offered to patients across the week.

Example 2: Improving patient flow and reducing external placements in mental health
The KMPT Chief Executive set a target to reduce private bed usage to zero by the end of the year. A weekly Programme Board was set up to achieve this, focussing on a number of work streams to improve patient flow. These work streams include initiatives to improve cross service line working, focus on patients with a Personality Disorder and ensure MDT review of complex cases. One of the most successful work streams has been setting up a daily patient flow conference call (including discharge planning). This call allows clinicians to review their caseload, escalate any issues, share best practice and consider alternative options for patient care allowing MDT discussions. In the six months to December 2016 the focus on patient flows within KMPT resulted in a significant decrease in the number of external placements (from 72 beds to 4).

Example 3: Medway went smoke-free
Medway NHS Foundation Trust went smoke-free in October 2016. This was the culmination of eight months of planning and preparation, involving clinical and non-clinical staff from across the Trust, non-executive directors and governors, and close partnership with Medway Council and Healthwatch Medway. The emphasis has been on providing support to staff, patients and visitors, so nicotine replacement therapy is available free for staff and for patients across all clinical areas support on quitting is offered from the council's stop smoking service. Communications have also been vital, and the hospital has been kitted out with banners, signs, tannoys and posters so no-one can be in any doubt about the policy. The initiative is backed up with smoke-free officers who patrol the site and move on people who transgress the rules. The initiative has been highly successful; where before visitors arriving at the site had to walk through a cloud of smoke, only a handful of people have been found smoking at the hospital since go live.

Example 4: Diabetes Prevention Programme
The NHS Diabetes Prevention programme (NDPP) is the first attempt of preventing Type 2 diabetes at a national scale anywhere in the world. Medway CCG and Medway Councils Public Health team were one of the seven demonstrator sites to pilot this work. The learning from the pilots, including the adoption of a primary care case finding tool developed in Medway, has been used to inform the wider roll out across England. The South East was one of the first wave of roll out areas in England to start referring into 'Healthier You', which aims to support those at risk of developing Type 2 diabetes

to make healthier lifestyle choices. The South East clinical network is now working with 20 CCGs and 6 Local authorities across the South East in partnership with Ingeus (the course provider) to roll out the programme, so anyone referred can attend a course near to their home or work. The NDPP is continuing in Medway and is being rolled out across Kent in three tranches: in September 2016, Swale and West Kent CCGs started referring; in January 2017, Dartford, Gravesham and Swanley will start referring; and in April 2017, Ashford, Canterbury & Coastal, South Kent Coast, and Thanet CCGs will start referring. Of the 75 patients who have already completed the course in Medway 70% of them reduced their HbA1c (glycated haemoglobin) and therefore their risk of developing diabetes.

Example 5: The use of a computerised clinical decision support system (CDSS) in primary care
East Kent University Hospitals Trust has implemented a CDSS in primary care to support the identification and management of chronic kidney disease. Since 2005 the CDSS has screened patients having serum creatinine (SCr) estimations (a test done to show how well kidneys are working). Data are regularly extracted from primary care databases and patient specific advice is given regarding referral, medicines management and further investigation. As a result, a study shows that this has significantly reduced the incidence of late referral to renal replacement therapy among patients with renal failure. This has important implications for patient outcomes, as late referral is associated with higher mortality, and people who are referred late are more likely to be denied treatment choice, pre-emptive renal transplant is usually not feasible and starting renal replacement therapy is less likely. Furthermore, the same system, combined with pay for performance, saw an improvement in blood pressure control in people with chronic kidney disease (from a mean of 146/79 mmHg to 140/76 and then to 139/75 mmHg over 4 years of follow up).

These kinds of improvements have helped the local health and social care system to change and adapt to provide good services for local people, but more still needs to be done to respond to local needs and consistently deliver the highest quality of care and ensure value for money.

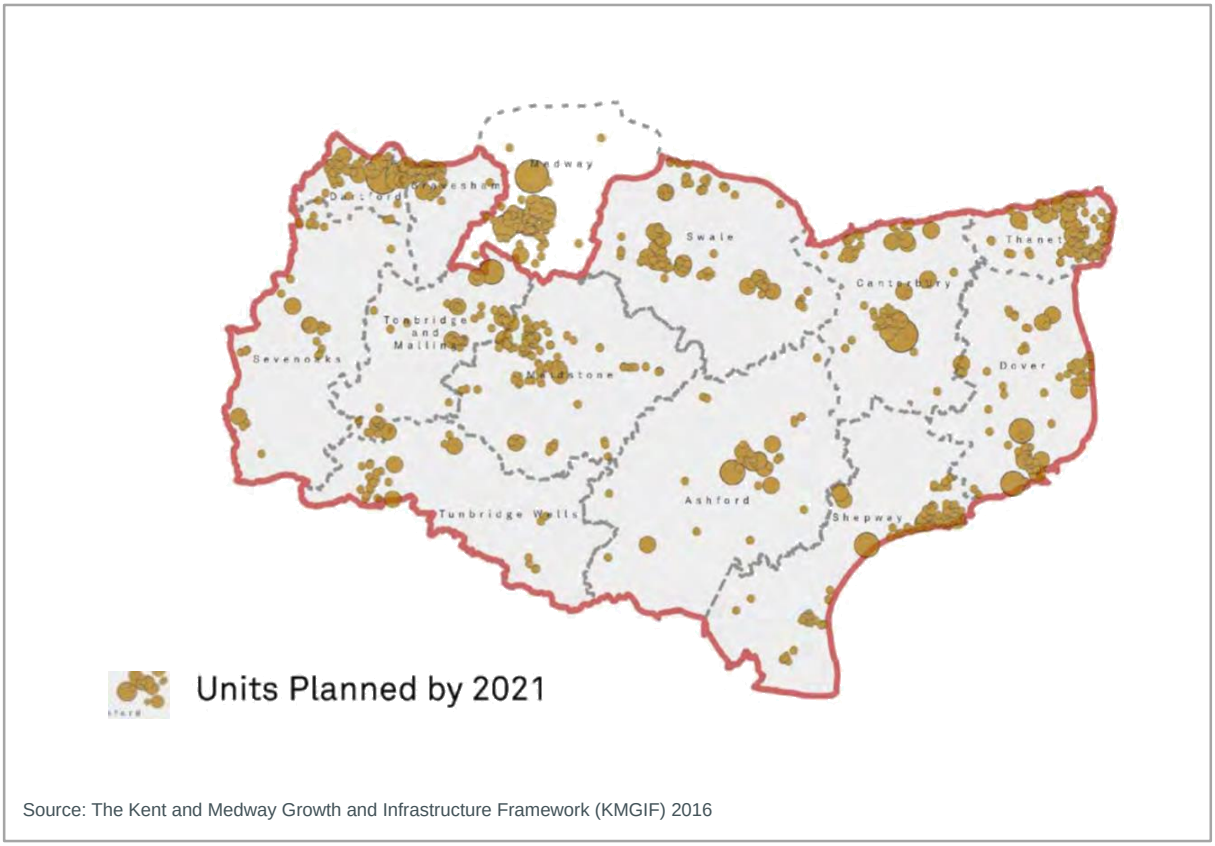
3. The needs of local people

Everyone in K&M has a different need for health and social care services. Some need intensive support and care (for example, in the final years of their lives) whilst others access services very infrequently (perhaps just to see a GP for common illnesses). Much of this need depends on demographic factors such as age, deprivation and lifestyle choices, but it also depends on whether people are living with one or more long term health condition such as asthma, cancer, dementia or mental illness. To understand the changing needs local people in K&M, it is important to understand the needs of local people.

3.1 The local population is growing rapidly

It is anticipated that the local population will grow rapidly over the coming years as there is substantial housing growth planned in many parts of K&M. From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people in K&M in 188,200 new homes[17]; 10,000 of these new homes will be in the new town in Ebbsfleet[18]. This represents a 24% increase in population, of which 18% is attributed to demographic growth[19] and 6% is incremental[20]. By comparison, the population of England is expected to grow by only 14% in the same period[21]. As shown in Exhibit 3, the greatest increases in housing are predicted in Medway, Dartford and Maidstone and will place pressure on health and social care services, such as maternity and children's services.

Exhibit 3 – Planned housing developments



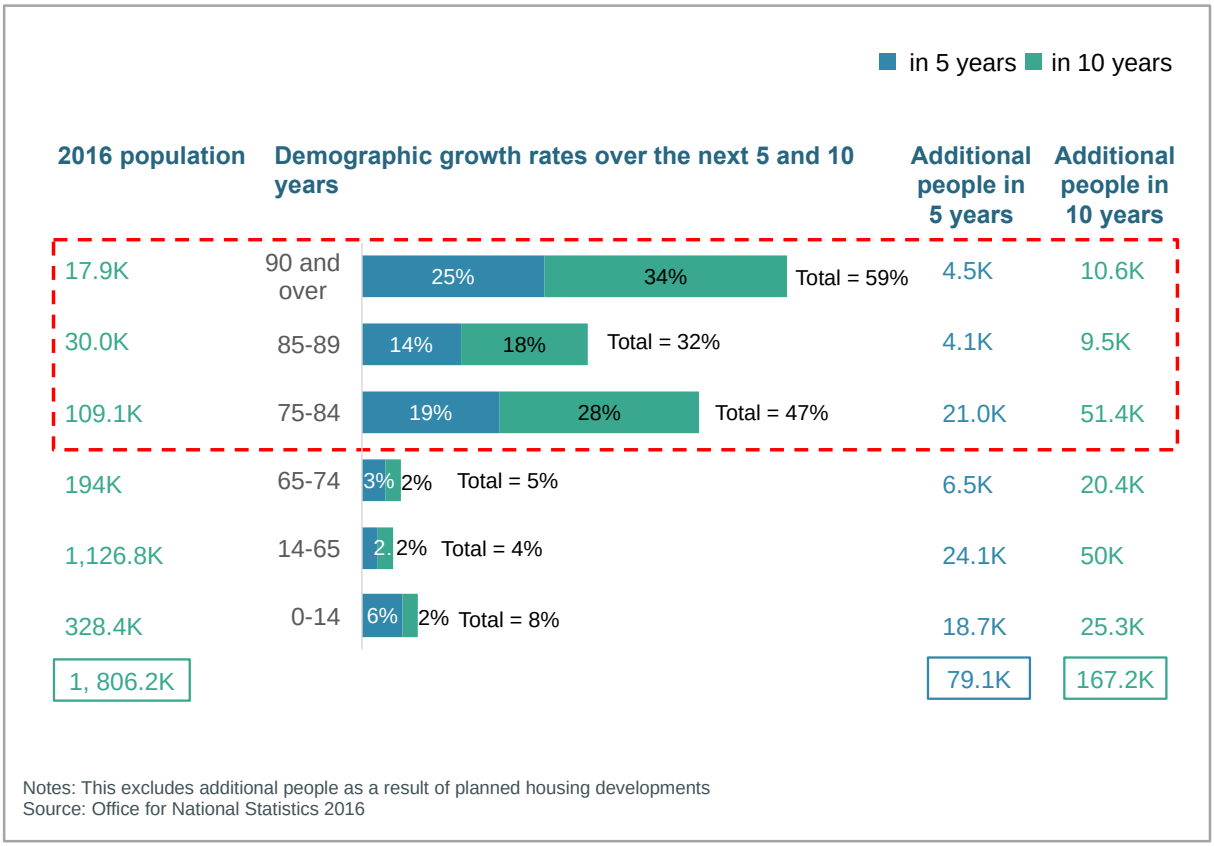
Source: The Kent and Medway Growth and Infrastructure Framework (KMGIF) 2016

3.2 Local people are living longer and older people tend to have additional health needs

As shown in Exhibit 4, older people (aged 75+) are the fastest growing group of people in K&M; growth in the number of over 65s is over four times greater than those under 65[22]. That people now

live for longer than they have ever done before is a cause for celebration. However, for local health and social services, an ageing population is hugely significant because older people are more likely to develop long term health conditions such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems[23] – which together means people tend to need more care and more treatment as they get older. Older people have much higher levels of health and care service use compared to other age groups, particularly hospital admissions and use of community services[24]. If nothing changes, it is estimated that an extra 773 hospital beds would be needed by 2021 just to meet the requirements of the growing, aging population[25].

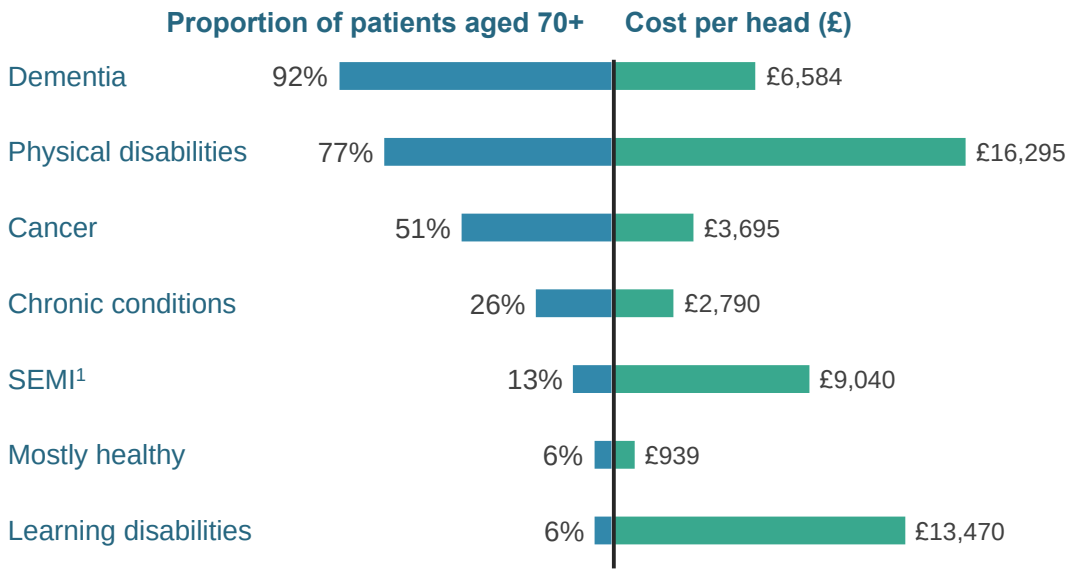
Exhibit 4 – Growth in numbers of people in K&M and England



An ageing population also means increasing numbers of people with dementia – there are around 12,000 people in K&M with dementia – and many more who do not have a formal diagnosis[26]. People aged 70+ make up the largest proportion of those with dementia, physical disabilities and cancer in K&M, which are all expensive services to run. For example, as shown in Exhibit 5, 92% of people with dementia in K&M are over the age of 70 and require an average £71m per year in health and social care[27]. At any one time, 34% of those occupying a hospital bed in K&M have dementia[28].

Older people also find it difficult to access services (especially if they must travel long distances), are likely to be living with more than one long term health need and may also be carers for another older person in poor health.

Exhibit 5 – Cost of services for older population



Note: [1] SEMI refers to Serious and Enduring Mental Illness
[2] Patient level data has been used to calculate disease prevalence for each age group, however, the proportion of elderly patients in the SEMI and learning disabilities categories may be artificially high due to poor data quality and errors in coding. It has not been possible to validate the extent to which this may be an issue

Source: CCG 14/15 spend by POD, Monitor Ready Reckoner Tool, Carnall Farrar analysis

3.3 There are widespread inequalities across K&M

There is a wide spread of deprivation across K&M, which comprises some of the most affluent and the least affluent districts in England. Deprivation across K&M is shown in Exhibit 6 – this shows deprivation at the level of local authority and it is important to note that when viewed at a more local level, high deprivation is present across K&M[29].

Exhibit 6 – Deprivation levels across K&M

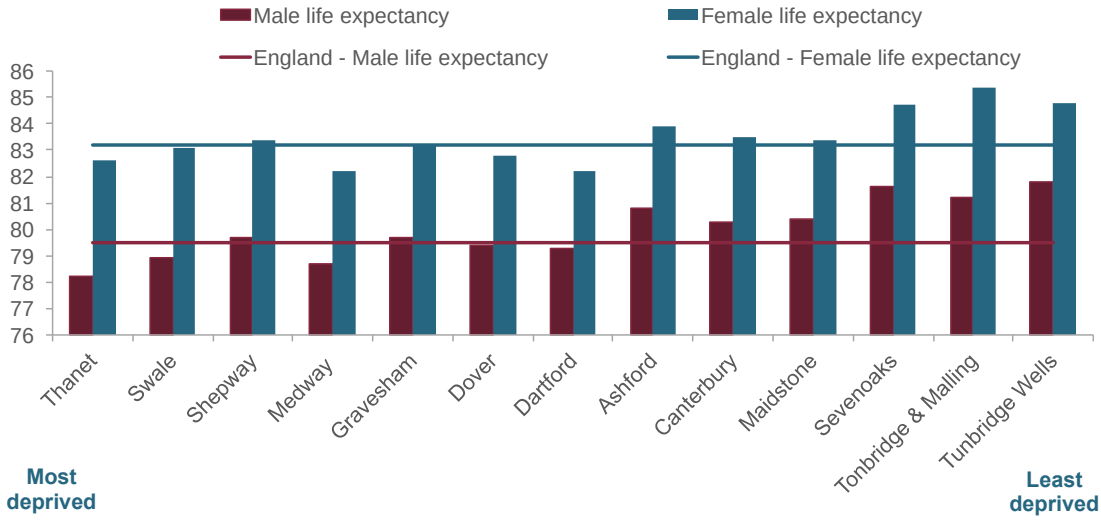
Quartile[1]	1	2	3	4
IMD score	12.9	18.1	25.2	42.0
	Least deprived			Most deprived

Local Authority District	IMD Score (2015)[1]
Thanet	31.6
Swale	25.7
Shepway	22.8
Medway	22.3
Gravesham	21.7
Dover	21.6
Dartford	17.8
Ashford	17.3
Canterbury	16.9
Maidstone	15.6
Sevenoaks	11.6
Tonbridge and Malling	11.3
Tunbridge Wells	11.0

Note: 1. Local Authorities of England have been divided into four groups of according to their Index of Multiple Deprivation (IMD) score; the 25% least deprived lie in quartile 1, while the 25% most deprived lie in quartile 4.
Source: Index of Multiple Deprivation 2015 (by local authority)

Poverty and deprivation are key causes of poor health outcomes. Higher levels of deprivation are linked to many health problems, such as prevalence of long term health conditions. As a result, deprivation is linked to poorer health outcomes, such as a lower life expectancy, as shown in Exhibit 7[30]. There are stark inequalities in life expectancy; for example, women in the most deprived areas in Thanet live on average 22 years fewer than those in the least deprived[31].

Exhibit 7 – Difference in life expectancy across K&M



Difference between life expectancy (LE) and healthy life expectancy (HLE), years

	Males			Females		
	LE	HLE	Difference	LE	HLE	Difference
Kent	80	64	16	84	64	**20**
Medway	78	62	17	82	60	**22**
England	80	63	16	83	64	**19**

Source: Index of Multiple Deprivation 2015 (by local authority); Office for National Statistics 2015

Lifestyle behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death[32]. As shown in Exhibit 8, the most deprived areas of K&M have higher levels of obesity[33], more children living in poverty[34] and more people who smoke[35]. Screening levels for diseases such as breast cancer are also lower[36]. Importantly, lifestyle and clinical risk factors tend to cluster in the same individuals and groups of people; for example, Thanet has the 4th highest rate of mortality from liver disease (considered preventable) in the South East and is one of the most deprived areas of the country[37]. Although mortality rates overall are falling, the gap in mortality between the most and least deprived areas in K&M has persisted for years[38].

Exhibit 8 – Lifestyle choices in areas of greater deprivation

Key

Better than national average | Within 5% of national average | Worse than national average

Least to most deprived

	Indicator	Tunbridge Wells	Tonbridge & Malling	Sevenoaks	Maidstone	Canterbury	Ashford	Dartford	Dover	Gravesham	Medway	Shepway	Swale	Thanet	England
Children	Excess weight in 4-5 year olds	21	21	21	21	20	24	26	25	23	22	24	23	25	22
	Excess weight in 10-11 year olds	30	29	28	32	33	34	36	34	39	34	35	33	35	33
	Children in poverty (2013)	10	12	12	14	17	16	15	21	20	21	22	23	26	19
	Low birth weight at full term	2	2	3	2	3	1	2	2	3	3	2	2	2	3
	Breastfeeding initiation at 48hrs	85	77	N/A	76	75	71	67	N/A	N/A	69	71	64	67	74
	Infant mortality rate/1000 live births (2012-14)	3	2	3	2	4	3	2	3	4	3	4	3	4	4
Adults	Smoking prevalence (2015)	15	x	16	13	15	15	19	30	16	22	16	18	19	17
	Physically inactive adults (2015)	24	24	20	24	24	30	25	32	27	29	28	28	35	29
	Breast cancer screening coverage	77	76	76	80	79	77	70	79	76	76	78	78	76	75
	Cervical cancer screening coverage	78	79	79	78	75	77	77	78	75	76	76	77	75	73
	Admission for alcohol related conditions	467	429	445	511	689	409	650	502	695	441	549	486	601	641

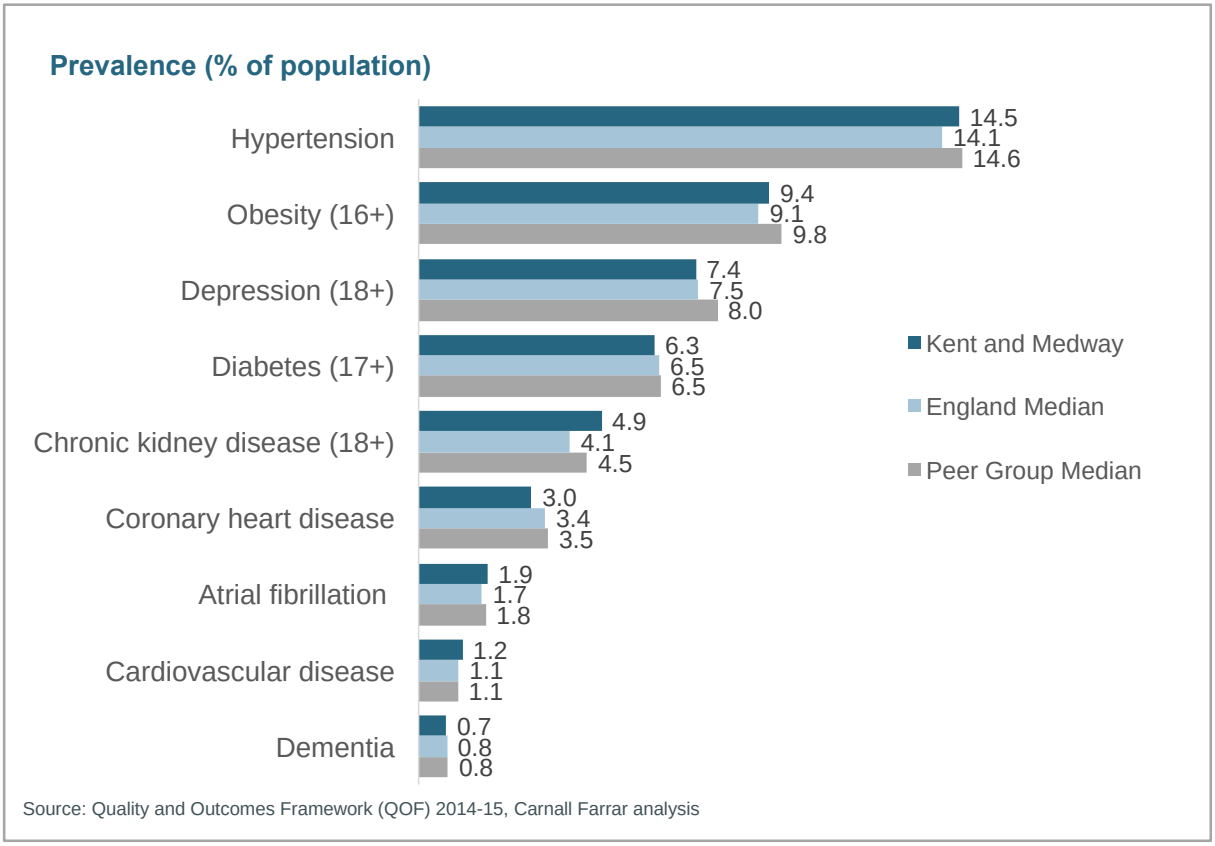
Notes:
Data is qualified as statistically better than England average if it is greater than 5% of the average
All figures in % and for 2014/15 unless indicated

Source: Public Health Outcomes Framework Data Tool, data collated by Public Health England, 2DSR; Index of Multiple Deprivation (2015)

3.4 People are living in poor health with preventable long term conditions

A long-term condition is a health problem that is present for over a year. There are 528,000 people (including 19,000 children) in K&M with one or more significant long-term condition. There are high levels of obesity, depression, diabetes (in adults) and asthma, and very high levels of hypertension (high blood pressure) compared to the national average and other similar places[39]. On average, a person with a long-term condition requires six times more health and social care support as a generally healthy person[40].

