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 26TH APRIL 2017
LECTURE ROOMS 1 AND 2, THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter/s	Attachment
4-1	To receive apologies for absence	Chair of the Trust Board	Verbal
4-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
4-3	Minutes of the Part 1 meeting of 29th March 2017	Chair of the Trust Board	1
4-4	To note progress with previous actions	Chair of the Trust Board	2
4-5	Safety moment	Chief Nurse	Verbal
4-6	Chair's report	Chair of the Trust Board	Verbal
4-7	Chief Executive's report	Chief Executive	3
4-8	Year-end review of the Board Assurance Framework, 2016/17 / Agreement of key objectives for 2017/18	Trust Secretary	4
4-9	Integrated Performance Report for March 2017 ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Safe / Effectiveness / Caring ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) ▪ Safe / Effectiveness (incl. Mortality)	Chief Executive Chief Operating Officer Chief Nurse Dir. of Infect. Prev. & Control Director of Finance Director of Workforce Medical Director	5
	Quality items		
4-10	Outcome of the current investigations regarding mortality / increased HSMR	Medical Director	6
4-11	Planned and actual ward staffing for March 2017	Chief Nurse	7
4-12	Board members' hospital visits	Trust Secretary	8
	Planning and strategy		
4-13	Next steps on the NHS five year forward view	Deputy Chief Executive	9
	Reports from Board sub-committees (and the Trust Management Executive)		
4-14	Quality Committee, 10/04/17	Committee Chair	10
4-15	Trust Management Executive (TME), 19/04/17 (incl. approval of the Sustainable Development Management Plan (SDMP))	Committee Chair	11
4-16	Finance Committee, 24/04/17	Committee Chair	12 (to follow)
4-17	**To consider any other business**		
4-18	**To receive any questions from members of the public**		
4-19	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chair of the Trust Board	Verbal

Date of next meetings:

- 24th May 2017, 10.30am, Academic Centre, Maidstone Hospital
- 28th June 2017, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 19th July 2017, 10.30am, Academic Centre, Maidstone Hospital

Kevin Tallett,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 29TH MARCH 2017, 10.30A.M AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Kevin Tallett	Chair of the Trust Board	(KT)
	Glenn Douglas	Chief Executive	(GD)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director (via teleconference, for items 3-12, 3-13, 3-14, 3-16, 3-22 and 3-23)	(AK)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention & Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Darren Yates	Head of Communications	(DY)
	Samantha Low	Vygon (UK) Ltd	(SL)

3-1 To receive apologies for absence

Apologies were received from Sara Dunnett (SDu), Non-Executive Director. It was also noted that Alex King (AK), Non-Executive Director, was unable to be present in person, but he would join via teleconference, to ensure the meeting was quorate for items 3-12, 3-13, 3-14, 3-16, 3-22 and 3-23.

3-2 To declare interests relevant to agenda items

KT declared his engagement with Medway NHS Foundation Trust (MFT) to deliver Programme Management Office (PMO) Services (via his company, Discidium Ltd) would end on 31/03/17.

PM confirmed he was the Responsible Officer for Kent Community Health NHS Foundation Trust, in relation to Medical revalidation, but it was confirmed that this was not required to be declared at each Trust Board meeting, as such joint arrangements were commonplace among providers.

3-3 Minutes of the Part 1 meeting of 22nd February 2017

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

3-4 To note progress with previous actions

The circulated report was noted.

KT then referred to action 1(2)-13 ("Arrange for an overall communications approach/plan to be developed, and submitted to the Trust Board for consideration"), which was listed in the 'actions log' for the 'Part 2' Trust Board meeting scheduled for later that day, and noted that it had been stated that a verbal update on progress would be reported to the 'Part 1' Board meeting. KR confirmed that a verbal update would be provided by JL under item 3-21.

3-5 Safety moment

COB reported that the focus of the month was preventing pressure damage, and 5 simple steps were being promoted by the Trust's Tissue Viability Nurses, which focused on the surface of the skin, skin inspection, keeping patients mobile, incontinence care (which was a major factor in pressure damage), and nutrition and hydration (which contributed to skin integrity). COB added that the engagement of the full multi-professional team was important.

KT asked whether Tissue Viability Nurses were funded by the Trust. COB confirmed this was the case. KT then asked whether mouth care was being considered. COB confirmed that this affected

nutrition, but noted that the Trust had recently engaged a member of staff to support a separate "Mouth Care Matters" initiative.

3-6 Chairman's report

KT reported that he was pleased to see progress being made in a number of the key areas of operational performance.

3-7 Chief Executive's report

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

- Additional funding for adult Social Care had been announced, but the Trust was awaiting the start of an interaction with Kent County Council (KCC) as to how this would be spent. This interaction had however been somewhat curtailed by the fact that KCC were in the midst of an OFSTED inspection regarding looked after children. The funding could possibly be used for domiciliary packages of care, and therefore the Trust needed to ensure it used its influence with KCC to ensure it was spent appropriately
- Although the increased funding appeared to be significant, the rate of pay for domiciliary care workers needed to increase, due to historical factors, and there was a risk that the funding may therefore just address a pay gap rather than provide significantly more care packages

KT asked whether KCC was likely to release any of the funds directly to the Trust. GD replied that statutorily, the funding would be added to the Local Authority grants, but there was certainly a desire, on behalf of the NHS bodies involved in the Sustainability and Transformation Plan (STP), to have more direct control over the use of the funding.

GD then continued, and highlighted the following points:

- KT should be thanked for presiding as Chair of the Trust Board in the interim period, but David Highton, the new Chair, would start on 08/05/17, & preside over his first Board meeting in May
- GD wished to formally thank the former Chairman of the Trust Board, Anthony Jones, for the contribution he had made to the Trust over the last 9 years. KT concurred.
- The fact that the Maternity staff from the Trust's `Better Births' team were runners-up at the Royal College of Midwives Annual Midwifery Awards was very good news. The Trust was a pilot for the national Maternity review, which was led by Baroness Cumberledge, and the Trust was one of very that could provide all options for birth, and therefore provide a full range of choice for women. Baroness Cumberledge had previously attended a Maternity event at the Trust, and had been a supporter of the Crowborough Birth Centre, which had recently held an Open Day which GD had attended
- GD was keen to ensure the Trust obtained optimum value from Crowborough Memorial Hospital, which was not currently being fully used, as a result of it not always being open. The Trust therefore needed to consider the potential use of that hospital
- The careers event referred to in point 6 was very well received by those who had attended, and was really important in the context of offering future opportunities to local young people
- The Trust had traditionally been a laggard in relation to research, so the recent progress described in point 7 was very pleasing
- The Kent Oncology Centre (KOC) had another successful inspection, and the comment that it "…remains an outstanding centre" was particularly pleasing to see

KT then referred to point 5, which described the thoughtfulness displayed by Vicki Belton, a Health Play Specialist at Maidstone Hospital (MH), and commended Ms Belton's actions. KT also commended the efforts being made to improve discharge arrangements, as described in point 1.

3-8 Integrated Performance Report for February 2017

GD referred to the circulated report and highlighted that progress had been made over the past month, but the key issues over the last few months remained the same. 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)

AG highlighted the following points:

- A&E 4-hour waiting time target performance had improved, to 85.1%, but MH's performance was more or less at 99%, with no Medical outliers. Tunbridge Wells Hospital (TWH) was seeing signs of a recovery, but slower, and the operations teams were doing all they could to deliver a sustainable improvement in this area
- There had been significant growth in emergency attendances and non-elective admissions, as well as a growth in the number of elderly patients, which had more conditions, and a longer Length of Stay. Such patients could therefore be directed to a frail elderly pathway
- Delayed Transfers of Care had not been below 7% in the year, and the reasons were described in the chart on page 2. The Trust was still working with its partners to deliver a Home First model, & this would be the main intended target for the increased funding GD referred to
- The next winter was now only 31 weeks away

KT referred to the Home First model, and asked whether all 3 Pathways were now operational. AG replied that Pathway 3 was limited by capacity constraints, but Pathways 1 and 2 were progressing well, and Pathway 2 included the use of beds at Tonbridge Cottage Hospital. AG pointed out that performance on A&E 4-hour waiting time target would be the ultimate beneficiary of the success of the initiative. KT also asked whether the Trust was treated as a "Trusted assessor". AG confirmed that this was not the case, as there was still some reservation in relation to that role, so further discussions were required (which were taking place).