Exhibit 9 – Prevalence of disease in K&M



As the population gets even older, more people are likely to have a long-term condition[41]. This is a challenge for health and social care services because people with one or more long-term condition need high quality, consistent and integrated health and social care. People with a long-term condition are also likely to have a long term informal carer (such as a spouse or grown-up child) and these carers also need to be supported.

3.5 There are differing levels of health and social care needs

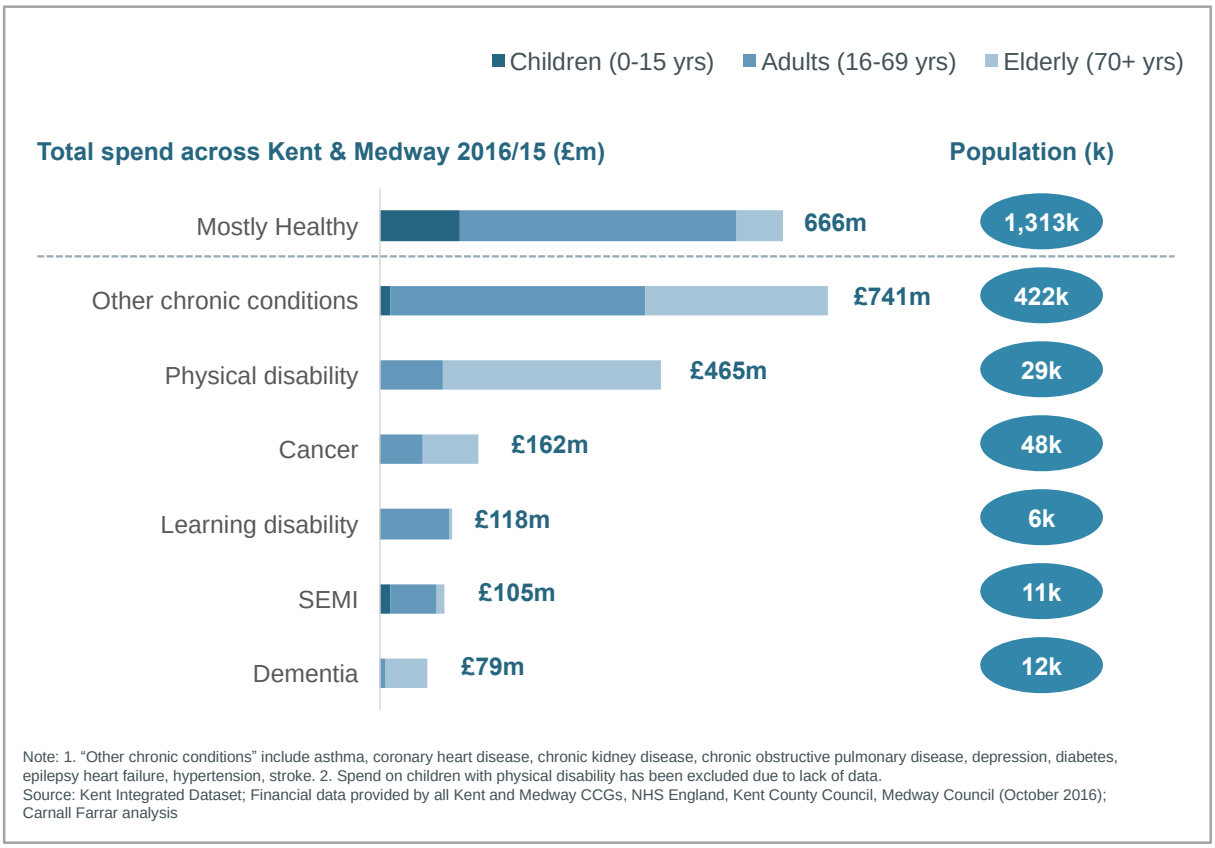
One way of understanding the needs of local people is to break down the population into different groups. This can be done by grouping people of a similar age and with similar health needs. The analysis can then be used to identify how work across health and social care can achieve a greater impact, and estimate the potential benefits that can be achieved through interventions targeting particular groups.

Exhibit 10 shows that there are around 1.3m people (71% of the population) in K&M who are mostly healthy and use an estimated 29% of health and social care. However, there are around 528,000 (29%) people with one or more significant long-term condition, who use an estimated £1.7bn (71%) of health and social care; the estimated 167,000 older people with long term conditions are particularly high users of health and social care (c. £5k per person per annum).

There are an estimated 11,000 people in K&M with severe mental illness who are individually very high cost (for example, c. £9k per person per year for those over 70), as are those with learning disabilities and severe physical difficulties; an estimated £182m is spent on approximately 12,000 adults with a physical or learning disability in K&M (c. £18k per person per year)[42]. Reported dementia affects an estimated 12,000 people, with an estimated spend of around £79m per year spent on this group (an average of nearly £7k per person per year). There are also around 48,000 people with cancer, costing an estimated £162m per year in total.

The calculation used to generate these figures is shown in more detail in Appendix 1.

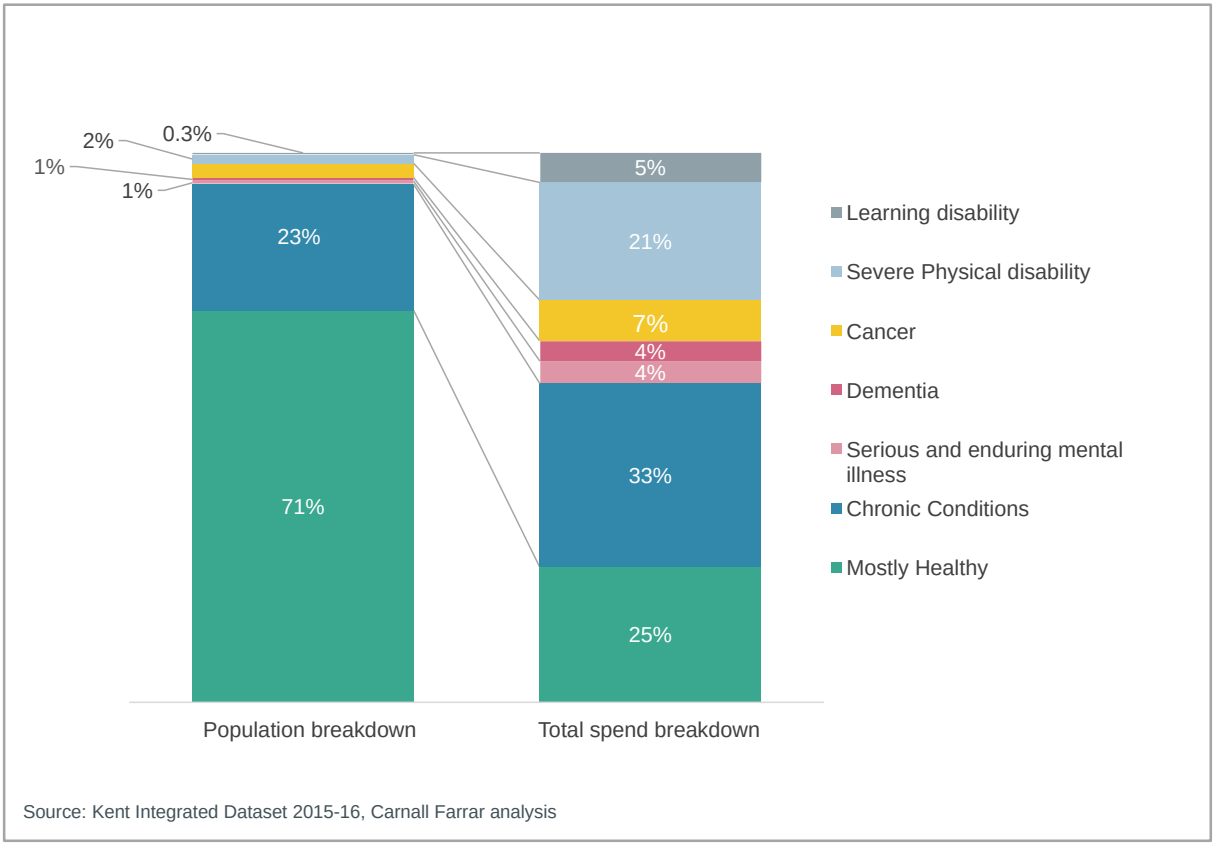
Exhibit 10 – K&M health and care segmentation, 2015-16



Note: 1. "Other chronic conditions" include asthma, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, depression, diabetes, epilepsy heart failure, hypertension, stroke. 2. Spend on children with physical disability has been excluded due to lack of data.
Source: Kent Integrated Dataset; Financial data provided by all Kent and Medway CCGs, NHS England, Kent County Council, Medway Council (October 2016); Carnall Farrar analysis

Exhibit 11 shows the same information in a different format. It shows that, in K&M, around 29% of local people use 75% of health and social care.

Exhibit 11 – Use of health and social care by different groups, 2014-15



Source: Kent Integrated Dataset 2015-16, Carnall Farrar analysis

This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high quality services are available when required for the majority of local people who are not high users of services.

3.6 Many people (including children) have poor mental health, often alongside poor physical health

Mental illness is relatively common in K&M with around 231,000 local people aged 18-64 having a common mental disorder such as depression or anxiety[43] and some 13,000 people having a more serious mental illness such as schizophrenia[44].

The number of people with a mental health disorder in K&M is generally in line with the rest of England but mental health problems disproportionately affect people living in the most deprived areas, as shown in Exhibit 12.

Exhibit 12 – Correlation between deprivation and mental health outcome

Key: Better than national average; Within 5% of national average; Worse than national average

Least to most deprived

		Year	West Kent	C&C	Ashford	D,G &S	Medway	SKC	Swale	Thanet	England
All ages	Socioeconomic deprivation: overall IMD score (2015)	2015	12	17	17	19	22	23	27	32	22
	Learning disability prevalence , %	2014/15	0.34	0.44	0.41	0.26	0.38	0.66	0.42	0.61	0.44
Children and young people	Prevalence of any mental health disorders in children (5-16 yrs),%	2014	8.2	9.0	8.9	9.2	9.6	9.6	9.8	9.9	9.3
	Prevalence of emotional disorders in children (5-16 yrs),%	2014	3.2	3.5	3.5	3.5	3.7	3.7	3.8	3.8	3.6
Adults	Estimated prevalence of common mental health disorders %	2014/15	12	13	13	12	16	12	12	13	16
	Serious mental illness prevalence, all ages[1],%	2014/15	0.7	0.9	0.7	0.7	0.6	0.8	0.6	1.0	0.9
	Adults with depression known to GPs	2014/15	7.0	7.6	8.6	5.6	8.3	7.5	7.8	9.0	7.3
Older people	Dementia prevalence, all ages[1],%	2014/15	0.8	0.9	0.7	0.7	0.5	0.9	0.7	0.8	0.7

Notes:
Data is qualified as statistically better than England average if it is greater than 5% of the average
All figures in % and for 2014/15 unless indicated

Source: Public Health of England (2016); 1 QOF data (2014/15); 2 RightCare Atlas of Variation; Index of Multiple Deprivation, CCG (2015); Carnall Farrar analysis

People with mental health conditions are more likely than the general population to have a lifestyle that leads to poor physical health. For example, almost half of adults with severe mental illness are smokers, compared to less than a quarter of people without a severe mental illness [45]. It is also well established that people with a mental illness often also have poor physical health.

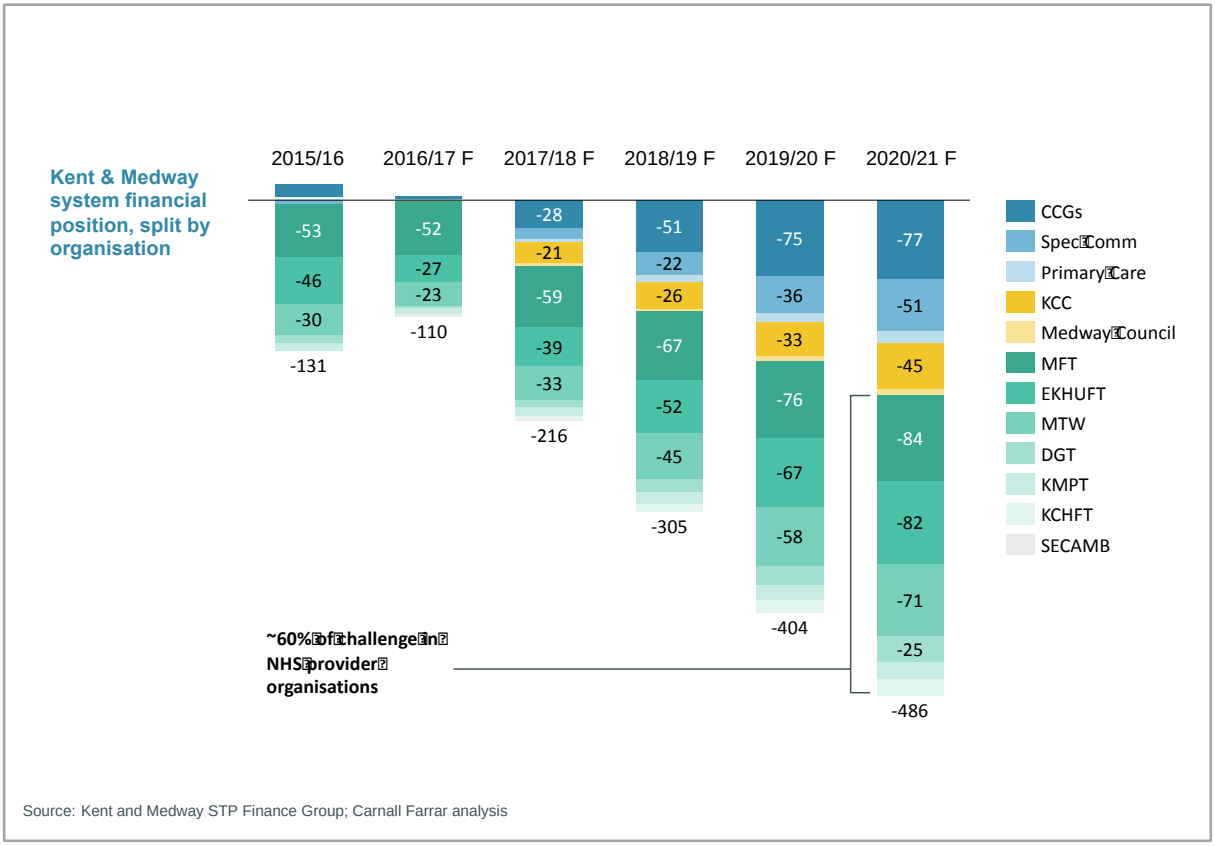
Approximately one in ten children in K&M aged 5 to 16 has a diagnosable mental health problem (this is similar to the national average), and there are many 'at risk' groups. Children from low income families are at highest risk of having poor mental health[46]. In K&M, there are large numbers of children who are living in deprived households, are asylum seekers or are looked after:

- in total, there are over 59,000 children in low income families in K&M. This makes up 17% of children (under 16) in Kent and 21% of children in Medway[47]. The national average is 19%[48].
- there are currently 3,000 looked after children, including 900 unaccompanied asylum seekers – a group which has grown by 77% in Kent over the last four years[49].

3.7 There is a substantial financial challenge facing health and social care organisations in K&M

There is a substantial financial challenge facing health and social care organisations in K&M. Health commissioners and providers are already £110m in deficit in 2016/17 and, if nothing changes, will be £486m in deficit by 2020/21[50]. Exhibit 13 summarises the 'do nothing' financial gap for K&M.

Exhibit 13 – K&M forecast financial gap



Source: Kent and Medway STP Finance Group; Carnall Farrar analysis

The consequence of doing nothing is that local health and social care services would not be maintained. A new way of providing services is needed, that can be delivered within the funding available. This cannot be done by one organisation, but needs to be done across health and social care, with everyone working together.

4. Key challenges

4.1 There needs to be a greater focus on prevention, especially in more deprived areas

The majority of people in K&M are generally healthy and well – around 71% of local people use health and social care services only occasionally[51]. Empowering people, families and communities to stay healthy, including having good mental health, means they need less health and social care in future. However, many of these people, especially those aged 40+, are at risk of developing long term health conditions such as obesity, raised cholesterol and high blood pressure and the older people get, the more likely they are to have multiple long term conditions and an increased sense of loneliness[52].

People who already have a long-term health condition can also be supported to reduce the risk of their condition becoming worse. For example, there are opportunities for better management and control of long term health conditions in primary care. For example, within K&M in 2015/16, the number of people with detected high blood pressure who did not sufficiently lower their blood pressure, putting them at risk of stroke and other acute problems, ranged from 58% to 93% across GP practices[53].

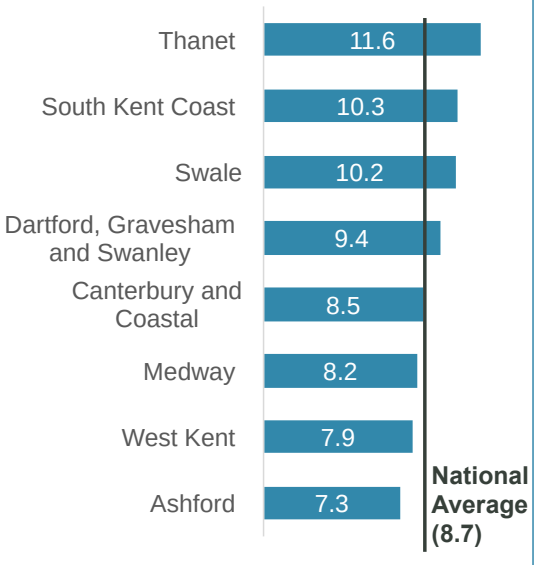
Around 1,600 early deaths each year in K&M are considered avoidable if more effective public health and medical interventions had been in place [54]. For example, chronic obstructive pulmonary disease (COPD) is a common cause of early death and this is almost completely avoidable as most cases (85%) are caused by smoking[55]. Exhibit 14 shows that Thanet, Swale and South Kent Coast have particularly high levels deaths that could have been avoided.