AG then continued, and highlighted the following points:

- Performance on the 62-day Cancer waiting time target was still below the Trust's trajectory and the national target, but there was confidence in the action plans, and each tumour site had an improvement plan. Following the latest Cancer Summit, the key drivers that needed to change were known. Urology, Upper Gastrointestinal (GI), and Lower GI were the key areas, but change was slow because of the limited number of treatments undertaken each month
- Referral to Treatment (RTT) performance had been adversely affected by patient flow, but there was still commitment to achieve the performance requested by NHS Improvement (NHSI) & achieve 92% performance by October 2017, and the plan that was in place would deliver this

KT acknowledged AG's earlier remark that winter was 31 weeks away, and noted the need to have both a summer and winter plan. AG agreed, and noted that the winter plan would be adjusted according to the aligned incentives contract.

KT asked what the longest wait time was in relation to RTT. AG confirmed that the Patient Tracking List (PTL) showed this detail for each specialty.

Safe / Effectiveness / Caring

COB then highlighted the following points:

- The pressure ulcer rate had reduced to 2.4 per 1000 occupied bed days. The number had reduced from that in January, but there was a need to sustain performance and further improve
- Falls had reduced again and the Trust should be on trajectory to meet its plan. Falls-related Serious Incidents (SIs) had also reduced, and there had only been 4 in the month
- There had been 1 Never Event in February, which related to the misplacement of a nasogastric tube. The patient had however recovered from the incident & a full investigation was underway
- Performance on compliance with Venous Thromboembolism (VTE) risk assessments was slightly above plan for the year
- Complaints response performance was behind plan, as a result of some vacancies within the Central Complaints Team. The Team also need to liaise with the Maternity department to address a recent backlog of responses

KT asked about the size of the complaints backlog in Maternity. COB replied that the number was not high, but several responses had become protracted.

COB then continued & highlighted that Friends & Family Test (FFT) response rates had improved. COB elaborated that the Trust would probably not meet the targets for inpatients and A&E, but positive responses continued to be received, which, considering the recent pressures, was very good. COB added that the positive responses for the Maternity FFT had not however improved, as many of the women had ticked 'don't know', so further work was needed to understand this.

Safe (infection control)

SM then highlighted the following points:

- There had been no cases of Clostridium difficile in February, and therefore the Trust was back on its trajectory, so the ratings for Clostridium difficile on page 6 should be green, not red
- There had been 1 case of MRSA bacteraemia, which had been subject to a full Root Cause Analysis (RCA). The case had been referred to NHS England for arbitration, as it was believed it should not be allocated to the Trust because the care provided had been exemplary
- Performance on elective and non-elective MRSA screening was satisfactory

Well-Led (finance)

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

- The Trust was behind plan for the month, and the largest factor in the variance was income, and clinical income in particular, for elective and Day Case activity. The Sustainability and Transformation Fund (STF) deliverables had also not been achieved, so the Trust was not eligible for the £1m of STF monies
- Pay expenditure had been the joint lowest for the year (along with January 2017), so the trend was very good. The Trust had also performed well in reducing its 90-day debt
- There would be significant expenditure of capital in month 12, which included the replacement Linear Accelerator (LinAc), which would enter into the country on 31/03/17, and then be delivered to a bonded warehouse until the enabling works had been completed
- Page 12 still compared actual delivery against the control total, but detailed analysis had identified that the best case year-end position was a deficit of £9.3m. However, the intended capital to revenue transfer was not now likely to proceed, so the worst case position would be a £14.3m deficit (although some mitigations may reduce the impact of the capital decision)
- The Cost Improvement Plan (CIP) target for 2017/18 was circa £32m, and only 66% of that value had been identified to date. Many of the identified schemes were also rated as amber, and there was therefore a need to ensure these were rated green

KT asked what the percentage of the CIP was for 2016/17 and 2017/18. SO confirmed that on turnover, the percentages were 5% for 2016/17 and 7.5% for 2017/18, but if meaningful spend was considered, the percentage for 2017/18 was circa 9%. SO added that the trend in relation to cost reduction was however positive.

Well-led (workforce)

RH then highlighted the following points:

- Sickness absence remained high, but this was being addressed. The areas affected were primarily 'back office' functions, and in particular Estates and Facilities
- There was also an increase in turnover, again within 'back office' functions, including the Human Resources department. Further work was needed to understand the reasons.

KT welcomed the need to understand whether there were any themes involved.

Safe / Effectiveness (incl. Mortality)

PM then highlighted the following points:

- Mortality involved 2 different areas of focus: Mortality reviews and the potential high mortality rates. For the former, the National Quality Board had published new guidance on how Trusts should undertake reviews. The new procedure was more stringent, with a clear notion of which deaths should be subject to structured reviews. For example, the death of any patient with a learning disability was mandated. Therefore a new structure for the Trust's Mortality Surveillance Group was required. The guidance had been accompanied by a letter from the Medical Director at NHSI, emphasising the need to follow the guidance, and work was ongoing

- In relation to the Trust's potential high mortality rates, following PM's previous reporting of the initial findings of a 'deep dive' review in Trauma & Orthopaedics (T&O), the focus had now moved to the current review by physicians. However, PM proposed that he submit a formal report on the T&O 'deep dive' to the April 2017 Trust Board, unless it was considered to be more appropriate to submit to the Quality Committee. KT proposed that this be reported to the Trust Board in April, in either the 'Part 1' or 'Part 2' meeting, dependent on PM's judgement of the content. This was agreed.

Action: Submit a report on the outcome of the current investigations regarding mortality/increased HSMR to the Trust Board in April 2017 (Medical Director, April 2017)

PM then continued, and highlighted the following points:
- Respiratory conditions had now become an area of concern for mortality, and the coded episodes that were of particular interest were for pneumonia. This was often listed as a cause of death, so did not lead to an immediate concern, but further investigation was required
- Paediatrics was an outlier, but still births had been erroneously recorded under Paediatrics, so this would be addressed
- The Trust's Hospital Standardised Mortality Ratio (HSMR) was now below 100 on a month by month basis, but remained red-rated on a rolling 12 month basis, as a result of the marked increases seen in April and May 2016. The HSMR data had been analysed by hospital site, and TWH was associated with the increases that had been seen

3-9 Update on the Workforce Transformation Programme

PM referred to the circulated report and highlighted the following points:
- The programme had been launched at the Trust Management Executive (TME) in March, and a verbal update had been given at the Finance Committee on 27/03/17
- The governance arrangements for the programme were still being finalised
- Cardiology would be the next area of focus, followed by General Surgery
- A desktop exercise was scheduled for all areas by July 2017. The overall programme of work may take 2 years, but comprehensive data would be available by July 2017
- Integration with other workstreams was required
- The main tool to be used was Job Planning, which SM was leading on, and the first draft of the new Job Planning Policy was due by 31/03/17

KT asked for a comment on the T&O pilot. PM reported he had met with the relevant Clinical Director and Director of Operations and discussed the relevant Lord Carter efficiency data, and it had been agreed that one of the key issues was the flow of patients through Theatres. PM continued that a Business Case was therefore being prepared in response. PM added that the most important aspect was to ensure that T&O were able to undertake activity during the winter, and therefore the winter plan was important.

GD remarked that the Trust's 'hottest' site, TWH, had been disproportionately affected by the changes that had to occur during winter, but the Trust may be better than the national average for General Surgery, due to the ease of access to General Surgical beds. PM acknowledged the point.

SO commented that one of the key features of the Directorate's CIP plan for 2017/18 was the flow through Theatres, and in particular the outsourced activity that had been lost, and the thought processes in relation to this had been crystallised by the Workforce Transformation programme.

KT commended the work, and proposed that a further update be scheduled for 3 months' time. This was agreed.

Action: Schedule a further update on the Workforce Transformation Programme at the Trust Board in June 2017 (Trust Secretary, March 2017 onwards)

Quality Items

3-10 Supplementary report on Quality and Patient Safety

COB referred to the circulated report and highlighted the following points:
- Actions in relation to Falls prevention continued, with the aim of not having any falls-related SIs

- A 'Take Five' initiative had been tried, with the aim of communicating key messages to teams. This had not been as successful as COB had hoped, but this would be tried again after a period of reflection, as there was a need to continue to use different forms of communication
- It was good to see FFT response rates had improved, but there was a need to embed this into the 'hearts and minds' of staff, including Ward Managers. One Ward Manager a month would be identified to present their results to the to the Nursing Engagement and Learning Forums
- The Trust was working with iwantgreatcare, and a draft case study for A&E would be published in the next month
- An audit of Pressure Ulcer prevalence would be carried out soon, which included community-acquired Ulcers

KT referred to the 'Take Five' initiative, and emphasised the benefit of 'you said, we did' type notice boards. COB acknowledged the point, and added that the initiative had however achieved some success within Maternity.