Exhibit 14 –Deaths that could have been avoided in K&M

Observed premature deaths
2009 - 2013

	Male	Female	Total
2009	1,005	726	1,731
2010	1,004	727	1,731
2011	931	676	1,607
2012	903	625	1,528
2013	914	670	1,584
5 year average	951	685	1,636

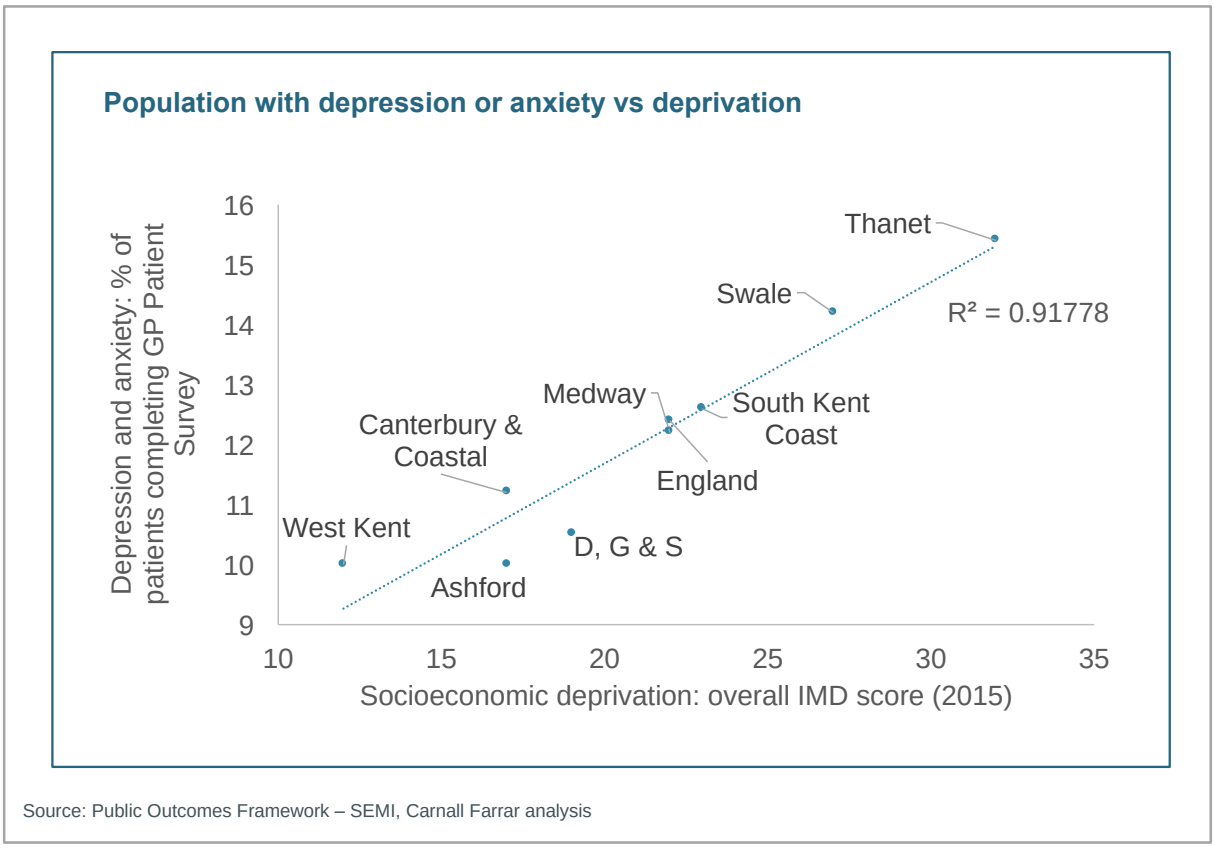
Premature death as proportion of the CCG population, %, 2013



Source: Public Health Outcomes Framework, 2014-15

Levels of deaths that could have been avoided may be linked to the fact that people living in K&M are worse than the national average for a number indicators relating to health and wellbeing, such as levels of obesity, smoking rates and children living in poverty[56]. These indicators are worse in more deprived areas such as Swale and Thanet, which helps to explain the higher number of preventable deaths. It is also worth noting that people living in poorer areas not only die sooner, but spend more of their lives with disability – an average of 17 years in total[57].

Exhibit 15 – Correlation between level of wealth and performance on indicators of poor future health outcomes

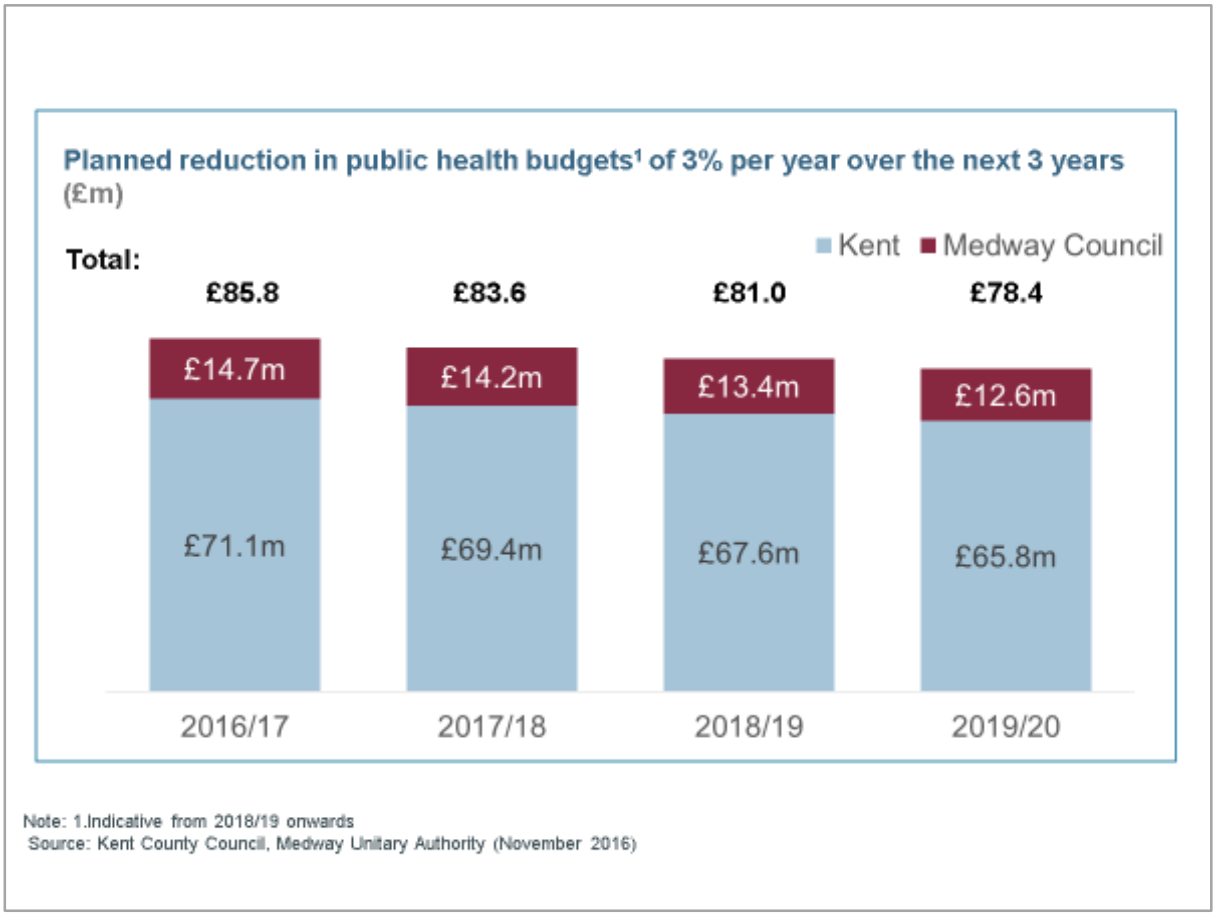


Source: Public Outcomes Framework – SEMI, Carnall Farrar analysis

These health inequalities are caused by many things – housing, income, education, social isolation, disability – and these are strongly affected by economic and social status. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. Health and social care services cannot address all of these areas but can address some of them. To reduce health inequalities, the Marmot Review recommends that the highest priority be given to giving every child the best start in life and also to strengthen the role and impact of ill-health prevention[58]. There is also evidence that increased investment in primary care can reduce health inequalities[59].

A focus on prevention and early intervention is therefore very important in improving health and wellbeing for local people, particularly those in more deprived areas. Despite this, only 2% of health and social care funding is spent on public health in K&M (that is, both care services and lifestyle intervention services to reduce the risk of avoidable disease and disability) and budgets are expected to decline by 9% over the next 3 years (3% per year) through the reduction in the national Public Health Grant[60].

Exhibit 16 – Planned reduction in public health budget



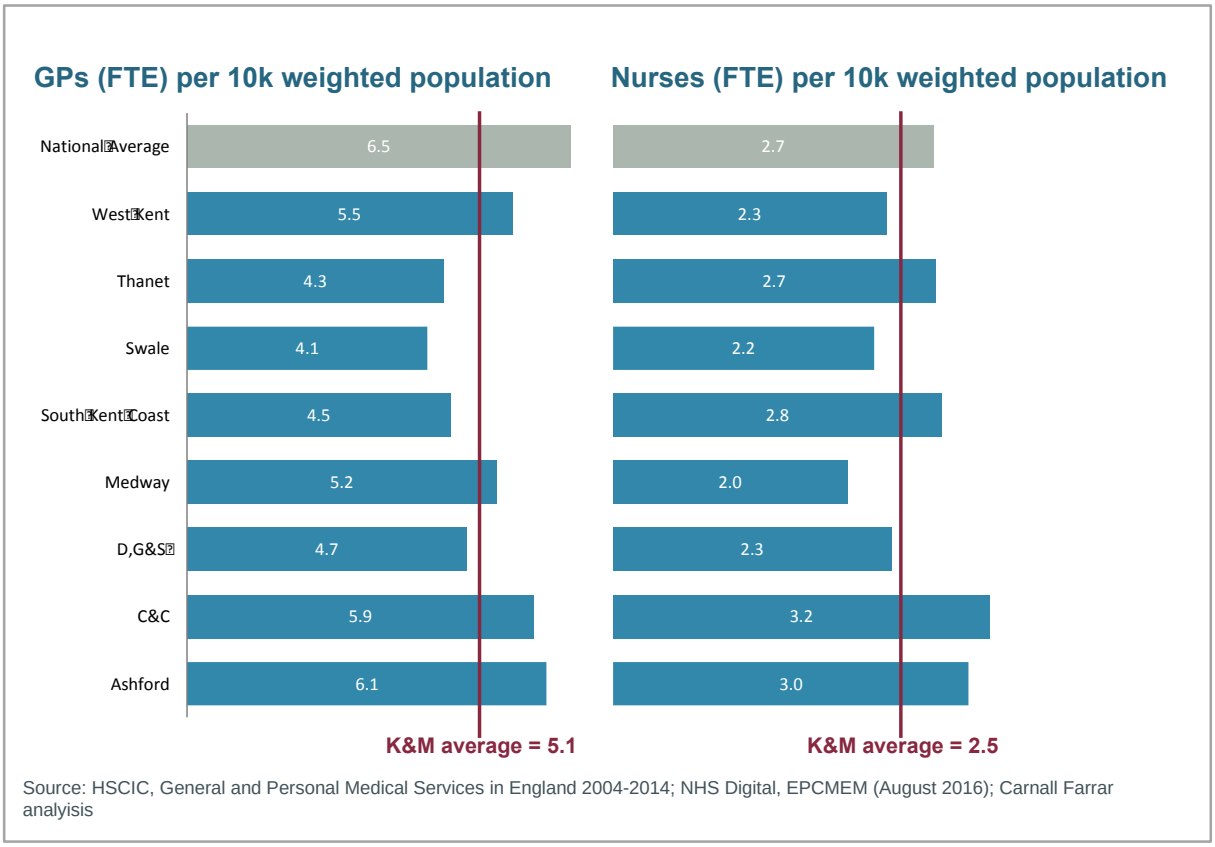
This requires a focus on health promotion and ill health prevention, particularly around those who are healthy and well but are at risk of developing long term health conditions. Investment in preventing ill health will be crucial to achieve this.

4.2 There are challenges in primary care, which is extremely fragile in some areas

Primary care includes GPs, practice nurses, pharmacists, opticians and dentists. They are usually the first point of contact for people with a health problem and are crucial in health promotion, treating minor illness, signposting to other health and social care services and managing people with more complex needs. Fragility within primary care is characterised by low numbers of GPs and practice nurses per head of population (meaning that access to primary care services is difficult), high vacancy rates and high locum use (meaning GPs and practice nurses do not know the patients or the services available locally). Nationally, funding for primary care is 8% of health spend; this should rise to almost 11% by 2020[61].

Some people in K&M are unhappy with existing GP services; on average 76% would recommend their GP surgery to a friend, compared to 78% nationally (this varies between 68% in Medway CCG and 84% in Canterbury & Coastal CCG)[62]. People find it difficult to contact their GP surgery and there are long waits to be seen when they get there[63]. This might be partly explained by the low number of GPs and practice nurses in many parts of K&M. As shown in Exhibit 17, half of the CCGs in K&M have low numbers of GPs and practice nurses compared to the national average, with particularly low levels of GPs in Thanet and Swale and practice nurses in Medway and Swale[64]. This means that there would be 245 more full-time GPs and 37 more full-time practice nurses in K&M if the area had the same numbers as the national average. It is also worth noting again that Thanet and Swale are the most deprived areas in K&M.

Exhibit 17 – K&M levels of primary care staff compared to national levels



Source: HSCIC, General and Personal Medical Services in England 2004-2014; NHS Digital, EPCMEM (August 2016); Carnall Farrar analyisis

There are also very high levels of vacancies across primary care in K&M, with an estimated 136 GP vacancies across K&M (12% of the total number of GPs), and 53% have been vacant for more than a year[65]. This creates a dependency on locum GPs - on average locum doctors constitute 8% of the GP workforce in K&M[66]. The situation is likely to get worse as 30% of GPs in K&M are aged 55 and over and are therefore expected to retire in the next 10 years[67]. This is compared to 22% nationally[68]. Furthermore, there are challenges in recruiting practice nurses; every single one of the vacancies reported in a recent survey of practices been open for more than 6 months[69].

Community pharmacy is facing significant challenges; pharmacists nationally will see their funding fall over the next two years[70]. The 335 pharmacies in K&M[71] play a central role in the delivery of primary care via the provision of medication and associated products, information and practical help on keeping healthy[72]. They are also taking on more of the clinical roles that have traditionally been undertaken by doctors; for example, the management of asthma and diabetes as well as blood pressure testing[73]. Pharmacists may respond to the reduction in funding by taking steps to reduce costs, such as by reducing opening hours and staffing, or by stopping the provision of services they do not have to provide (such as the home delivery of medicines)[74].

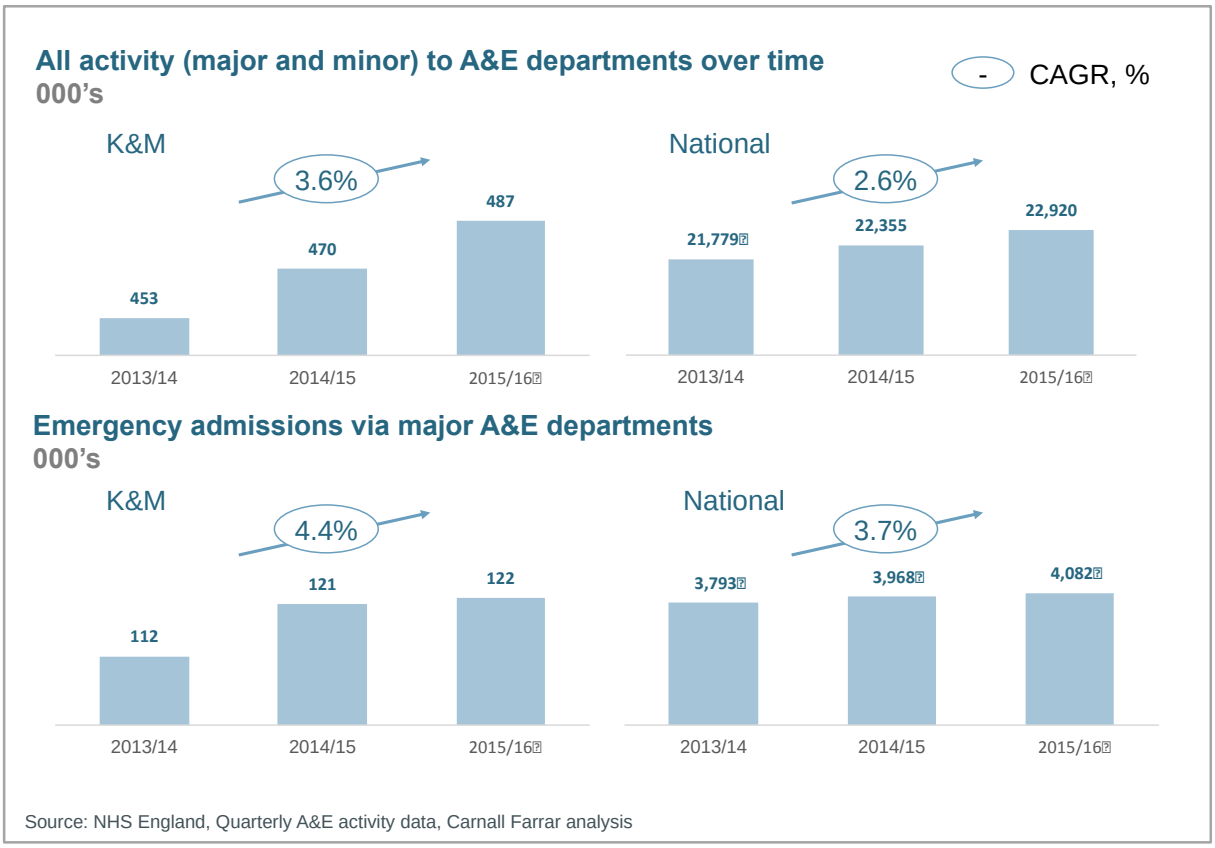
Fragility in primary care services is an issue because it can lead to:

- Later identification of disease if early indicators of disease such as obesity and smoking are not identified and addressed in primary care. In K&M, for example, there are low levels of early detection of heart disease and dementia and low levels of immunisation for people with COPD[75].
- More complications and worsening of disease if monitoring of people with long term conditions is not comprehensive. In K&M, for example, there are high lengths of stay in

hospital for children with asthma[76] and low numbers of asthma and arthritis patients who have had preventative reviews[77].

- Increasing activity in hospitals if local people use A&E rather than their local GP surgery for urgent care. In K&M, attendances at A&E departments has risen by around 3.6% per year over the last three years, compared to 2.6% nationally; this would be an increase in A&E attendances of over 70,000 per year by 2020/21 if noting changes[78]. This is shown in Exhibit 18. If attendance continues to rise in line with current trends, we can expect that there will be over 560,000 people visiting A&E in 2020/21 (15% higher than current levels).
- Pressure on mental health services if poor mental health is not identified until it results in a crisis. For example, in parts of K&M attendances to A&E for psychiatric disorder in adults is significantly higher than the national average[79].

Exhibit 18 – Rise in A&E attendance and emergency admissions in K&M



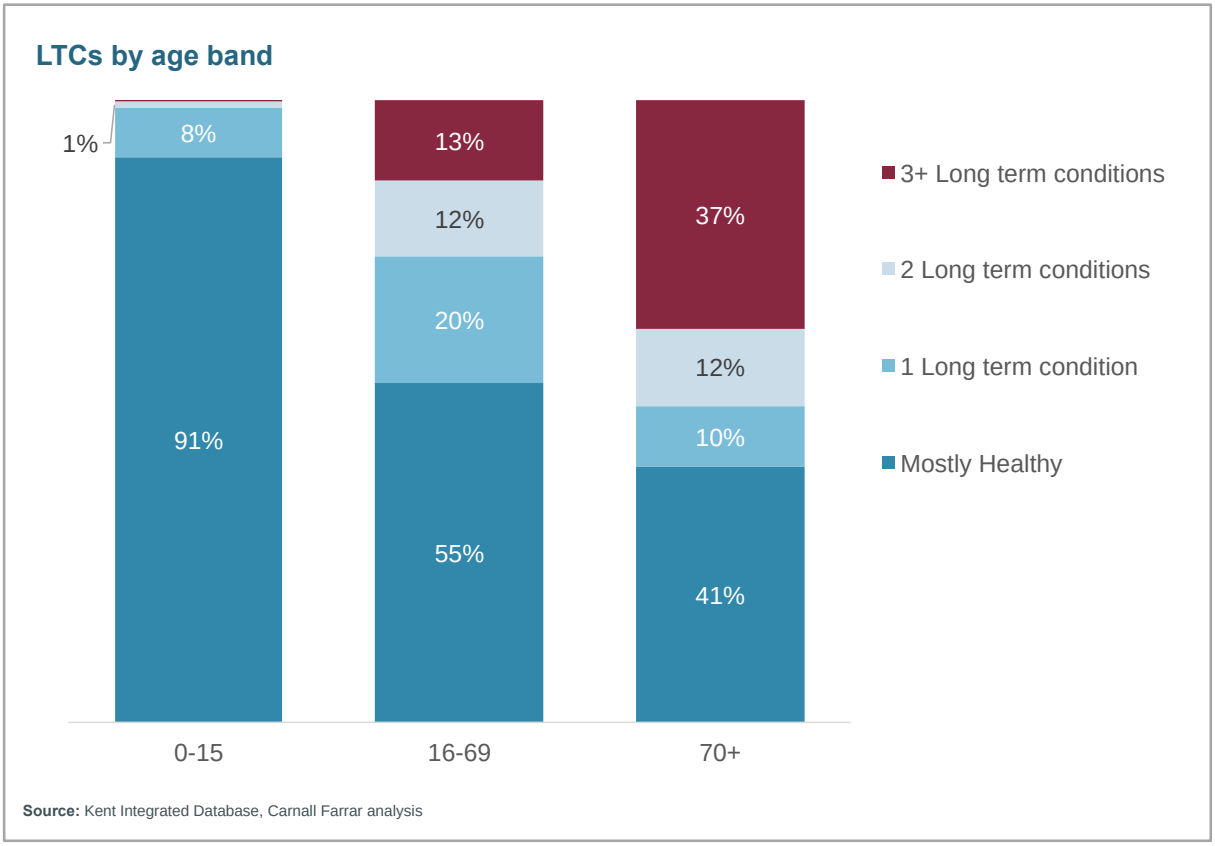
Source: NHS England, Quarterly A&E activity data, Carnall Farrar analysis

This requires that a priority area for focus is recruitment and retention of primary care staff, especially GPs.

4.3 There are gaps in service and poor outcomes for those with long term health conditions-

There are over 528,000 people in K&M with a significant long term health condition and many people have multiple long term health conditions, resulting in complex needs[80]. The number of people with multiple long term health conditions tends to increase as the population ages, as shown in Exhibit 19; in Kent one third of people over the age of 70 have three or more long term health conditions such as asthma, diabetes and hypertension[81].

Exhibit 19 – Number of long term health conditions in K&M by age



Many people with long term health conditions in K&M do not feel supported to manage their condition – this is the case for up to 45% of people in Dartford[82]. There are also high levels of admissions to hospital for some people with chronic conditions. Evidence from elsewhere suggests that 25-40% of emergency admissions could be avoided if alternative care was available outside hospital[83].

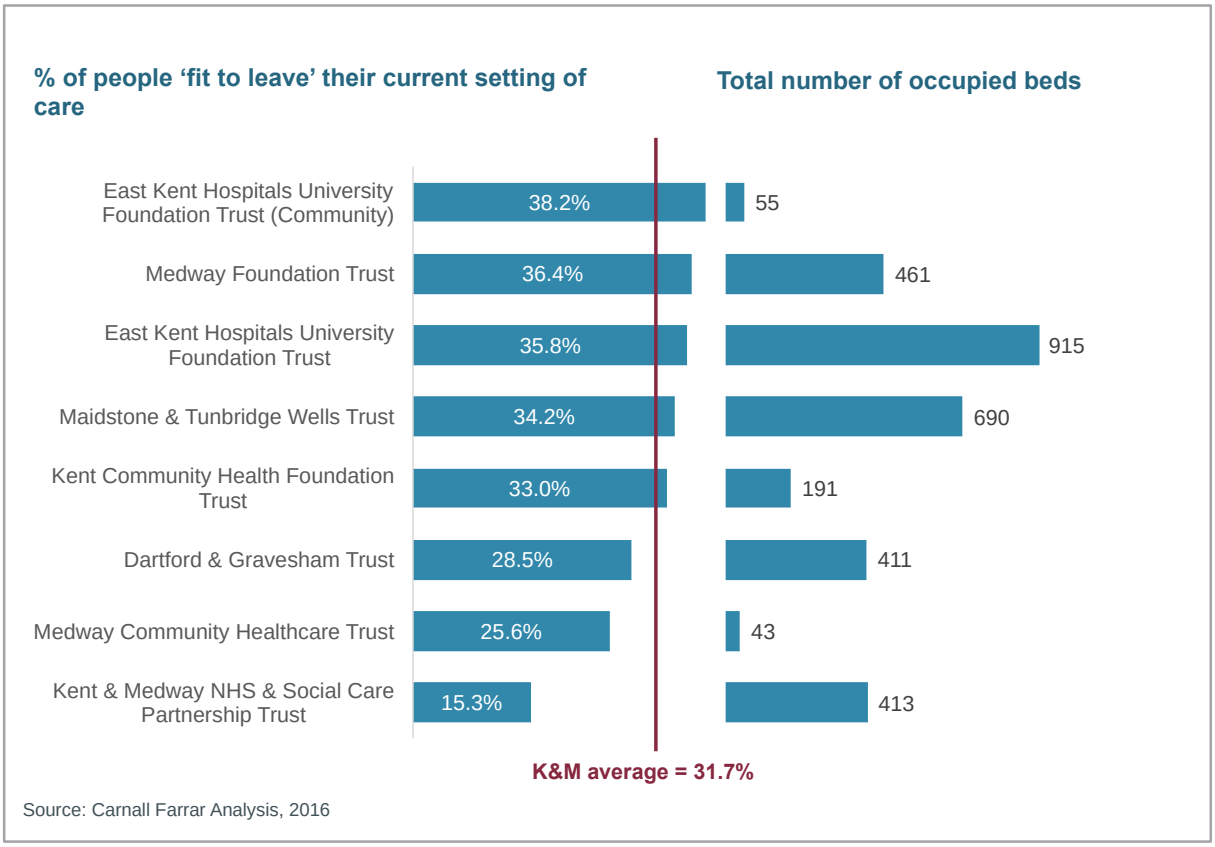
Many people with long term health conditions are looked after by unpaid carers, who are often elderly and may have their own long term health conditions. However, health and social care services rely on these carers to support people who are ill. Fewer than half of all carers in K&M are satisfied with their experience of care and support and only a third have as much social contact as they would like[84].

This requires that a priority area for focus is avoiding hospital admissions for people with long-term conditions and supporting their carers.

4.4 Many people are in hospital who could be cared for elsewhere

When people go to hospital in K&M, they tend to stay in hospital for a long time and have difficulty getting out of hospital and back home. Every day over 1,000 people are in local hospitals when they could be elsewhere[85], as shown in Exhibit 20 (this is similar to other hospitals in England). The vast majority of these patients are over the age of 70 and more than half are over the age of 85. A third of all people in acute hospitals who are medically fit have been medically fit for over a week, whilst 43% of people in community hospitals have been medically fit for over a week.

Exhibit 20 – Proportion of people who are medically fit to leave hospital



When people are ready to leave hospital, local services are often not ready to look after them, so they must stay in hospital longer. More time spent in hospital does not necessarily mean better outcomes – often the reverse – and many people could be cared for sooner, at home. Longer stays are not always driven by medical need and can be harmful to health – the longer the stay, the greater the risk of getting infections[86], muscle decline[87], becoming less able to walk or do everyday tasks, less able to return home and more likely to need residential or nursing care[88]. It is also expensive – it costs, on average, £220 per day[89] to care for someone in an acute hospital bed and this money could be better used elsewhere. People would also rather not die in hospital; only 43% of people who die in K&M can do so in their usual place of residence[90] even though, given a choice, most declare their home to be their preferred place of death[91].

Some of the main causes of delay are awaiting care home placement (14%) and awaiting a care package in their own home (14%)[92]. These services are often unable to accept transfers or set up care packages at weekends, so people who are medically fit are stuck in hospital and needing such support. In K&M, there are issues with:

- **the availability of social care:** the majority of patients medically fit to leave hospital require basic essential care such as feeding and washing[93].
- **the quality of residential care:** over 40% of local residential care homes are rated as inadequate or requires improvement by the Care Quality Commission[94].
- **the availability of nursing home care:** there are also issues with the availability of nursing home care; over the last year there has been a significant reduction in nursing home beds in K&M and 25 (8%) have closed in the last two years[95].

- **care outside hospital for people with dementia:** an estimated one third of the people who are in a hospital bed and are medically fit to leave also have dementia[96] – and care homes are often unable to accept people with dementia, especially at short notice.

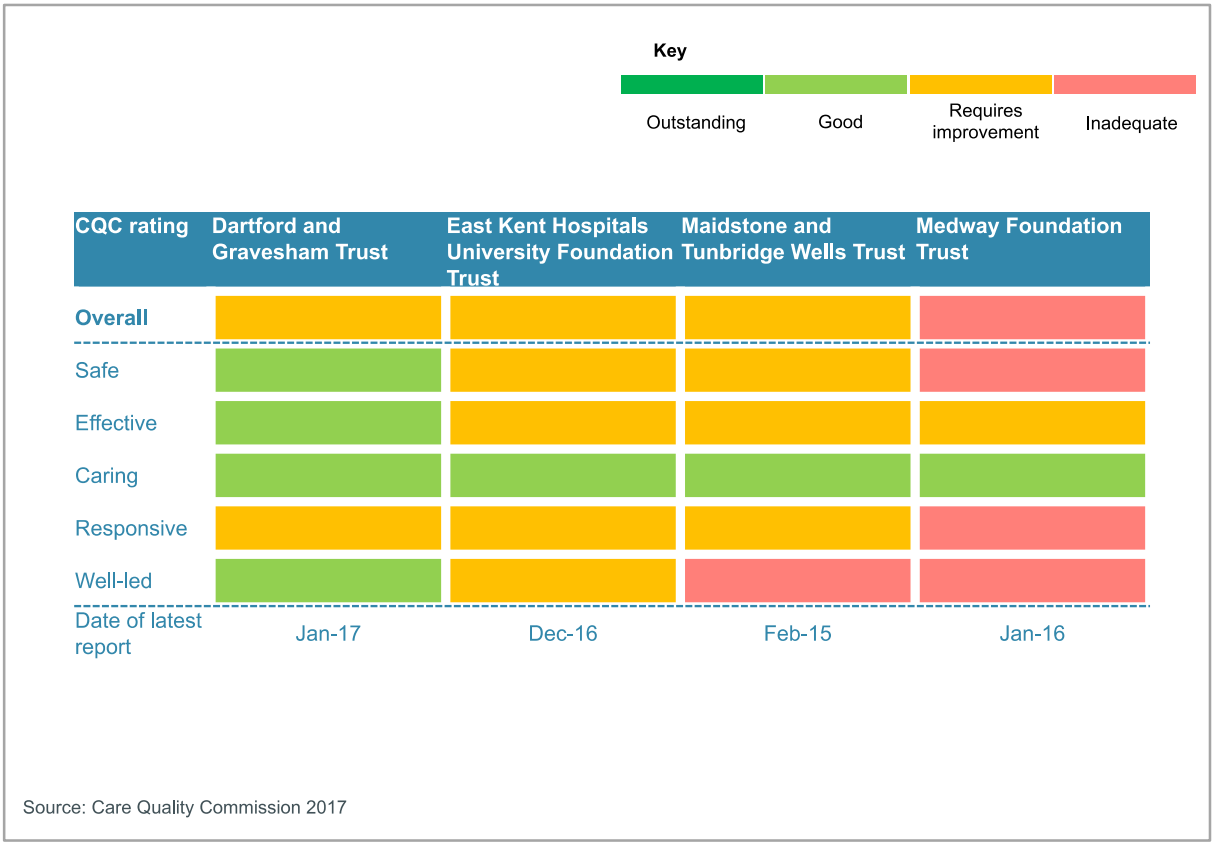
Delays in discharge contribute to a poor experience for local people – especially at weekends – and can have a lasting negative impact on independent living. It also represents poor value for money because hospital services are being used by people who are medically fit to leave the hospital.

This requires that a priority area for focus is reducing the length of stay in hospitals especially for older people, in partnership with social care.

4.5 Some local hospitals find it difficult to deliver services for seriously ill people

Some local hospitals are finding it difficult to provide care for a small number of seriously ill people who use hospital services. Exhibit 21 shows the most recent Care Quality Commission (CQC) ratings for local providers which shows some require improvement or are rated inadequate in one or more areas. Hospitals need senior doctors seven days a week to make sure that there is someone with sufficient skill and experience to spot problems and deal with them, and that care is effective when it is needed. Doctors, nurses and technical staff also need a minimum number of cases to maintain the high levels of expertise needed in these services. Specialist tests and equipment also need to be available 24 hours a day. Evidence shows that it is better for seriously ill people to travel further for this more specialist care[97].

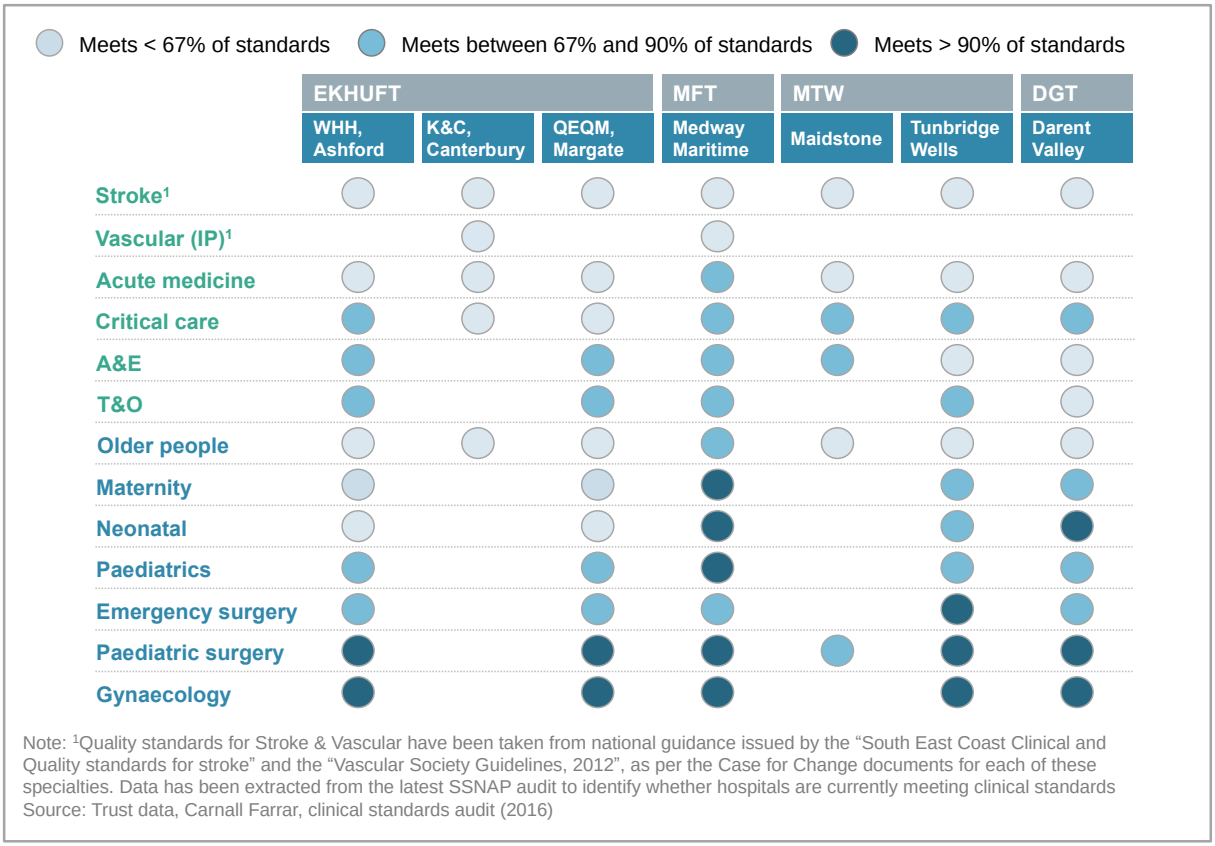
Exhibit 21 – Overview of CQC inspection ratings for the four acute trusts



There are a number of challenges facing services for some seriously ill people in K&M. There are some services in K&M that are small, and senior staff and specialist tests and equipment are not always

available 24 hours a day. This leads to issues with junior doctor training which needs to provide the quality of experience, levels of clinical supervision and services that satisfy training requirements. There are also issues with services outside hospital, particularly at weekends, making it difficult for people to go home when they are able. This leads to delays along the patient pathway; including waits to be seen by a senior doctor, for diagnostic tests, for a hospital bed, for treatment and to leave the hospital. This is shown across K&M in Exhibit 22.

Exhibit 22 – Results of the clinical standards audit



Note: [1]Quality standards for Stroke & Vascular have been taken from national guidance issued by the "South East Coast Clinical and Quality standards for stroke" and the "Vascular Society Guidelines, 2012", as per the Case for Change documents for each of these specialties. Data has been extracted from the latest SSNAP audit to identify whether hospitals are currently meeting clinical standards
Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Examples of key challenges include:

- In **stroke**, all the hospitals in K&M provide an emergency stroke service. There is now strong evidence that people who have a stroke need to have rapid access to a range of specialist interventions within the first 24 hours, in order to improve their chances of survival and minimise disability[98]. Local standards are that all eligible patients should be thrombolysed within 60 minutes[99]; none of the hospitals in K&M meets this standard and, in 2015/16, the worst performing trust only met the standard for 16% of cases[100]. National guidelines also state that specialist doctors, nurses and therapists should be available 24 hours a day, 7 days a week[101]; none of the hospitals in K&M achieve this across all three staff groups[102]. Performance of local hospitals against a range of guidelines and targets is shown in Exhibit 23.
- In **vascular**, there are several national guidelines about the number of cases that need to be seen at each hospital, access to specialist teams and specialist imaging[103]. There are two hospitals in K&M who provide emergency vascular services and neither meet the majority of the guidelines[104].

- In **acute medicine**, workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across most hospitals in K&M. National evidence shows that delays to consultant reviews and a lack of senior medical involvement in patient care are consistently linked to poor patient outcomes[105]. In some hospitals in K&M, senior doctors are not present at the weekend or are trying to cover more than one clinical area at a time[106]. Support services for discharge are also not always available at the weekend including pharmacy, social care and mental health liaison. This means people stay in hospital longer than they might if these services were available[107].

Exhibit 23 – Performance of hospitals in K&M against stroke standards and targets

Key: Above national average | In line with national average | Below national average

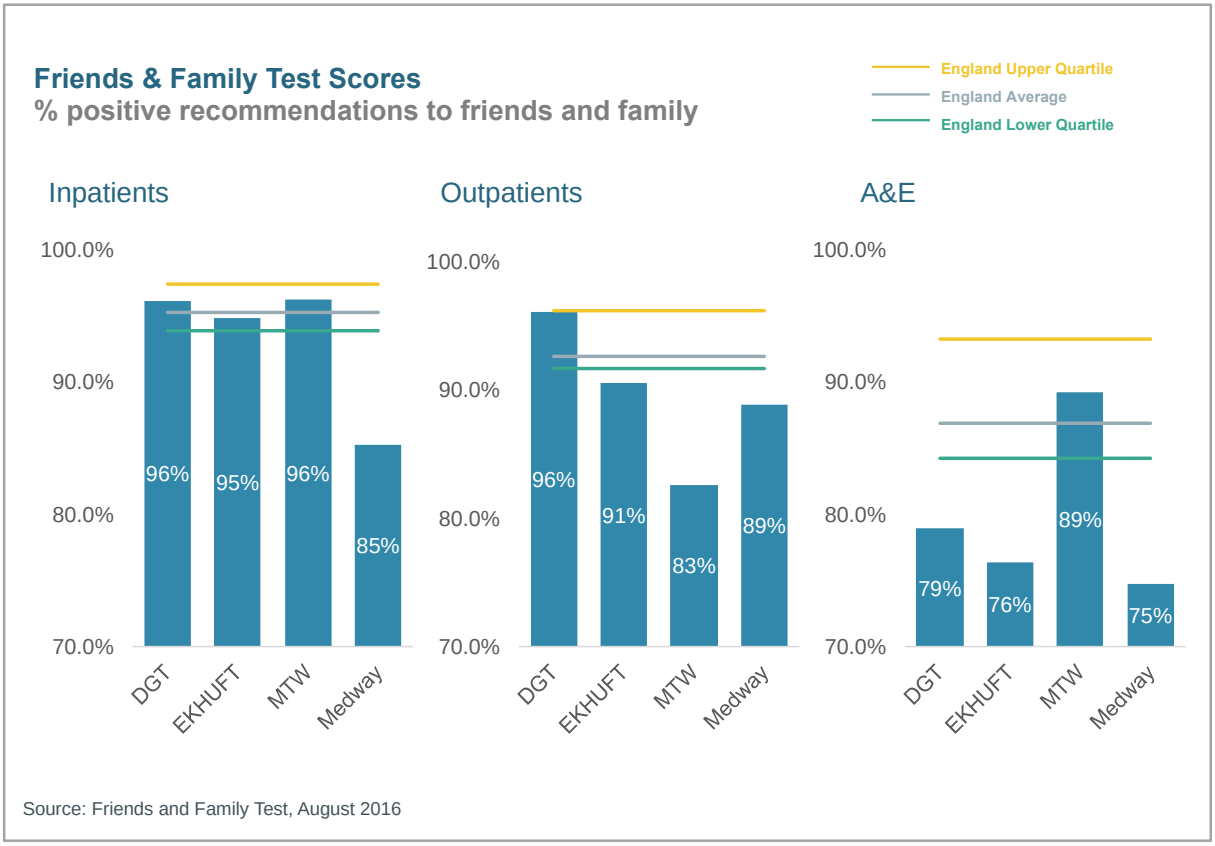
Aims	National recommendation/Target	DVH	MFT	MH	TWH	WHH	K&C	QEQM	National
Rapid and accurate diagnosis	Imaging within one hour of admission	50%	50%	55%	56%	61%	59%	69%	48%
Direct admission	Patients admitted directly onto a specialist stroke unit within four hours	41%	43%	56%	41%	53%	51%	60%	58%
	Patients stay in the stroke unit for 90% of the inpatient episode	84%	79%	87%	67%	84%	88%	85%	84%
Immediate access to treatment	Thrombolysis within 60 mins	42%	16%	43%	59%	60%	38%	48%	59%
	Speech and language therapy communication assessment within 72 hours of clock start	22%	67%	35%	39%	24%	26%	37%	39%
Specialist centres with sufficient numbers of patients and expert staff	Assess patients by specialist stroke consultant and within 24 hours.	62%	55%	61%	73%	81%	86%	91%	79%
Rapid assessment	Assess patients by stroke trained nurse and therapist within 24 hours.	91%	87%	91%	88%	87%	91%	89%	88%
SSNAP performance Q1 2016 (Apr-Jun)	Target: A	D	D	B	D	C	D	C	

Source: K&M Case for Change stroke, South East Coast Clinical and Quality standards for stroke, SSNAP audit (April 2015-Mar 2016)

The ambulance service is extremely stretched with increasing numbers of calls, especially time critical calls, and a deterioration in response times over the last three years; between 2013 and 2015 the number of Red 1 (serious and time critical) emergency calls to South East Coast Ambulance Service rose by 148% - 5 times faster than the national average of 30% whilst the proportion of total calls responded to within the national 8 minute target fell by 5%" (from 77% to 72%")[108].

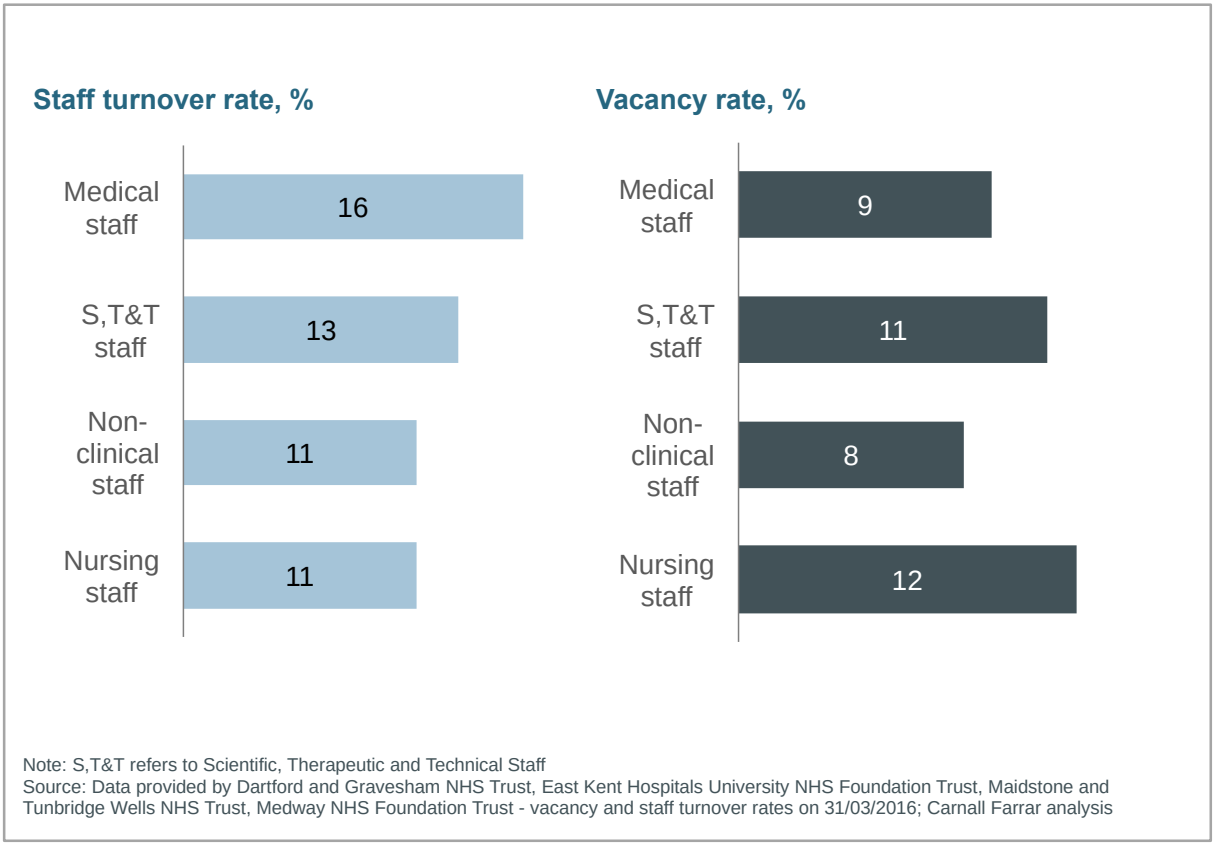
These challenges also result in poor access for patients; several hospitals in K&M have some of the worst patient satisfaction scores in the country for A&E. This is shown in Exhibit 24. Quality of services is the main issue of concern raised by patients accessing services in some part of K&M[109].