KT also asked about whether iwantgreatcare would help identify best practice. COB clarified that the aforementioned case study had identified some areas of best practice.

KT then asked whether the SAFER bundle was used in the Trust. AG confirmed this was the case.

3-11 Planned and actual Ward staffing for February 2017

COB referred to the circulated report and drew attention to the following points:
- Enhanced Care had been used in some areas including Edith Cavell, Stroke and Ward 20
- Some escalation areas had been used, which increased the actual usage compared to plan
- Stroke, Ward 2 & Ward 30 had been amber-rated following triangulation with quality metrics

KT asked how Enhanced Care provision was controlled. COB explained that the Policy had recently been revised, to introduce a slightly easier risk assessment process, but a Ward Manager was required to complete the assessment. COB continued that this did not however automatically mean that extra staff would be provided, as sometimes patients could be cohorted to particular areas. COB added that if more staff were however required, the Matron or Site Manager had to authorise these. SO added that the numbers of additional staff requested for Enhanced Care had reduced dramatically since the same period in 2015/16. RH also pointed out that a recent Internal Audit review had provided a 'reasonable assurance' conclusion on the subject. KT confirmed he had read the report of the review to which RH referred.

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

COB referred to the circulated report and stated that the Trust was required to provide a declaration each year. COB added that there had been 12 breaches in the latter part of the year, but this related to a single occurrence pertaining to escalation within the Surgical Assessment Unit (SAU), and the situation had since been remedied.

KT commended the report, and then invited questions or comments. None were received.

The declaration was approved as circulated.

Planning and strategy

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

PM referred to the circulated report and highlighted the following points:
- The public facing document (pages 2 to 25) and the technical document (pages 26 to 80) had been provided. The governance of the STP was developing but it had been considered at a Programme Board that the provider Trust Boards should support the former document, whilst Clinical Commissioning Groups (CCGs) should be asked to support the latter document
- The cover of the public facing document contained KCC's logo, which showed the commitment of all involved in the STP

- The chart on page 59 of 80 ("Exhibit 22 – Results of the clinical standards audit") had been the subject of discussion at the 'Part 2' Trust Board meeting in February 2017. The case for change contained suggestions as to how this could be used to improve care
- No decision had been made regarding public consultation, but it was a possibility that service transformation may require public consultation in due course

GD added that the point PM had made regarding KCC's logo reflected the fact that the case for change was quite negative, and did not present any solutions, but it was important to demonstrate the need for change in the first instance, before determining what solutions could be applied. GD emphasised that this was therefore an important first step.

AK pointed out that the case for change had been supported by KCC in its last meeting before the pre-election period. AK added that once the forthcoming local elections had been held, and the key local politicians appointed, it was important to obtain their support for the STP, and for the Trust to use its influence to make it succeed. KT concurred.

AK also noted that the case for change had formed part of a private presentation to the Kent Ambassadors and had been well received.

KT stated that it would be useful to have a session exploring the STP in more detail, perhaps at a Trust Board 'Away Day'. PM instead suggested that the Board's attention would be better directed towards the future action required, rather than the case for change. AK suggested that it may be beneficial to hold a Trust Board session on the origins of the STP, and the future, when the new Chair of the Trust Board joined. KT agreed. GD added that the Trust's own strategy now needed to take the opportunity to include and reflect on the case for change.

The Trust Board agreed to support the case for change for the Kent & Medway Sustainability and Transformation Plan.