Exhibit 24 - Patient satisfaction scores for hospitals in K&M



The answer is not simply to recruit more doctors, however. Although there is a shortage of doctors in some specialties[110], even if the workforce was available, local doctors would not see enough patients to maintain their skills[111]. All local hospitals are having problems recruiting and retaining staff; as shown in Exhibit 25, there are average vacancy rates of around 10% and turnover of medical staff is 16%.

Exhibit 25 – Vacancy rates and turnover in K&M acute hospitals



Note: S,T&T refers to Scientific, Therapeutic and Technical Staff
Source: Data provided by Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust - vacancy and staff turnover rates on 31/03/2016; Carnall Farrar analysis

This requires a focus on specialised services which need to be configured so there is sufficient senior workforce to continue to provide high quality services. This needs to be balanced against the need to provide local access to services, where possible.

4.6 Planned care is not delivered as efficiently and effectively as it could be

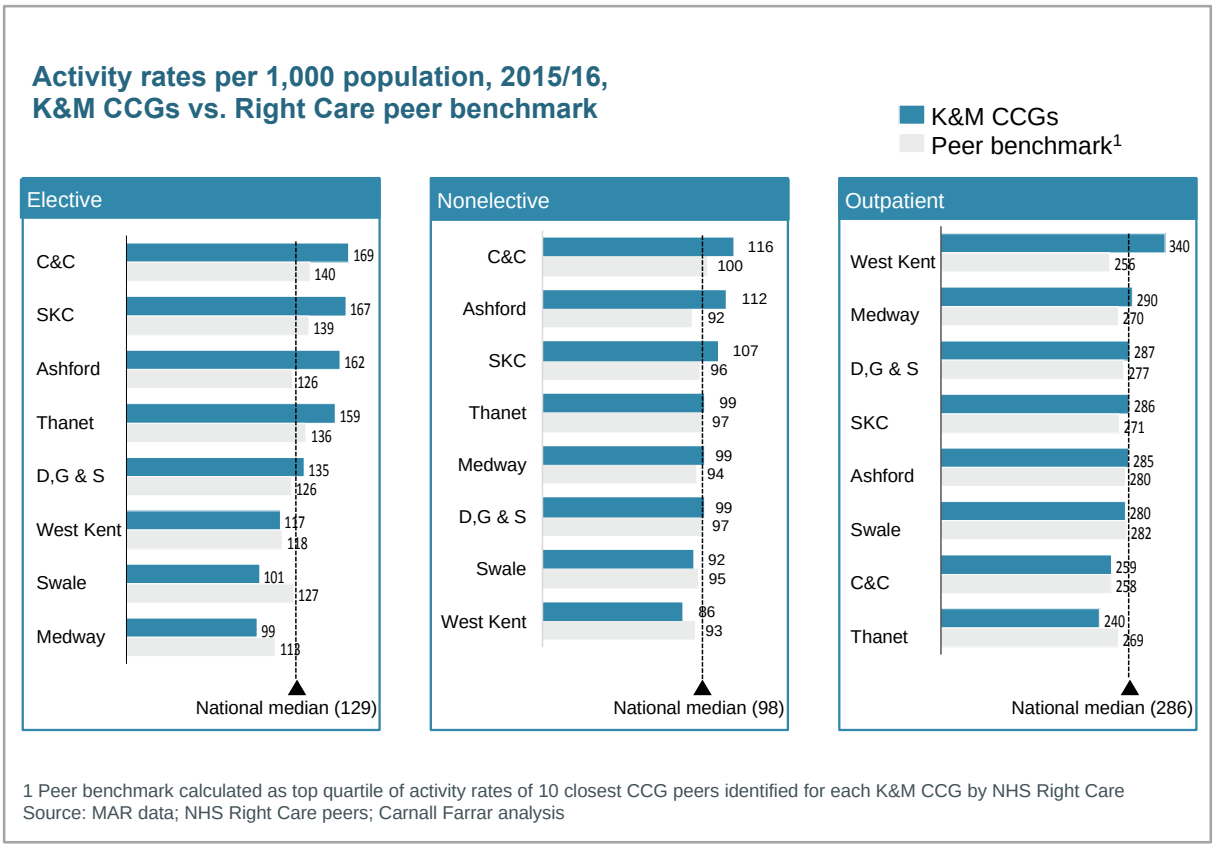
When people have a planned procedure or operation, it is usually done through a referral from a GP and then an outpatient appointment with a specialist; this may result in a planned procedure or operation, which can be done either as a day case or as a case with an overnight stay. It should be possible to standardise planned care according to best practice across K&M and therefore deliver it as efficiently as possible[112]. This might mean referring someone to a different service for some issues (or not referring at all) or standardising the way in which operations are done.

Therefore, for planned care, there should be similar levels of referrals from GPs to specialists (once differences in the local people, such as age and deprivation, are taken into account). Once the patient gets to see the specialist, there should also be similar processes and patient experience. There are many reasons why this might not happen, including variation in: the health needs of local people, the skills and experiences of GPs, the ability of GPs to get a specialist opinion and access to diagnostics in primary care. Additionally, a key cause may be the rise in numbers of people accessing hospitals for urgent health problems, as this reduces the number of available beds, theatres and staff for planned care.

As shown in Exhibit 26, the level of referrals from GPs to hospital specialists in K&M are higher than other places with a similar population[113]. This may reflect different levels of patient need, or it may be due to differences in clinical practice between doctors and nurses at any point where care is given. However, if the level of referrals were the same as top performing CCGs in similar areas,

outpatient activity would reduce by 9%[114]. If planned activity in hospitals were the same as top performing areas CCGs in similar areas, it would reduce by 14%[115].

Exhibit 26 – Levels of referrals for elective and outpatient services in K&M

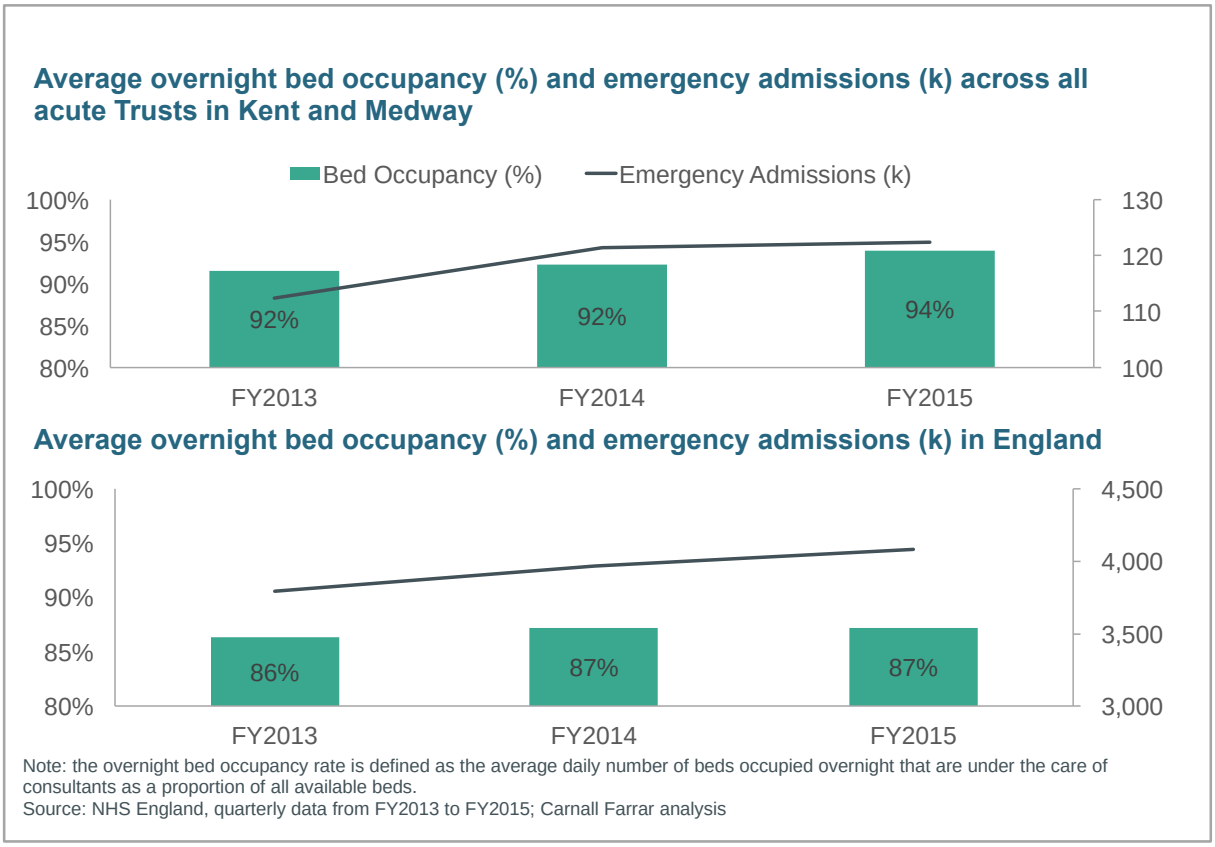


1 Peer benchmark calculated as top quartile of activity rates of 10 closest CCG peers identified for each K&M CCG by NHS Right Care
Source: MAR data; NHS Right Care peers; Carnall Farrar analysis

There are also differences between hospitals in the delivery of planned care. For example, a recent Monitor report concluded that patients with planned major hip procedures could be reduced[116]. The Right Care work shows the biggest potential opportunity for K&M for elective care is musclo-skeletal with a potential £7.8m savings along the pathway[117].

One potential cause of differences in the delivery of planned care is levels of emergency care. Exhibit 27 shows that emergency activity is increasing and so are occupancy rates (the proportion of beds that are full in the hospital) which may explain some of the issues in delivering planned care.

Exhibit 27 – Levels of emergency activity and bed occupancy in K&M acute hospitals



Note: the overnight bed occupancy rate is defined as the average daily number of beds occupied overnight that are under the care of consultants as a proportion of all available beds.
Source: NHS England, quarterly data from FY2013 to FY2015; Carnall Farrar analysis

This requires a focus on reducing differences in referrals into planned care, and the differences in the delivery of planned care within hospitals, including the relationship with emergency services.

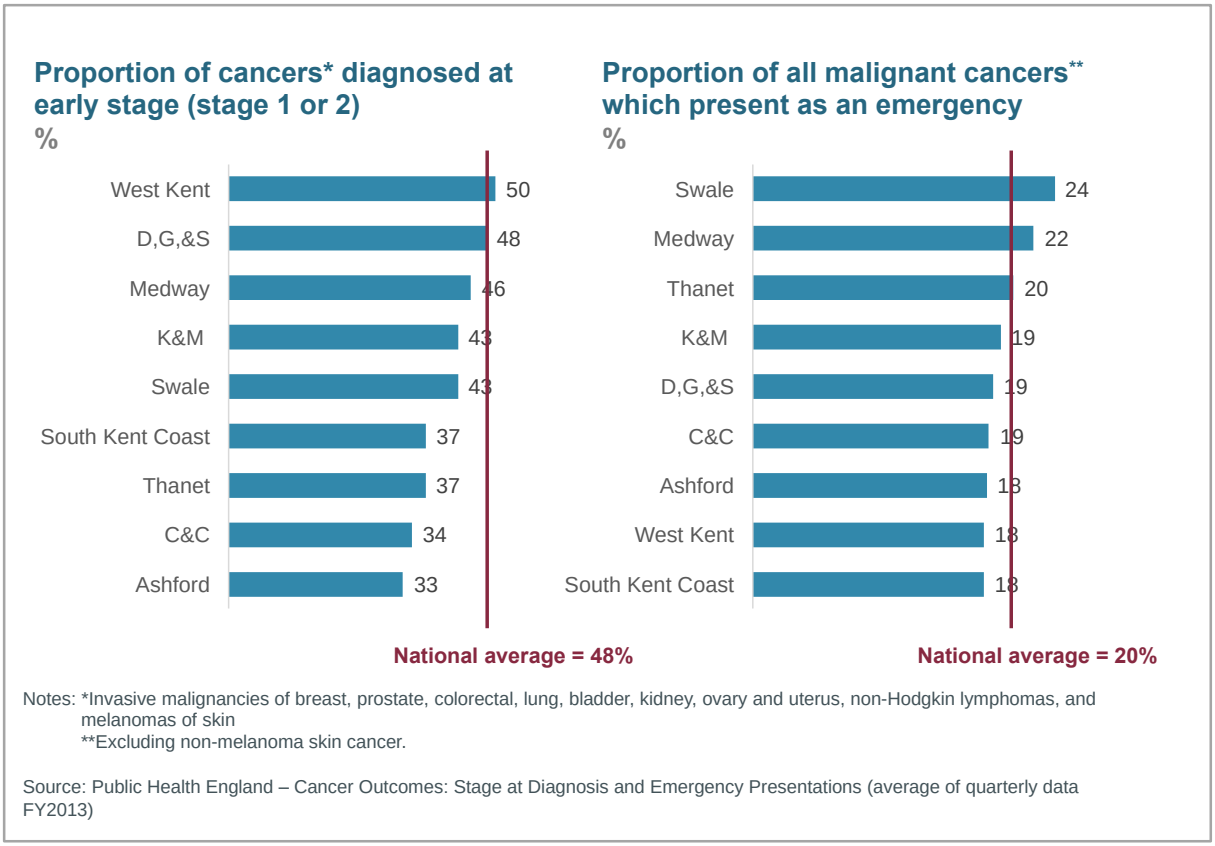
4.7 There are particular challenges in the provision of cancer care

There are many opportunities to save lives and deliver cancer services more efficiently in K&M. More than 1 person in 3 will develop cancer at some time in their lives, and 1 in 4 will die of the condition[118]. Cancer can develop at any age, but it is most common in older people – more than 3 out of 5 new cancers are diagnosed in people aged 65 or over, and more than a third are diagnosed in those aged 75 or over[119]. There are over 48,000 people with cancer in K&M, including 175 children, and the cost for each person with cancer is over 6 times that for a generally healthy person[120]. Mortality from cancer in K&M is similar to other parts of England [121]. However, compared to other countries such as Sweden, the UK has much lower survival rates, suggesting that improvements could be made[122]. 1-year survival rates from cancer are significantly lower than the national average in Medway and in the two most deprived CCGs: Swale and Thanet[123].

Late diagnosis of cancers is a particular issue that contributes to lower one-year survival rates. Exhibit 28 indicates that the percentage of cancers detected at an early stage is generally low in K&M, especially in Ashford and Canterbury & Coastal CCGs[124]. Medway and Swale CCGs also have high numbers of people getting their first diagnosis of cancer when they present as an emergency patient in hospital[125]; patients with cancers that present as an emergency have significantly worse

outcomes[126]. There is particularly low awareness of the symptoms of cancer amongst black and minority ethnic groups[127].

Exhibit 28 – Percentage of cancers diagnosed at an early stage or as an emergency



Notes: *Invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin
**Excluding non-melanoma skin cancer.

Source: Public Health England – Cancer Outcomes: Stage at Diagnosis and Emergency Presentations (average of quarterly data FY2013)

Low levels of take-up for cancer screening is one reason for late diagnosis of cancer. Although screening take-up in K&M is similar to the national average, less than 60% of the targeted population has bowel cancer screening and only 75% have breast cancer screening[128].

Once cancer is suspected, waiting times to see a specialist and then for treatment are long across K&M[129], as shown in Exhibit 29.

Exhibit 29 – Cancer wait times compared to national average (providers)

National quartiles: 4 | 3 | 2 | 1

Metric, unit of measure	EKHUFT	DGT	MTWT	MFT	National median	National upper quartile
Two week wait from GP urgent referral to first consultant appointment[1], %	90.8	92.0	91.1	86.7	95.0	96.5
Two week wait breast symptomatic (where cancer not initially suspected) from GP urgent referral to first consultant appointment[1], %	86.7	94.7	90.8	93.3	96.4	97.8
31 day wait from a decision to treat to a first treatment for cancer[1], %	95.6	100.0	96.6	92.6	98.6	99.4
31-day wait from a decision to treat to a subsequent treatment for cancer (surgery)[1], %	89.0	100.0	77.2	95.2	97.8	100.0
62-day wait from GP urgent referral to a First treatment[1], %	86.0	86.7	86.9	71.5	85.2	87.9
Overall cancer patient experience[2], scored out of 10	8.4	8.6	8.8	8.6	8.7	8.8

Source: 1. NHS England, Cancer Waiting time Statistics (admitted and non-admitted cancer care) Q1 16/17 by Provider; 2. NHS England, National Cancer Experience Survey 2015 – Patient reported experience (case mix adjusted) scores.

Nationally, the number of referrals to cancer specialists have almost doubled over the last five years[130]. This may be partly due to current guidance, but may also reflect both increasing demand from local people, and issues with access to diagnostic tests and specialist advice in primary care. There are also delays in seeing a specialist, often caused by long waiting lists for diagnostics[131]. Patient satisfaction with services is also low for most of the acute providers[132].

This requires a focus on improving efficiency, quality and access on the cancer pathway across primary and acute providers.

4.8 People with mental ill health have poor outcomes and may not always be able to access services

It is important that mental health has equal priority with physical health, that discrimination associated with mental illness ends and that everyone who needs mental health care should get the right support, at the right time. More must also be done to prevent mental illness and promote mental wellbeing[133].

There is a lot of evidence that links poor physical health with mental illness. For example, having depression doubles the risk of developing coronary heart disease – and people with depression have significantly worse survival rates from cancer and heart disease[134]. People with a serious mental illness are at risk of dying on average 15 to 20 years earlier than the general population[135].

Spend per head on physical health care for those with mental illness combined with long-term physical health conditions is almost 50% higher than for those with only long-term physical health conditions.[136] People with a long-term condition and a mental illness spend longer in hospital, have more investigations and make slower recovery. They are also more likely to die – for example,

people with diabetes and co-morbid depression are 36-38% more likely to die early as those without depression[137]. Children with diabetes and depression are much more likely to get long-term damage to their eyes[138]. People with a mental illness are also less likely to be able to manage their own illness and more likely to do things that will make their long-term condition worse, such as smoking or drinking[139].

Nationally, years of low prioritisation have led to CCGs underinvesting in mental health services relative to physical health services[140]. There is widespread dissatisfaction with services, particularly for crisis care and changes in who the person sees[141]. There are also problems with recruiting and retaining staff; for example, the vacancy rates for medical staff in mental health is 31%[142].

At any one time, around 14% of patients in a mental health hospital bed are fit to leave. Over half of all these patients require further social care or overnight support to be discharged to their normal place of residence. A recent audit of patients in mental health beds found that the primary reason for delayed discharge is due to patients "awaiting completion of assessment" or "awaiting a health package of care"[143].

This requires a focus on the provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.

4.9 Services could be run more productively across Kent & Medway

Although local providers have comparable levels of efficiency to hospitals of a similar type in many areas of spend, and some are amongst the most efficient, all providers in K&M could do more to reduce costs and run services more efficiently, including through increased collaborative working and reduced duplication. It is estimated that approximately £190m of savings could be made if services were run as efficiently as top performing hospitals of a similar type[144]. Key areas for focus are nursing staff, medical staff, agency staff and clinical supplies and services.

This requires a focus on improving productivity across providers in K&M.

5. Enablers

5.1 Workforce

Throughout this case for change, the issue of workforce and the difficulty recruiting and retaining staff has been a common theme. The quality of care and patient/client experience is dependent on having a well-trained, motivated and experienced workforce and staff in K&M work very hard to deliver high quality services. However, there are several workforce challenges in K&M including:

- **Recruiting and retaining staff:** there are very high levels of vacancies across primary care, with an estimated 136 GP vacancies across K&M (12% of the total number of GPs), of which 53% have been vacant for more than a year[145]. This creates a dependency on locum GPs - on average locum doctors constitute 8% of the GP workforce in K&M[146]. There are also challenges in recruiting practice nurses; every single one of the vacancies reported in a recent survey of practices been open for more than 6 months[147]. There are also problems with recruiting and retaining staff in mental health services; for example, the vacancy rates for medical staff in mental health is 31%[148] and in local hospitals where there are vacancy rates of around 10% and turnover of medical staff is as high as 34% in one hospital. In social care, the cost of living in some areas in West Kent makes it very difficult to recruit staff (for example, the cost of buying a house is almost double in West Kent compared to East Kent[149].
- **Availability and skills of staff:** there are low numbers of GPs and practice nurses compared to national average and many hospital services in K&M that are small where senior staff are not always available 24 hours a day. The answer is not simply to recruit more doctors. Although there is a shortage of doctors in some specialties[150], even if the workforce was available hospital doctors would not see enough patients to maintain their skills[151].
- **Carers:** many people with long term health conditions are looked after by unpaid carers, who are often elderly and may have their own long term health conditions. However, health and social care services rely on these carers to support people who are ill. Fewer than half of all carers in K&M are satisfied with their experience of care and support and only a third have as much social contact as they would like[152].

To transform services, it will be crucially important to make sure that a skilled, experienced and committed workforce is in place. A medical school might help overcome issues with the attraction and retention of a clinical workforce in K&M, building on the training already delivered for the non-medical workforce. Research shows that 70% of UK doctors hold their first career post in the same region as either their home, medical school or their place of training[153]. Workforce is a key issue that needs to be considered and addressed as new service models are developed and implemented.

5.2 Estates are generally good but not always fully utilised

Generally, the hospital estate within K&M is relatively new and fit-for-purpose, especially when compared with England averages[154]. There are new PFI (public finance initiative) hospitals in Pembury (Tunbridge Wells Hospital), Dartford (Darent Valley Hospital) and Gravesham (The Gravesham Community Hospital). The William Harvey Hospital and the Kent & Canterbury Hospital have the oldest and least fit-for purpose estate (although still in line with the national average)[155]. There is much more mental health estate that is old and not fit-for purpose; for example, the Thanet Mental Health Unit, of which 87% is not fit-for purpose[156]. GP practices are in reasonably good condition; for example, only 14 of 101 practices (14%) have a red rating for quality of accommodation[157].

Furthermore, there is a lot of space in community hospitals that is not being used. In many community hospitals, up to half of the bed spaces are not used; although overall, 13% of the total bed space is either under-used or empty[158].

Exhibit 30 Community hospital bed occupancy rates

	Hospital	Ward	Ward type	Open Beds	Occupied Beds	Occupancy Rate
Kent Community Health Foundation Trust	Faversham Cottage Hospital	Cottage Ward	Rehab/ Assessment	25	22	88%
	Whitstable & Tankerton Community Hospital	Friends Ward	Medical	18	15	83%
	Queen Victoria Memorial Hospital	Heron	Rehab	21	17	81%
	Deal Community Hospital	Elizabeth Ward	Rehab	20	19	95%
	Hawkhurst Community Hospital		Community Hospital	22	20	91%
	Edenbridge Community Hospital	Hever And Chartwell	Community Hospital	14	13	93%
	Tonbridge Community Hospital	Goldsmid And Primrose & Somerhill	Community Hospital	20	20	100%
	Sevenoaks Community Hospital	Stanhope And Holmesdale	Community Hospital	18	16	89%
	Westbrook	Victoria Unit	Rehab/Assessment	30	28	93%
	West View	Benenden Unit	Rehab	30	21	70%
Medway Community Healthcare	Amherst Court	Britannia Suite	Rehab	12	12	100%
	Amherst Court	Endeavour	Stroke Rehab	15	14	93%
	Frindsbury Hall	Rehab Unit	Rehabilitation	10	9	90%
	Wisdom Hospice	Inpatient Unit	Palliative Care	15	8	53%
	TOTAL			270	234	87%

Source: Trust data (November 2016), Carnall Farrar analysis

The cost per bed for community hospitals is around £285 per day[159]. This space could be used for something else, such as other services or community spaces. There may also be an opportunity to consolidate some of this space and spend the money elsewhere.

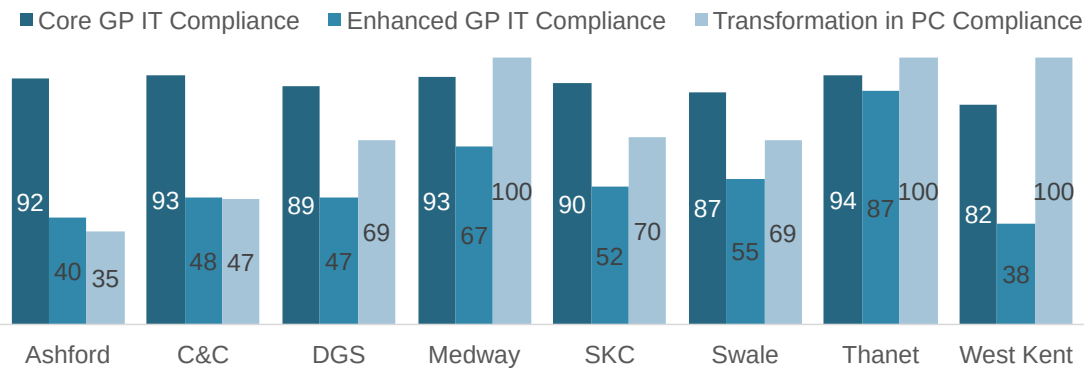
5.3 Information technology needs to better support integrated care

Information sharing between people and between organisations is essential to deliver safe, effective and efficient care. Information sharing supports people to stay healthy, multi-professional teams to deliver integrated care and organisations to identify opportunities to reduce variation, waste and clinical harm. Patients and the public expect to be told who is using their information, why it needs be shared, who has access to it and what safeguards have been put in place to keep it secure. They also increasingly expect information to be shared with them, in a format they understand, and to help them to contribute their own data and let their care preferences be known. Furthermore, understanding of the disease and people at risk of ill health is important for commissioning across health and social care.

The NHS Digital Maturity Assessment provides a framework against which healthcare providers and CCGs can assess their progress towards digital adoption. Digital maturity in primary care is measured against core, enhanced and transformational IT compliance. Most CCGs in K&M agree that they are performing well against the "core IT compliance" indicators, however, no CCG in K&M currently meets the requirement for at least 80% of elective referrals made using the NHS e-referral system and there are issues with data quality across K&M. CCGs in K&M have lower compliance with the requirements for IT support for extended hours and for 7 day services. There is mixed performance

in terms of "transformation in primary care", which forms a later stage in digital maturity and covers indicators such as wifi for all clinical staff, auditable electronic records in local community and consistent local data sharing. This is shown in Exhibit 31.

Exhibit 31 – Digital Maturity Assessment in primary care



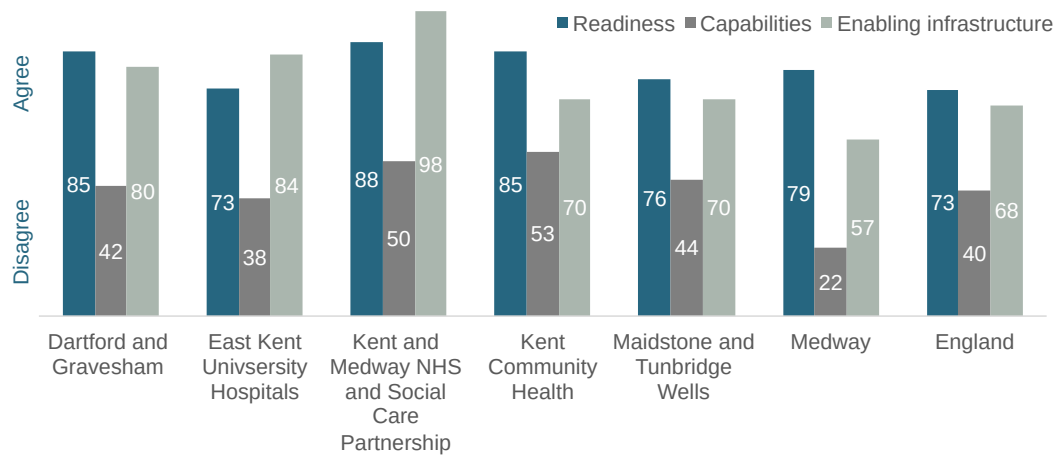
The worst performing indicators across all CCGs include:

	Indicator	Ashford	C&C	D,G,S	Medway	SKC	Swale	Thanet	West Kent
Core	At least 80% of elective referrals are made using the NHS E-referral system	X	X	X	X	X	X	X	X
Core	Data Quality Accreditation Programme	X	X	X	N/A	X	X	N/A	X
Core	Data Quality Service	X	X	X	N/A	□	X	N/A	X
Enhanced	IT support for extended hours services	Urgent service	Urgent service	Restricted service	N/A	No service	Restricted service	N/A	No service
Enhanced	IT support for 7 days services	Urgent service	Urgent service	Restricted service	N/A	Restricted service	Restricted service	N/A	No service

Source: NHS England, Primary Care Digital Maturity Assessment 2015-16

Similarly, exhibit 32 demonstrates that the level of digital maturity of provider organisations varies across K&M and local capabilities are generally low[160]..

Exhibit 32 – Digital maturity assessment by provider of acute, mental health, social and community care services



Section	Description of assessment
Readiness	Organisation's ability to plan, deliver and optimise the digital systems it needs to operate paper-free at the point of care
Capabilities	Digital capabilities available to the organisation and extent to which those capabilities are available and being optimised across the organisation as a whole
Enabling Infrastructure	Extent to which the underpinning infrastructure is in place to support delivery of these capabilities

Notes: Each answer is assigned a score from 0 to 100, where 0 represents 'disagree completely' and 100 'agree completely'

Source: NHS England, Digital Maturity Assessment 2015-16

6. Next steps

This case for change has shown the significant scale of the challenges in K&M and the urgency with which they need to be addressed. We need to address these challenges to make sure that local people are supported to be independent, that when they need high-quality care they can find it as close to home as possible, and that they can enjoy the health and wellbeing they aspire to. This must be supported by a K&M health and care system which works effectively and sustainably.

Across K&M there are many examples of excellent work taking place to improve the way people are cared for. For example, in Swale, integrated care teams made up of community nurses and social care practitioners have been introduced and attached to general practice clusters, allowing more joined up care. In Herne Bay, 7-day access to a range of urgent and outreach services, including diagnostics, have resulted in better patient experience and reduced admissions to hospital and A&E attendances. In the South Kent Coast area, rheumatology care is being delivered closer to home, supporting self-care, making space in hospitals and developing primary care skills and knowledge.

While these improvements are promising, they are only happening in some parts of K&M. The changes we need to make are greater than those already made, and so we must work together on a scale greater than we have before.

In this spirit, health and social care commissioners and providers across K&M – from the NHS, local authorities, public health and other organisations – have come together to create a 5-year Sustainability and Transformation Plan (STP). This way we can learn from local successes and make the most of them and we can make sure that the quality of care is consistently high across K&M.

The aim of the STP is to meet the challenges outlined in this Case for Change, to deliver clinical and financial sustainability for health and social care in K&M and, most importantly, to improve quality of care and outcomes for local people.

This is an exciting opportunity to change how we provide care. We are exploring and pursuing opportunities around four key themes:

1. **Care transformation:** preventing ill health, intervening earlier and bringing excellent care closer to home.
2. **Productivity:** maximising efficiencies in shared services, procurement and prescribing.
3. **Enablers:** investing in buildings, digital infrastructure and the workforce needed to deliver high-performing health and social care services
4. **System leadership:** developing the commissioner and provider structures which will deliver the greatest impact

We will focus more on preventing ill-health and promoting good health and our local care will improve the health of people in K&M. This means supporting people to lead healthy lives, as well as reduce demand and costly clinical interventions. We also need a greater focus on people whose health outcomes are the worst.

We will work with local people to transform local care through the integration of primary, community, mental health and social care and re-orientate some parts of traditional hospital care into the community. This allows patients to get joined-up care that considers the individual holistically – something patients have clearly and consistently told us they want.

We believe the way to achieve this is to enhance primary care by wrapping community services around a grouping of GP practices, to support the communities they serve, so that we can:

- Meet rising demand for health and social care, including providing better care for frail elderly people, people at the end of life, and people with complex needs;
- Deliver prevention interventions across K&M, improve the health of local people, and reduce the reliance on institutional care;
- Reduce the number of people in hospitals and instead support them in the community.

Clinical evidence tells us that many patients, particularly the elderly frail, who are currently supported in an acute hospital are better cared for outside hospital. Changing the location of care for these individuals will be truly transformational. We know it is possible to deliver this change and already have local examples to build upon where this new approach is being delivered (such as the Encompass Vanguard comprising 16 practices in east Kent who are operating as a multi-specialty community provider, providing a wide range of primary care and community services to 170,000 people).

In response to this, hospital care will need to change to improve patient experience and outcomes; make best use of the available workforce; and make best use of our buildings. We want to continue to create centres of hospital clinical expertise that see a greater separation between planned and emergency care. This would end the current issue of surgery being delayed because of pressure on beds for emergency patients. Through this we will deliver targets; increase the availability of senior staff, improve staff retention and morale; and release significant savings, even after investment in care outside hospital.

With these plans, we are confident that we can overcome the challenges which our health and care system faces and provide the high quality services and outcomes for local people.

Critical to the way we work together has been the establishment of several joint oversight boards, including the Clinical Board. This group includes GPs, hospital consultants, nurses, public health professionals, social care e leads, pharmacists and other clinical experts. This group commissioned this Case for Change report and will oversee the plans to resolve the challenges it highlights. This will make sure the changes we propose are led by clinical expertise and experience.

Over the coming months, health and care professionals across K&M will continue work around the four transformation themes. Through this process, we will engage patients and service users, carers and local residents to ensure their views are heard and considered. Some improvements will start to be made immediately and some will need careful planning and preparation to be phased in over the coming months and years. Where there are significant changes, we will consult the public on our proposals and the options to make K&M services the best they can be.

This is an ambitious plan of work and we are committed to progressing it for the benefit of local people.

7. Appendix 1: population segmentation detail and methodology

2015/16 population size, total spend and spend per head by condition and age band

Spend per head, £ | Population, Thousands | Spend, £ Millions

Age	Mostly healthy		Chronic conditions		Serious and enduring mental illness		Dementia		Cancer		Severe physical disability		Learning disability	
0-15	£405		£948		£13,095				£9,765		-		£2,594	
	328.7	£133.2	17.1	£16.2	1.3	£16.7			0.2	£1.7	tbc	tbc	0.5	£1.2
16-69	£506		£1,427		£9,672		£9,005		£2,920		£15,535		£20,357	
	903.7	£457.4	297.1	£423.9	8.0	£77.6	0.9	£8.4	23.6	£70.0	6.7	£104.3	5.5	£112.2
70+	£939		£2,790		£9,040		£6,584		£3,695		£16,295		£13,470	
	80.6	£75.7m	107.8	£300.7	1.2	£11.2	10.8	£71.1	22.2	£90.3	22.1	£360.6	0.4	£4.9

Notes: People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. CAMHS, non-PbR acute activity). Children's social care, prescribing costs and continuing care costs are not included.
Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 30/11/2016

Population	• Only patients registered to GP practices flowing data into the Kent Integrated Dataset (KID) have been used • Patients have been assigned to segments depending on their age and health status • Patients with zero associated spend or activity during 2015/16 have been assigned to the "mostly healthy" category • Population has been scaled to meet 100% of each CCG's population to account for those practices excluded from the KID • Manual adjustments for some data not available from the KID (e.g. physical disabilities, CAMHS)
Spend	• Total spend across primary care, mental health, community, acute and social care services have been summed for each of the segments • Spend has been scaled to 100% of spend by POD for each CCG to account for spend not included in the KID (e.g. non-PbR acute activity) • Manual adjustments for some spend categories outside of the KID (e.g. physical disabilities, CAMHS) and apportionment of "other acute" spend across the population segments
Output	• Breakdown by age and condition with population, total spend, spend per capita, and a breakdown of spend by POD • Kent-wide segmentation complete • Individual CCG segmentations almost complete
Limitations	• Medway has been excluded as required primary care data is not included in the KID[1] • Child social care spend, continuing care spend and prescribing costs have been excluded[2]

Notes [1]KID data has been scaled up to give an estimation for Medway
[2]These categories total £507m of spend across the seven Kent CCGs
Source: Kent Integrated Database, Carnall Farrar analysis

CCG	Registered Population	Flowing Practices					Scaling Factor
		With activity during 15/16		Without activity during 15/16		Total	
Ashford	129,000	59,000	+	46,000	=	105,000	1.23
Canterbury & Coastal	220,000	115,000	+	82,000	=	197,000	1.12
DG&S	261,000	210,000	+	31,000	=	241,000	1.08
SKC	202,000	112,000	+	53,000	=	166,000	1.22
Swale	110,000	62,000	+	15,000	=	77,000	1.44
Thanet	144,000	78,000	+	39,000	=	117,000	1.23
West Kent	479,000	228,000	+	106,000	=	333,000	1.44
Kent Total	1,556,000	864,000	+	372,000	=	1,236,000	1.25

Note: Where figures are scaled to from Kent population to Kent and Medway population, a further scaling factor of 1.19 was applied
Source: Kent Integrated Dataset, Carnall Farrar analysis

9. Endnotes

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Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-14	**Senior Information Risk Owner update** (including approval of the Information Governance Toolkit submission for 2016/17)	**Chief Nurse (Senior Information Risk Owner / SIRO)**

Summary / Key points

The Board is advised that as Senior Information Risk Owner (SIRO), I have received and been satisfied with assurance reports in relation to Information Governance from the Information Asset Owners of the Clinical Directorates as well as from the Heads of Corporate functions.

These reports provide assurance against the six areas of Information Governance as outlined in the IG Toolkit:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

Information Governance Management Framework (IGMF)

The Information Governance Committee reviewed the IGMF in July 2016. The Information Asset Owner Group was established to provide assistance and support to myself as Senior Information Risk Owner in the performance of my duties in relation to information risk management. The Group reports to the Information Governance Committee. The purpose of this Group is twofold:

1. To provide assurance that:
    - Information Assets have been appropriately identified;
    - Documentation containing all information necessary to respond to incidents or recover from a disaster affecting the information asset has been completed and tested;
    - Business continuity plans have been completed and tested;
    - Risk assessments have been completed in relation to individual information assets;
    - Risks logs are maintained and risks reported to the Senior Information Risk Owner at least annually.
    - Information Asset registers have been completed and reviewed annually;
    - Data flow Mapping has been reviewed and risk assessed and that the legal basis for sharing has been clearly identified;
    - When necessary Information Sharing Agreements are in established;
    - When new systems or processes are to be put in place or substantial changes to existing systems or processes are to be made Information Governance sign off has been received;
    - Staff are aware of and comply with IG working practices;
    - Mechanisms are in place to identify, report and manage incidents in relation to owned assets;
    - System Specific Security Policies are completed and reviewed annually;
    - Forensic readiness plans have been completed and reviewed and both internal and external dependencies identified;
    - Pertinent Information Standards Notices have been reviewed and actioned.
2. To provide a platform for information risk management training to ensure skills and capabilities are update date and relevant.

The Caldicott Guardian and Data Protection Officer were happy to approve the framework as meeting the needs of the organisation for the year.

General Data Protection Regulation

The Data Protection Act 1998 (DPA) will be superseded by new legislation on 25 May 2018. The General Data Protection Regulation (GDPR) unifies data protection for all individuals within the 28 member states of the European Union (EU).

The UK Government has confirmed that even though the United Kingdom is exiting from the EU the GDPR will be implemented.

The main concepts and principles of the GDPR are similar to those in the current DPA with added detail and a new accountability requirement. The accountability principles require organisations to be able to demonstrate how they are complying with the principles.

Key Changes

The key changes introduced by the Regulation affecting the Trust include:

1. The definition of personal data is broader – it can now include factors such as genetic, mental, economic and cultural or society identity. On-line identifiers such as IP addresses can be personal data. Pseudonymised data can be personal data depending on how difficult it is to attribute the data back to a particular individual.
2. Privacy notices – the GDPR set out the information that should be supplied and when individuals should be informed.
3. Children's data – privacy notices must be written in clear, plain language that Children will understand. Consent is required from a parent or guardian if online services are offered to children.
4. Changes to the rules for obtaining valid consent – the Trust will need to review its consent mechanisms to make sure they meet the GDPR requirements on being specific, granular, clear, prominent, opt-in, documented and easily withdrawn.
5. Data protection officer (DPO) – should report to the highest level of the Trust i.e. Board level, should operate independently and not be dismissed or penalised for performing their tasks, is adequately resourced to meet their GDPR obligations.
6. The introduction of mandatory privacy risk impact assessments – PIAs must be completed and submitted to the Information Commissioner's Office before processing of data commences (guidance is awaited from the ICO as to how this process will work)
7. New data breach notification requirements – All breaches must be reported within 72 hours
8. Data processor responsibilities – additional obligations are incorporated within the Regulation requiring the Data Controller to ensure that contracts with Data Processors comply with the GDPR.
9. Data portability – allows individuals to obtain and reuse their personal data for their own purposes across different services – the information must be provided free of charge and within one month.
10. Privacy by design – there is a general obligation to implement technical and organisational measures to show that the organisation has considered and integrated data protection into all processing activities.

Information Governance Partnership Board (IGPB)

The Trust has played an active role during the year on the Kent and Medway Information Governance Partnership Board. The board is responsible for maintaining the Kent and Medway Information Sharing Agreement. Donna-Marie Jarrett, Director of Health Informatics, assumed the responsibility of Chair of the Board in February 2017.

Information Governance Regulator Activity

The Trust was required to report one information governance data protection breach incident to the Information Commissioner's Office and the Department of Health in the year. Investigations are currently ongoing to identify the root causes of the incident and any actions that may be taken to prevent a reoccurrence.

There have also been a couple of complaints made to the Information Commissioner's Office

relating to the Trust's handling of subject access requests. In each case the Information Commissioner has been satisfied with the Trust response and no further action has been taken. Whilst this is the case the Information Commissioner has advised that they will keep the concerns on file as this will help them build up a picture of the Trust's information rights practices.

Information Risks

The Trust Board is advised that no new Information Governance risks have been added to the Trust risk register since the last annual report by the SIRO in March 2016. All Directorates and Departments have been requested to review their Business Continuity Plans to ensure they have been updated to reflect to Trust's ongoing journey to a paper-light environment.

IG Toolkit V14

- The Trust is required to make its year end submission to the Information Governance (IG) Toolkit by 31st March 2017
- The Toolkit is a self-assessment completed annually by the Trust; it consists of 45 requirements; for each requirement the Trust is required to self-assess and provide a score; scoring is on the basis of a Level 0 to Level 3 (3 being the highest); the overall score is marked as a percentage and also marked as satisfactory or unsatisfactory; to achieve a satisfactory mark the Trust is required to score at least a Level 2 for each of the 45 requirements of the Toolkit
- The Board is advised that the Trust is achieving the minimum Level 2 score and a number of the requirements will be met at level 3. This might increase between circulation of this report and the Trust Board meeting and a verbal update will be given at the meeting
- Internal Audit (TIAA) has undertaken an independent review of evidence pertaining to 10 of the 45 Toolkit requirements. The objective of the audit is to provide assurance on the integrity of the set-assessment against the toolkit criteria, the overall effectiveness of information governance processes within the Trust and wider risk exposures through non-compliance with IG processes. The audit adopted a two stage approach, the second part of which will not be complete until the last week of March 2017
- The Board is asked to support a recommendation for year-end submission of not less than 70% (satisfactory). A detailed breakdown of the Toolkit requirements and proposed submission details by attainment level is enclosed, at Appendix A.

Which Committees have reviewed the information prior to Board submission?

- Information Governance Committee, 15/03/17
- Trust Management Executive, 22/03/2017

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

Review, and to approve the proposed year-end submission to the IG Toolkit

[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

Version 14 (2016-2017) Assessment

Requirements List

Req No	Description	Status	Attainment Level
Information Governance Management			
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 2
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 2
14-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Updated	Level 3
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 2
Confidentiality and Data Protection Assurance			
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Reviewed And Updated	Level 2
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Reviewed And Updated	Level 2
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Reviewed And Updated	Level 2
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Updated	Level 2

14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Reviewed And Updated	Level 2
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Reviewed And Updated	Level 2
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Reviewed And Updated	Level 2
14-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Reviewed	Level 2
Information Security Assurance			
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 2
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 2
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 3
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Reviewed And Updated	Level 2
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Updated	Level 2
14-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed And Updated	Level 2
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed And Updated	Level 2
14-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed And Updated	Level 2

14-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Updated	Level 2
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Reviewed	Level 2
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Reviewed	Level 2
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed	Level 2
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed And Updated	Level 2
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 2
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed	Level 2
Clinical Information Assurance			
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed	Level 2
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed	Level 2
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed	Level 2
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	Reviewed	Level 2
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Reviewed And Updated	Level 2
Secondary Use Assurance			
14-501	National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop	Reviewed	Level 2
14-502	External data quality reports are used for monitoring and improving data quality	Reviewed	Level 2

14-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Reviewed And Updated	Level 2
14-505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	Reviewed And Updated	Level 3
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Reviewed And Updated	Level 2
14-507	The secondary uses data quality assurance checks have been completed	Reviewed	Level 2
14-508	Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity	Reviewed And Updated	Level 2
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	Reviewed And Updated	Level 2
Corporate Information Assurance			
14-601	Documented and implemented procedures are in place for the effective management of corporate records	Reviewed	Level 2
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Reviewed	Level 2
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Reviewed	Level 2

Trust Board meeting – March 2017

Maidstone and Tunbridge Wells NHS Trust

3-15	Summary report from Charitable Funds Committee, 20/02/17	Committee Chair (Non-Executive Director)

Summary / Key points

The Charitable Funds Committee met on 20th February 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 Venous thromboembolism (VTE) prevention and referenced the awareness-raising and training initiatives underway to maintain the Trust's sound performance in this area
- The audit approach for the 2016/17 Charitable Fund accounts was confirmed: the funds would be subject to an independent review for 2016/17 (rather than an external audit) and that with effect from the current year, the completion of the accounts would be brought forward to May, for consideration of the Report and Accounts at the Committee meeting in June (this was normally conducted at the November meeting)
- Progress with the review of performance of the investment portfolio was reported and it was agreed that:
  - Due diligence should be undertaken on the alternative products presented and the practicalities / implications of moving from existing accounts clarified
  - Pressure should be increased on CAF to respond on how the Charity could achieve better value from its products
  - Checks should be made with other Acute Trusts (e.g. East Kent Hospitals University NHS Foundation Trust) to identify any recommendations on further alternative products
  - The recommendations arising from this process should be finalised and circulated to the Committee for agreement
- The financial overview at Month 10 was considered and it was noted that:
  - Total income received for months 1-10 was £83k
  - Total expenditure for the period was £495k
  - The fund balances at 31/01/17 stood at £1,313k, a decrease of £412 since 01/04/16
  - No items of expenditure had been refused in the period
  - There had been no purchases of revenue expenditure over £150k
  - There were currently 3 funds with balances over £100k at 31/01/17: David Crow Legacy - £162k; Mollie Hayling Legacy - £351k; Oncology equipment - £155k
- The Head of Financial Services reported that a majority of responses had been received in response to the Committee Chair's recent letter to fund holders about spending plans and that the few that remained outstanding were being actively followed up on
- The Director of Finance reported that, following a detailed review of expenditure in months 1 to 9, a total of c£196k had been identified that would potentially meet the criteria for retrospective charitable funds allocation. The Committee agreed that the proposed reclassification of expenditure be applied, subject to agreement at Divisional Board level. It was also agreed to provide a report for the Trust Board detailing the agreed reclassification of expenditure as charitable funds for the full year 2016/17 after the year-end
- An updated proposal to establish a fundraiser role within the Trust was considered and agreed. The report included more detail and clarity on the nature of the proposed role (including grading, job specification and comparative remuneration information); likely financial targets and proposed themes for fundraising appeals, which had included liaison with the General Manager for the Cancer and Haematology Directorate. A list of potential appeals focussed on the Kent Oncology Centre, was tabled for information.

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:

- The Committee agreed to support the establishment of a fundraiser role, linked to a strategic appeal and as part of a wider engagement strategy within the Trust, and that the Trust Board should be invited to approve the establishment of the post. (The establishment

of this post was approved at the Trust Board Part 1 meeting on 22/02/17 (Trust Board Part 1 minute 2-16)).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information

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

Trust Board meeting – March 2017

Maidstone and Tunbridge Wells NHS Trust

3-16	Summary report from Patient Experience Committee, 08/03/17 (incl. revised ToR)	Committee Chair (Non-Executive Director)

Summary / Key points

The Patient Experience Committee (PEC) met on 8th March 2017.

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

- The Committee noted the retirement of its Chair for the past 9 years, Sylvia Denton, and recorded its recognition of her outstanding service to the Trust during that period
- The Terms of Reference, which were due their annual review, were considered. A number of minor / 'housekeeping' changes had been proposed. As well as agreeing these, the Committee decided: to extend the current standing invitation to a Junior Doctor to attend each meeting to include junior members of other health professions; to include explicit reference to maintaining awareness of the Sustainability and Transformation Plan (STP) for Kent & Medway (due to its potential implications for patient experience); and to invite the Associate Director of Nursing (or equivalent) from each Division to attend each meeting. The revised Terms of Reference, as agreed by the PEC, with the proposed changes 'tracked', are enclosed at Appendix 1, for approval
- An update report on the performance and usage of the Trust's translation service, including latest usage by division and type of session (face to face, telephone or British Sign Language) was noted
- Ongoing improvements in performance in the Trust's Stroke provision were reported and it was agreed that an exception report on developments in Stroke performance and services, in the context of the STP, would be provided for the next meeting.
- A presentation was given on the 'Home First' discharge to assess model which had been implemented within the Trust from late 2016
- An update on Complaints and PALS contacts for Quarter 3, 2016/17 was noted
- An report on Healthwatch activity was noted, which included the report on the Enter & View visits to Outpatients (which had taken place in September 2016)
- An update was given on progress against the Quality Accounts priorities for 2016/17
- The draft and provisional Quality Accounts priorities for 2017/18 were noted
- An update on progress against the Patient Led Assessments of the Care Environment (PLACE) Action Plan was given
- A report from the 'Patient and their Medicines Working Group' was noted. Reported recent activity included: a survey to assess patients' understanding of the role of pharmacists and pharmacy in hospital; introduction of a monthly survey on wards which would allow continuous monitoring of improvement against relevant areas of the National Inpatients Survey; implementation of the medicines information system 'MaPPs'; review of medications management processes and committees by the newly appointed Chief Pharmacist; and liaison with Pharmacy teams from other Trusts
- Notification of recent/planned service changes was received, including an update on the introduction of the "Mouth Care Matters" programme, aimed at promoting oral hygiene within the Trust
- An update was received on work from the West Kent Clinical Commissioning Group (WKCCG), which included confirmation of a new CCG representative for the PEC
- A report on Communications activity was noted
- Latest findings from the local patient survey (including Friends and Family) were reported. It was noted that: overall patient satisfaction rates remained stable, but that there had been a slight reduction in positive responses to the question: 'Were you involved as much as you wanted to be in decisions about your care and treatment?'; responses to the question "did you get enough help from staff to eat your meals?' remained inconsistent, and there had been a slight decrease in positive responses to the question on ward cleanliness at Maidstone Hospital
- An update was received on the work of the Patient Information and Leaflets Group (PILG)

- A report from the Quality Committee meetings on 04/01/17, 11/01/17 and 06/02/17 was noted
- A report from the Patient Representative Working Group was received. Reported recent activity included: support for monthly CQC audits within the Trust; support for the monthly Trust-wide PLACE audits (including a planned audit of patient mealtimes); a meeting with a member of the Estates and Facilities department who was leading on a 'Way finding' project; plans for specialist training for Patient Representatives

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

- The Trust Secretary was to confirm the status of funding for the SWAN initiative pilot (for end of life care), which was reported on 08/03/17 as not starting due to lack of funding
- To receive a further report at its next meeting on the reasons for patient transfers (raised by a Junior Doctor at the PEC meeting in September 2016)
- The Trust Secretary was to consider the development of a one page report that provided an overall summary of key indicators that might be used by the PEC and other committees to quickly assess the latest position within the Trust
- The Trust Secretary was to provide PEC patient representative email addresses to the Communications Team to enable their inclusion on the distribution for the re-launched e-bulletin for stakeholders
- The Trust Secretary was to confirm when the parking payment machines at MH and TWH will accept the new £1 coin piece
- The Trust Secretary was to liaise with the Trust's fire safety officer to provide a report for the next meeting on the processes in place for fire drills within the Trust
- The Trust Secretary was to provide PEC patient representative email addresses to the Communications Team to enable their inclusion on the distribution for the Chief Executive's weekly update and the Governance Gazette

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

- The Committee agreed that the Trust Board should be made aware of the current absence of dedicated A&E pharmacist roles within the Trust as reported by the Deputy Chief Pharmacist (it was noted that other Trusts had implemented this measure)

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 approve the revised Terms of Reference for the Patient Experience Committee (Appendix 1)
2. 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

PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

NHS
Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Committee's purpose is to

1. Aim to capture~~Present~~ the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. Monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee), as required

2. Membership

From the Trust:

- Non-Executive Director (Chair)
- Non-Executive Director (Vice Chair)
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse (x 1)
- Associate Director for Quality Governance
- Complaints & PALS Manager
- Trust Secretary

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

3. Attendance and quorum

The Committee will be quorate when 4 members from the Trust~~,~~ (including 1 Non-Executive Director)~~,~~ and 4 members external to the Trust are present. Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum.

The Associate Director of Nursing (or equivalent) from each Division will be invited to attend each meeting.

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are entitled to attend any meeting of the Committee.

A representative from the 'Doctors in training' (Junior Doctors) and/or junior members of other healthcare professions at the Trust will be invited to attend each meeting, and provide a report on their reflections of the patient experience-related matters relevant to their role.

A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting, and provide a report on relevant matters.

The Chair/s of the Patient Experience Committee's sub-committee~~s~~ will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the ~~objectives of the~~ Committee's duties.

4. Frequency of meetings

Meetings will be generally held quarterly.

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

5. Duties

- To positively promote the Trust's partnership with its patients and public
- To aim to capture~~provide~~ the perspective of patients and the public, and ~~to~~ present the patients' and public's perception of the Trust's services
- To oversee the development of patient information within the Trust, via the Patient Information Leaflet Group (PILG)
- To contribute to the development of Trust Policies, ~~and~~ procedures, and strategies in so far as they relate to patient experience
- To advise on priorities for patient surveys and on the methods for obtaining local patient feedback
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - The planning of the provision of its services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media
  - Complaints and PALS contacts information
  - ~~PALS contacts information~~
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
  - Patient experience-related findings from the "Patient Representative Working Group", as required~~Care Assurance Audits (including reports from external members of the Committee)~~
- To review the work being undertaken by Clinical Directorates in relation to patient experience
- To maintain awareness of the developments with the Kent and Medway Sustainability and Transformation Plan (STP)

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Quality Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:

- Patient Information Leaflet Group (PILG)

The frequency of reporting will depend on the frequency of sub-committee meetings.

8. Quality Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee. The summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose.

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda, minutes and 'actions log'
- ~~The meeting minutes and the action log~~

10. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

11. Review

The Terms of Reference of the Committee will be agreed by the Patient Experience Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2016
- Terms of Reference (amended) approved by the Trust Board, 23rd March 2016
- Terms of Reference (amended) agreed by the Patient Experience Committee, 8th March 2017
- Terms of Reference (amended) approved by the Trust Board, 29th March 2017

Trust Board meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-17 Workforce Committee Report Cttee. Chair, Non-Executive Director

This report provides a summary of the issues discussed at the Workforce Committee on 09/03/17.

Pay progression for Consultants and Whistleblowing

The Committee agreed the pay progression for Consultants self-declaration and the Director of Workforce outlined that a review of the Trust approach to Speaking Out Safely (formerly Whistleblowing) would be conducted and outcome reported to the June 2017 Workforce Committee.

Staff Engagement

The Committee received a detailed presentation on the 2016 staff survey results. The presentation examined:

- Overall staff engagement
- Key metrics for staff recommendation – care and work
- Top & bottom 5 ranking scores
- Results by key finding (32)
- Results at a glance (13)- NHS Employers infographic
- National picture
- Local picture
- The MTW journey so far…a snapshot
- Data required for the Workforce Race Equality Standard (WRES)

While it is evident that the Trust has maintained many of the better scores it achieved in 2015, which is a credit to our staff given the challenges we have faced, it was unable to emulate these successes and drive through further improvements in key areas during 2016. In terms of the overall staff recommendation of the organisation as a place to work or receive treatment:

		MTW 2016	Average for acute trusts	MTW 2015	MTW 2014
Q21a	"Care of patients / service users is my organisation's top priority"	79%	76%	79%	74%
Q21b	"My organisation acts on concerns raised by patients / service users"	75%	74%	74%	74%
Q21c	"I would recommend my organisation as a place to work"	63%	62%	65%	63%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	75%	70%	75%	73%
KF1	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	**3.84**	**3.77**	**3.85**	**3.80**

The Director of Workforce explained that the Trust has not witnessed a significant step change in relation to staff engagement in recent years. Successive staff survey action plans, both trust wide and within directorates, have assisted in improving the overall position but have been unsuccessful in making a significant change to a relatively stable organisation in relation to staff engagement and satisfaction. Therefore it is clear that to move from average to good we need a vehicle to make this transition.

The draft staff engagement and communications plan was circulated. Included within the plan was confirmation that the Trust would adopt Listening into Action (LiA). LiA has been trialled and proven over the past several years in the NHS with significant success in shifting the way organisations work and lead. NHS Improvement and CQC advocate the approach and over 100 NHS organisations have used it. The Director of Workforce explained that the process involves a 12 month journey with 4 clear phases that build a sustainable approach to staff engagement: fundamentally putting staff (who know the most) at the centre of change. The approach will be led the Deputy Chief Executive.

Action plans will be developed in response to the staff survey findings and the Workforce Committee will be kept informed with regard progress and the deployment of LiA in the Trust.

The Annual Equality report was circulated detailing the progress that had been made over the past year and plan for the year ahead. The report will now be published on the Trust website.

Nurse Recruitment Plan

The Workforce Committee were provided with a report detailing the nurse recruitment plan for the next 12 months. The Committee agreed with the plan.

Education, Learning & Development

The Director of Medical Education presented the Committee with an updated against the detailed action plan in relation to the GMC Survey and an update of progress with the following areas:

- HEKSS Programme Quality Review Visits
- New Post Opportunities
- Physicians Associates
- A Career in Medicine event – this popular annual event with local schools has been organised for 22nd March 2017.
- Medical Humanities – the 3rd Regional Medical Humanities Seminar is to be held in the Trust on 23rd March 2017.
- Undergraduate Programme – the Trust remains a popular destination with Undergraduate students from King's and St George's. The new Year 4 curriculum commenced in September 2016, current feedback is very good and more encouraging than the initial. Work has started on the new Year 5 curriculum which will be implemented in May 17.
- Quality and Innovation in Education (EDQUIN) - Funding was secured from HE KSS to work on the following proposals:
    i. Feedback workshops
    ii. Team based education projects
    iii. Departmental Induction videos

An update was provided to the Committee in relation to the Trust response and approach to apprenticeships. The Committee requested that all potential roles be mapped and communicated to managers.

The Workforce Committee were asked to approve Dementia training for all staff. The Committee agreed that training would become mandatory and once all staff had received the training, the frequency for update would then be reviewed.

Guardian for Safe Working Report

The Workforce Committee received the first quarterly Guardian for Safe Working Report from Dr Matt Milner (Guardian for Safe Working). The Report is enclosed at Appendix 1.

E-Rostering System Deployment Update

The report provided an update on the deployment for the replacement rostering system. The Committee were informed that the pilot stage went well and a detailed plan of deployment was provided to the Committee. A presentation on the detailed KPI's available from the system will be provided to a future Committee.

Workforce Information

The Director of Workforce presented the Committee with an example of the new automated

workforce reports. The reports will be available on day 1 of each month and cascaded to all managers. The Workforce Committee noted the hard work that had gone into the development and requested that the Workforce Performance Dashboard be replaced with the report.

The Committee received a report on the workforce dashboard which highlighted the issues of temporary workforce, vacancies, payroll compliance and provided an update in relation to the overall Trust compliance with DBS checks.

Enc: Appendix 1 - Guardian for Safe Working Report

Which Committees have reviewed the information prior to Board submission?

- Workforce Committee, 09/03/17

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

1. Information and Assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

WORKFORCE COMMITTEE – 9th March 2017

09/03/17	GUARDIAN FOR SAFE WORKING REPORT	DR MATT MILNER GUARDIAN FOR SAFE WORKING

Summary / Key points

Report covers October –December 2016

In August 2016 the new Terms & Conditions (TCS) were introduced for doctors in training. Currently there are 66 doctors working in the Trust under the 2016 TCS. Gynaecology ST3 & above, and F1 doctors across specialities are currently involved. There are clear guidelines of safe working hours and adequate supervision. Trainees file 'exception report' if these conditions are breached.

- In total seven reports were filed, all by F1 doctors. Mainly in medicine.
- The main issues were extra hours worked and one F1 was concerned with inadequate supervision.
- These issues have been addressed with the relevant clinical supervisors and Clinical Director.
- All F1 doctors under took a diary card exercise in November 2016 for which was shown to be compliant with the TCS 2002
- Agency expenditure for the period was £2,338,828
- Bank expenditure was £797,014
- 'Doctor in training' staff vacancies were 23 WTE

Which Committees have reviewed the information prior to Workforce Committee submission?
None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.) [1]
- Information
- Assurance

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

Introduction:

In August 2016 the new Terms & Conditions (TCS) were introduced for doctors in training. The TCS clearly indicate the importance of appropriate working hours that are safe and have a direct effect on the quality and safety of patient care. Currently there are 66 doctors working in the Trust under the 2016 TCS.

Aligned to this new contract, is the development of the role of a 'Guardian for Safe Working'. This role is to oversee the safeguards outlined in the contract and will ensure that issues of compliance with safe working hours are addressed by the doctors and/or the employer.

Exception reports are raised by junior doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through the DRS system. They notify the Guardian for Safe Working and the Educational Supervisor for the individual doctor to review the Exception Report and take appropriate action to rectify. Such action may include time off in lieu or payment for additional hours worked. Where issues are not resolved or a significant concern is raised the Guardian may request a review of the doctors work schedule. The Guardian may levy fines against departments where considered appropriate.

The Guardian for Safe Working is required to report no less than quarterly to Trust Board via Workforce committee and provide an annual report. This report gives information on numbers of junior doctors in the trust on 2016 contract, exception reports raised and outcomes, work schedule reviews, locum bookings, vacancies for training grades and fines levied.

In line with the 2016 TCS a Junior Doctors Forum has been jointed established with the Guardian of Safe Working and the Director of Medical Education. It is chaired by the Guardian for Safe working. The inaugural meeting was held on 19th October 2016, membership and the constitution were discussed. The second meeting on 11th January included discussion on the exception reports raised.

High level data:

Number of doctors in training (total):	357
Number of doctors in training on 2016 TCS (total):	66
Amount of time available in job plan for guardian to do the role:	2 PA per week
Amount of job-planned time for educational supervisors	0.25 PA/trainee
Admin support provided to the Guardian by EA to Director of Workforce	As required.

a) Exception reports (with regard to working hours)

Between 1st October & 31st December 2016 at total of 7 exception reports have been raised. The tables below give detail on where exceptions have been raised and the response times to deal with the issue raised.

Since October 2016 only Gynae ST3 & above and F1 doctors have been engaged on the 2016 TCS. Of the 7 exception reports raised, all where received from F1 doctors and related to working extra hours, reported to be due to inpatient levels. In addition, 2 of these reports also raised concern about the level of support given to junior doctors involved.

These issues have been addressed by discussions held with Educational & Clinical supervisors and also with the Clinical Directors for Urgent Care directorate. Winter pressures and escalation wards in General Medicine have increased the work of Medical teams and may benefit from a review across all specialties on sharing of workload.

There were no concerns raised by doctors on 2016 TCS within the Obstetrics & Gynecology department.

Exception reports by department: Oct 2016 – December 2016				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Surgery	0	1	1	0
Gastroenterology	0	2	2	0
Respiratory	0	1	1	0
Stroke	0	3	0	3
Total	**0**	**7**	**4**	**3**

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	7	4	3
Obs & Gynae ST3+	0	0	0	0
Total	**0**	**7**	**4**	**3**

Exception reports (response time)				
Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	4	3
Obs & Gynae ST3+	0	0	0	0
Total	**0**	**0**	**4**	**3**

b) Diary card exercises

Six diary card exercises were undertaken during the period of review, all of which were found to be compliant at time of undertaking.

Hours monitoring exercises (for doctors on 2002 TCS only)						
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**	**Percentage Return**
General Medicine TW	F1	47.1	52.28	1B	Y	75%
General Medicine MGH	F1	47.44	52.24	2B **	Y	86%
Psychiatry	F1	43.15	41.5	1A	Y	60%
Anaesthetics	F1	43.15	44.5	1A	Y	100%
General Surgery	F1	47.37	48.51	1A	Y	89%
Trauma & Orthopaedics	F1	44.25	58.05	1B	Y	100%

** Rota is banded 1B but results showed 2B

c) Work Schedule reviews

As shown in the table below, no work schedule reviews were required in the quarter Oct – Dec 2016.

Work Schedule reviews by Grade	
F1	0
Obs & Gynae ST3+	0
Total	**0**

d) Locum bookings

i) Staff Bank:

The tables below give detail of the shifts/hours/costs of bank cover used by specialty and also by grade of doctor.

Specialty	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover £**
Accident and Emergency	1046	4957	306,884.40
General Management / Acute Medicine	218	1690	82,325.09
Anaesthetics	253	2383	127,144.15
Cardiology	5	20	1,000.00
Cytology	14	96	11,065.29
ENT	35	517	30,413.00
General Surgery	199	1845	82,589.10
Neurology	2	28	2,600.00
Obstetrics and Gynaecology	125	1191	64,585.00
Oncology	54	409	20,175.00
Opthalmology	38	323	18,631.75
Trauma & Orthopaedics	54	569	29,076.00
Paediatrics	29	352	18,775.00
Urology	7	35	1,750.00
Total	**2079**	**14415**	**797,013.78**

Grade of Doctor	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover £**
F1	275	2818	189,903.78
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	35	286	8,034.25
ST3+, Specialty Doctor (Registrar Level)	904	5220	264,760.55
Consultant	865	6091	334,315.20
TOTALS	**2079**	**14415**	**797,013.77**

ii) Agency

As shown above for bank staff usage, these tables given detail of agency staff used to provide cover.

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover £
Accident and Emergency	774	6445	422,446.61
General Medicine / Acute Medicine	1839	14535	1,022,570.65
Anaesthetics	50	367	22,088.38
Cytology	25	200	16,235.20
General Surgery	260	2299	150,246.33
GU Medicine	65	550	53,708.60
Histopathology	84	651	64,473.44
Obstetrics and Gynaecology	104	1214	75,096.79
Oncology	47	362	29,190.00
Opthalmology	161	1151	90,416.91
Trauma & Orthopaedics	578	4472	276,711.48
Paediatrics	26	283	18,765.82
Radiology	82	659	71,229.90
Urology	41	337	25,647.57
Total	**4136**	**33524**	**2,338,827.67**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Agency Cover £
F1	57	467	17,045.38
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1262	10,021	522,215.72
ST3+, Specialty Doctor (Registrar Level)	1875	15,159	981,431.53
Consultant	942	7877	818,135.04
TOTALS	**4136**	**33523.57**	**2,338,827.67**

e) Locum work carried out by Trainees

There is currently insufficient data available to report effectively.

f) Vacancies WTE

Vacancies by month						
Specialty	Grade	Oct-16	Nov-16	Dec-16	Total gaps (average)	Comments
General Management /Acute Medicine	F1	1	1	1	1	
General Management /Acute Medicine	ST1	4	4	4	4	
ENT	GPST1	1	0	0	0.333333	Deferred Start Date from August Changeover
General Surgery	F1	1	1	1	1	
General Surgery	ST1	1	1	1	1	
Emergency Medicine	ST1	2	2	2	2	
Anaesthetics	ST3+	2	2	2	2	Department Did not wish to fill
Histopathology	ST3+	1	1	1	1	Department Did not wish to fill
Paediatrics	ST4+	1	0	0	0.333333	Candidate started 07/11/2016
Paediatrics	ST1	1	1	1	1	
Emergency Medicine	ST3+	1	1	1	1	
Acute Medicine	ST3+	3	3	3	3	
General Surgery	ST3+	1	1	1	1	
General Medicine	ST3+	1	1	1	1	
Trauma & Orthopaedics	ST3+	3	3	3	3	
Obstetrics & Gynaecology	ST3+	4	4	4	4	3 x Trainees on Mat Leave

g) Fines

There have been no fines imposed for the quarter Oct 16 – Dec 16.

Summary of findings:

This is the first report from the Guardian of safe working. This report outlines the period of October-December 2016.

Out of all the doctors in training, only Obstetrics & Gynaecology ST3 & above and F1 doctors across specialties are currently contracted to work on 2016 TCS therefore, eligible to raise an exception report.

There were 7 reports in total, all related to working more than the hours set out in work schedules and 2 referred to inadequate senior support.

The main area of concern is the F1 doctors in general medicine across site. They performed a diary card exercise, before exception reporting was initiated for them in early December. The diary card exercise was undertaken before the inclusion of escalation beds in their everyday work.

Information received from the F1 doctors indicates that covering escalation beds has significantly increased their workload.

There is now an imbalance of work load between medical and surgical specialities cross site, with the medical teams having patients on surgical wards, as there has been a reduction in elective surgical work, as a consequence of increased medical emergency admissions.

I have discussed the position with Laurence Maiden; Clinical Director for General Medicine and Akbar Soorma, Clinical Director for Acute Medicine, the matter was also discussed at the CD's meeting. There needs to be better organisation of escalated bed allocation and surgical juniors need to help with the medical junior doctors' workload, as they themselves have had a reduction of workload intensity.

This action will reduce the work load of the F1 doctors in general medicine cross site. The position will be reviewed before my next report.

Two reports have been received from an F1 with regard to the level of supervision they have been given. I have discussed these issues with their clinical supervisor and the Clinical Director for the service, for which Dr Maiden is addressing

With regard expenditure on bank staff for the period of October – December 2016 this was £797,014 and Agency use was £2,338,828.

The Trust currently has 26 WTE vacancies across the specialities at training grade.

In conclusion the main area of concern across the Trust, received from exception reports is the level of work being undertaken by the medical trainees across site. The Clinical Directors for Urgent Care and myself, as Guardian are aware of the issues and have agreed there must be a better distribution of work between the medical and surgical junior doctors which the Clinical Directors will facilitate.

Trust Board Meeting – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-18 Summary report from Quality C'ttee, 15/03/17 C'ttee Chair (Non-Executive Director)

The Quality Committee has met once since the last Trust Board meeting, on 15th March (a 'main' meeting).

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

- A review of the **progress with actions** agreed from previous meetings, in which the Committee was assured that the previously reported issues regarding the Medical cover for the Maidstone Orthopaedic Unit (MOU) had now been resolved.
- The Medical Director reported on **quality matters arising from the Financial Recovery Plan**, and stated that although he had been assured that Quality Impact Assessment (QIA) process was robust, it had been identified that QIAs had not been undertaken recently for all schemes. It was however noted that the Director of Finance would investigate this, and ensure QIAs were completed and 'signed off' by the Medical Director and Chief Nurse
- The Chief Operating Officer reported on the **work being undertaken to reduce Length of Stay**, and it was agreed to arrange for future update reports to include details about a) the intended improvement trajectory and b) contextual factors (i.e. increased clinical activity and higher patient acuity)
- A report of the **Trust Clinical Governance Committee** meetings held on 17/01/17 and 10/02/17 was discussed, and each Directorate highlighted their key issues, which included:
  - The continued efforts to improve the number of Mortality Reviews undertaken. Trauma & Orthopaedics reported that improvements had been made to their Review process, particularly in relation to accessing healthcare records
  - Staffing-related challenges continued, particularly in the Specialist Medicine & Therapies and Acute and Emergency Directorates, within Pharmacy, and for Sonographers. Some recent successes were however reported, including the appointment of 6 new Emergency Department Practitioners posts, a new Clinical Skills Facilitator in Trauma and Orthopaedics, a new Specialty and Associate Specialist (SAS) Doctor in Critical Care, and an improved staffing situation within Medical Physics
  - The Symphony A&E IT system would be unsupported in August 2017, and the version currently being used had not had the last circa 9 updates applied. The Chief Operating Officer explained that the situation was linked to the delay in the replacement of the Trust's PAS, and agreed to ensure that the current issues relating to Symphony were included within the report on "the current status regarding the implementation of the replacement PAS+" to be submitted to the 'Part 2' Trust Board meeting in March
  - The A&E Friends and Family Test (FFT) response rate had improved recently, and the Chief Nurse paid particular tribute to the efforts of the relevant Matrons (Kate Hallewell and Stella Davey). The highest percentage of those who would recommend A&E had been also been achieved
  - Ophthalmology continued to work on a project relating to Anti-VEGF injection treatment
  - The escalation of the Short Stay Surgery Unit had been very challenging over past few months, and activity had been cancelled as a result, which affected performance against the various access targets, including the Cancer waiting time targets (as the cancellations had included a small number of Cancer patients). Additional lists were however being scheduled for weekends
  - The Theatre recovery areas were now being de-escalated, and Theatres were functioning much better
  - The latest outcome data from the National Emergency Laparotomy Audit (NELA) showed that the Trust's mortality rate had increased for the last Quarter, so the Clinical Director for Critical Care will retrieve and review the relevant healthcare records
  - The Preventing Future Deaths (PFD) report from the Inquest into the death of Mrs Cappuccini had been issued, and the case would be presented again at the next Clinical Governance meeting, which would be held jointly with Obstetrics

  - There had been some discussion in relation to clinical audits of NICE guidelines, and the Medical Director offered to be copied into email communication between the Directorates and the Clinical Audit department
  - Chemotherapy capacity continued to be an issue, and a Business Case for 6-day working was being developed
  - The Consultant-to-Consultant referral process for CT scan requests had been relaxed, and as a result the number of requests had doubled, which was placing the 6-week target and other diagnostic pathways at risk, and Directorates therefore needed to act as 'gatekeepers' for such requests. The Medical Director agreed to liaise with the Clinical Director for Diagnostics & Pharmacy, to consider the response
  - An incident in which an Obstetric patient had to be given a significant amount of blood would be subject to a full Root Cause Analysis (RCA) but the staff's management of the case was commended
  - The Woodlands Assessment Unit was now open until midnight, and the opening times of the Paediatric A&E had changed (the Department was now open between 10am and 10pm, as most patients visited the Department between 3pm and 10pm)
- The Clinical Director for Diagnostics and Pharmacy reported on **the traceability of Blood products**, which stemmed from concerns following a recent inspection by the Medicines and Healthcare products Regulatory Agency (MHRA). It was noted that the present system to 'fate' blood products was semi-automatic/semi-manual, but the next phase of the Bloodhound Management System enabled bar-coding technology to be used to perform fating at patients' bedsides. The Business Case for this next phase was currently being considered by the Executive Team
- The Medical Director spoke to a **response to the relevant recommendations within the 'Learning, candour and accountability' report from the Care Quality Commission**, & it was agreed to submit an updated response to the next 'main' Quality Committee, in May
- The Chief Nurse presented an **assurance report on the "Summary of findings" within the Care Quality Commission's Quality Report for the Trust**, February 2015, which had arisen from an action at the 'Part 2' Trust Board meeting in February 2017. It was agreed that an updated report should be submitted to the 'main' Quality Committee in May, and that the report should include the actions required (and planned) to achieve an overall rating of "Good" at the Commission's next inspection
- The Medical Director reported on the latest **Serious Incidents** (SIs), and noted that the number had reduced, but this was not related to an overall reduction in incident reporting
- The **recent findings from relevant Internal Audit reviews** were noted, as were the **minutes of the Quality Committee 'deep dive' meetings** held on 04/01/17 and 06/02/17
- Finally, the very successful outcome of the recent **CHKS review for Cancer** was reported

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

- N/A

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

- The Symphony A&E IT system would be unsupported in August 2017, and the version currently being used had not had the last circa 9 updates applied. The Chief Operating Officer explained that the situation was linked to the delay in the replacement of the Trust's PAS, and agreed to ensure that the current issues relating to Symphony were included within the report on "the current status regarding the implementation of the replacement PAS+" to be submitted to the 'Part 2' Trust Board meeting in March

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 – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-19	Summary of the Trust Management Executive (TME) meeting, 22/03	Deputy Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Chief Nurse highlighted the work taking place to mark the safety theme for the month (the prevention and management of Pressure Ulcers)
- The draft **Information Governance Toolkit year-end return for 2016/17** was reviewed and endorsed (this has been submitted for Board approval in March via a separate item/report)
- 3 **replacement Consultant posts were approved** (for an ENT Surgeon, an Ophthalmologist with Corneal expertise, and a Haematologist)
- The report of the **post-project review of the Business Case for the Crowborough Birth Centre** was reviewed, & the recommendation to continue was supported, prior to this being considered at the Finance Committee on 27/03/17. It was however also agreed that a more detailed action plan should be developed, to supplement the high-level actions in the report
- The Medical Director gave a presentation to formally launch the **Workforce Transformation programme** (which is also the subject of a separate item at the March Trust Board)
- Updates were given on the **national 7 day service programme** and the **Financial Recovery Plan (FRP) / Financial Special Measures (FSM),** which include the latest year-end forecast
- The **Performance for month 11**, 2016/17 was discussed. The issues raised included the continuing efforts being made to understand the increased Hospital Standardised Mortality Ratio (HSMR) at the Trust, the Never Event that occurred in month 11, performance on the A&E 4-hour and 18-week referral to treatment waiting time targets, and Length of Stay
- A detailed report on **62-day Cancer waiting time target performance** was received (the same report has been submitted to the March Trust Board, under a separate item)
- The latest **infection prevention and control** position was reported, which noted there had been 27 cases of Clostridium difficile for the year to date, against the limit of 27. The increasing importance being given to E. Coli bacteraemia was also discussed
- The **reports from Divisions** (which were given jointly by the relevant Director of Operations and Clinical Directors) highlighted that for Urgent Care, the key issues were the vacancy rate (there were circa 150 Registered Nurse vacancies across the Division), & capacity/patient flow. The Director of Operations for Urgent Care agreed to consider whether the funds that were currently being saved as a result of the Nursing vacancies could be used to support the currently-stalled plans for the development of the Acute Oncology Service. For Planned Care, the key issues were the development of the Business Case for Orthopaedic activity (which related to the future use of Theatre 6 at Tun. Wells and the continued operation of the Maidstone Orthopaedic Unit (MOU)), and the CIP target for 2017/18. For Women's, Children's & Sexual Health, the key issues were the increase in Sonographers' workload, financial challenges, and Gynaecology activity/18 week wait performance
- The key issues discussed at the latest **Clinical Directors' Committee** were noted, which included the discussions that had taken place regarding the proposed Divisional operational management structure. The issues discussed at recent **Executive Team meetings** were also noted, which were similar to the issues discussed at the TME
- The findings from the **National NHS Staff survey 2016** were considered, and the intention to launch a 'Listening into Action' programme of staff engagement was noted
- The Chief Nurse reported on the intention to undertake **overseas recruitment of Nurses** from India and/or the Philippines
- A brief update was given on the **Kent & Medway STP**, which acknowledged the recent announcement from East Kent Hospitals University NHS Foundation Trust regarding Kent and Canterbury Hospital
- The Chief Nurse presented the **Annual Report from the Senior Information Risk Owner (SIRO)** (which has also been submitted to the March Trust Board, under a separate item)
- The summary report from the **Trust Clinical Governance Committee** was received, as was the 1 **recently-approved business case**

- A report describing the latest on the provision of Positron Emission Tomography (PET) and Computed Tomography (CT) scanning within West Kent under the new national contract (which began in April 2015 and will last for 10 years) was received. This highlighted that the Trust had agreed with Alliance Medical to develop a purpose built fixed PET/CT unit at Maidstone, which would connect through to the Nuclear Medicine department, at the Oncology end of the site. Work had now started, and & it was planned for the new Unit to be ready in late August 2017
- An update on the **implementation of the replacement PAS+** noted that in light of the delays to the implementation, two assurance programmes were underway, one internal and one external (by NHS Digital) and the findings were expected soon. A separate report on the PAS+ has been submitted to the 'Part 2' Trust Board meeting in March
- Formal updates were received on the recent activity of the TME's main **sub-committees** (Clinical Operations & Delivery Committee, Informatics Steering Group, Information Governance Committee, Policy Ratification Committee, and MTW Programme Committee). The report from the latter noted that a Task and Finish Group was being established in relation to the creation of a GP Unit within A&E

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 – March 2017

NHS Maidstone and Tunbridge Wells NHS Trust

3-20 Summary report from Finance C'ttee, 27/03 Committee Chair (Non-Exec. Director)

The Finance Committee met on 27th February 2017.

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

- The actions from previous meetings were discussed, and it was agreed to schedule a report to be considered at the Committee in May, on the options being considered in relation to the PFI contract at Tunbridge Wells Hospital
- Under the "Safety Moment", the Trust Secretary reported that month's theme was the prevention and management of Pressure Ulcers
- An update on progress in implementing the Financial Recovery Plan was given, and the month 11 financial performance for 2016/17 was reviewed. The likely year-end position was highlighted, as well as the associated risks. A report on the Cost Improvement Plan for 2017/18 highlighted the value of identified CIP schemes this far, along with the level of risk. The format of the proposed "Cost Improvement Dashboard" report to the Committee was also discussed, and some comments were made, which would be reflected in the dashboard
- An update on the Workforce Transformation programme was given by the Medical Director, and it was agreed that future monthly updates would continue to be given (but verbally)
- An update on the Lord Carter efficiency review described the progress of the latest specialty 'deep dive' meetings. It was agreed to continue to receive updates at each meeting
- The Clinical Director for Diagnostics & Pharmacy and General Manager for Pathology attended, to present a report on the proposed extension of the Managed Laboratory Service (MLS). The Committee supported the preferred option to extend the contract for 3 years (until 31/05/20), but it was agreed that this should be submitted to the 'Part 2' Trust Board for a formal decision. It was also agreed to clarify the cost of the financial penalties involved should the contract be terminated within the 3-year extension period; & clarify whether the assets relating to the MLS could be purchased at residual value at the end of that period
- A post-project review of the Business Case for the Crowborough Birth Centre was reviewed, and the Committee agreed to support the recommendation, which was to continue to manage the Centre, and work to increase the overall activity. It was however agreed to schedule a further review, in September 2017, of the financial performance of the Centre
- The financial aspects of the Risk Register were reviewed, and it was agreed to schedule a report on the Trust's longer term financial position for consideration at the Committee in April (and then be submitted to the Trust Board)
- The Deputy Director of Finance (Financial Performance) gave the latest update on progress with the Finance Department Improvement Plan, and the good progress was noted
- The usual report on breaches of the external cap on the Agency staff pay rate was noted, and the Committee was notified of 2 recent uses of the Trust Seal
- The Committee reviewed the previous decision to invite the Chief Operating Officer and Director of Workforce to participate in the 'monthly performance' item at Finance Committee meetings, and agreed that the invitation could be withdrawn

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

- The Committee should be provided with the reasons for the 'amber' rated performance on the "Timely identification and treatment for sepsis in acute inpatient settings" CQUIN target
- There should be a consistent approach, within the monthly finance report, to the presentation of financial performance 'Actuals' that represent a negative position
- The Trust Secretary should arrange for the text within the Risk Register entry for risk 2289 ("Over use of temporary staff creates a cost pressure") to be refreshed/updated

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

- The Trust Board should be asked to consider a proposed extension of the Managed Laboratory Service (MLS) (this will be considered in the 'Part 2' meeting

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 – March 2017

Maidstone and Tunbridge Wells NHS Trust

3-22 Review of the Terms of Reference for the Trust Board — Chair of the Trust Board

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. This review and approval last took place in March 2016.

The Terms of Reference have been reviewed, and a number of minor amendments are proposed. These have been 'tracked' in the enclosed. None of the proposed amendments are significant, and can largely be categorised as 'housekeeping', to reflect changes that have already been agreed (as part of the approval of revised Standing Orders), or occur in practice.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval

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

Trust Board

Terms of Reference

Purpose and duties

1. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to an Executive Director. The Trust Board consists of a Chairman (Non-Executive), five other Non-Executive Directors (voting members), the Chief Executive, and four Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making.

3. The Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its Committees –are described in the Trust's Standing Orders.

<u>General responsibilities</u>

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

<u>Leadership</u>

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

<u>Strategy</u>

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;

9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Board Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Members. This Code is incorporated within the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Governance

12. The Trust Board:
12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
12.2. Ensures that the Trust complies with its governance and assurance obligations;
12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
12.5. Ensures that the statutory duties of the Trust are effectively discharged;
12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Trust Board:
13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Executive Directors.

Ethics and integrity

14. The Trust Board:
14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
14.2. Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Trust Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Trust Board:
    17.1. Ensures that the Trust operates effectively, efficiently, economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chairman

18. The Chairman of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chairman is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chairman is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chairman of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
    24.1. A Non-Executive Chairman
    24.2. Non-Executive Directors (5). One of these will be designated as Vice- Chairman
    24.3. The Chief Executive
    24.4. The Director of Finance
    24.5. The Medical Director
    24.6. The Chief Nurse
    24.7. The Chief Operating Officer

Non-voting Board Members will be invited to attend at the discretion at the Chairman.

Quorum

25. The Board will be quorate when four ~~of the~~ Trust Board Members including at least the Chairman (or Non-Executive Director nominated to act as Chairman), one other Non-

Executive Director, the Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (member) are present[2].

~~25.~~26. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

~~26.~~27. The Trust Secretary will attend each meeting.

~~27.~~28. Other staff members and external experts may be attend ~~the~~ Trust Board meetings to contribute to specific agenda items, at the discretion of the Chairman

Frequency of meetings

~~28.~~29. The Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chairman.

Board development

~~29.~~30. The Chairman, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a "balanced board" where the skills and experience available are appropriate to the challenges and priorities faced;

~~30.~~31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

~~31.~~32. The Trust Board has the following sub-committees
- ~~31.1.~~32.1. The Quality Committee
- ~~31.2.~~32.2. The Patient Experience Committee
- ~~31.3.~~32.3. The Audit and Governance Committee
- ~~31.4.~~32.4. The Finance Committee
- ~~31.5.~~32.5. The Workforce Committee
- ~~31.6. The Foundation Trust Committee~~
- 32.6. The Charitable Funds Committee
- ~~31.7.~~32.7. The Remuneration and Appointments Committee

~~32.~~33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance Committee, Charitable Funds Committee, and Workforce Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair~~man~~ of that meeting) in a timely manner

~~33.~~34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

~~34.~~35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman of the Trust Board after having consulted at least two Non-Executive Directors.

~~35.~~36. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

[2] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chairman and members (including at least one Executive Director and one Non-Executive Director) is present"

Administration

~~36.~~37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

~~36.1.~~37.1. Agreement of the agenda for Trust Board meetings with the Chairman and Chief Executive;

~~36.2.~~37.2. Collation of reports for Trust Board meetings;

~~36.3.~~37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;

~~36.4.~~37.4. Advising the Trust Board on governance matters.

~~37.~~38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chairman and Chief Executive ~~from time to time~~.

Conflict with Standing Orders Set

~~38.~~39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

~~39.~~40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 29th ~~23rd~~ March 201~~6~~7