Assurance and policy

3-14 Update from the Senior Information Risk Owner (SIRO) (incl. approval of the IG Toolkit submission for 2016/17)

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

- As Chief Nurse, COB was also the SIRO, and the report provided an update on a range of issues, including the Information Governance (IG) Toolkit
- The report had been considered at the TME in March 2017, and the TME had endorsed the proposed IG Toolkit submission
- The Data Protection Act would be superseded by the General Data Protection Regulations, and a small Task & Finish Group had been established to consider the implications
- One data protection breach had to be reported to the Information Commissioner's Office (ICO), and was currently being investigated. There had also been complaints relating to the handling of some subject access requests. However, the ICO had been satisfied with Trust's response

KT asked about the potential for monetary penalties from the ICO. COB confirmed these were not anticipated at present.

COB then continued, and highlighted that the Trust was required to achieve Level 2 on the IG Toolkit, and although the proposed submission only resulted in a 'satisfactory' rating, it had been acknowledged that further improvement was required.

The Information Governance Toolkit submission was approved as circulated.

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

3-15 Charitable Funds Committee, 20/02/17

In the absence of SDu, SO referred to the circulated report and highlighted the following points:

- The audit approach for the 2016/17 Charitable Fund accounts was confirmed, in that an independent examination would be undertaken

- Charitable donations had been low when compared to other Trusts in Kent, and the funds from the legacies had had been received in the past were planned to be spent
- The Committee had agreed to the establishment of a fundraiser role

3-16 Patient Experience Committee, 08/03/17 (incl. revised Terms of Reference)

AK invited KR to give the report. KR duly highlighted the following points:

- The Committee had noted the retirement of its Chair for the past 9 years, Sylvia Denton, and recorded its recognition of her service to the Trust during that period
- The Terms of Reference, which were due their annual review, were considered, and a number of proposed minor changes were agreed. The Terms of Reference had now been submitted to the Trust Board, for approval
- A report on the performance and usage of the Trust's translation service was reviewed, as was a report on the Trust's Stroke service. It was agreed that a further report on Stroke, with particular regard to the Kent & Medway Stroke review, should be submitted to the next meeting
- Notification of recent/planned service changes was received, which included the introduction of the "Mouth Care Matters" programme that COB had referred to under item 3-5

The revised Terms of Reference for the Committee were approved as circulated.

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)

In the absence of AK, RH referred to the circulated report and highlighted the following points:

- The findings from the national NHS staff survey had been considered, and the 'Listening into Action' initiative was discussed
- The Guardian of Safe Working report was received for the first time, and had been appended in full. The new Junior Doctors contract was being implemented widely, and the Guardian of Safe Working, Dr Milner, had been very proactive in working closely with management teams. The next report was due in the next Quarter, and more exception reports (with regard to working hours) were anticipated at that point, given the wider implementation of the contract
- The Committee received a demonstration of a new reporting tool on workforce metrics, which would enable such metrics to be reported on the first day of the following month

SO and AG commended the new reporting tool.

3-18 Quality Committee, 15/03/17

In the absence of SDu, KT referred to the circulated report and highlighted the following points:

- The absence of recent Quality Impact Assessments for CIP schemes had been identified
- The concerns regarding the Symphony A&E IT system would be discussed in the 'Part 2' Trust Board meeting scheduled for later that day

3-19 Trust Management Executive, 22/03/17

JL referred to the circulated report and noted that the implementation of the replacement PAS+ would be discussed in the 'Part 2' Trust Board meeting scheduled for later that day, but added that good progress had been made in relation to the development of a purpose built fixed Positron Emission Tomography (PET) / Computed Tomography (CT) scanning unit at MH.

3-20 Finance Committee, 27/03/17

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

- The PFI contract at TWH would be considered at the Committee's meeting in May 2017
- The proposed extension of the Managed Laboratory Service would be discussed in the 'Part 2' Trust Board meeting scheduled for later that day
- The financial position of the Crowborough Birth Centre would be reviewed again in September
- A query was raised regarding the performance again the CQUIN Sepsis target

Other matters

3-21 Update on the development of an overall communications approach

JL reported the following points:

- The Board had previously discussed a report produced by AK in the 'Part 2' meeting in January 2017. External communication with stakeholders needed to be consistent and communicate in simple terms. A single page of key facts was envisaged, to include performance on the A&E 4-hour waiting time target
- The messages given by the Trust needed to provide appropriate context for an external audience, and recognise that the Trust was improving its relative performance (which for the A&E 4-hour waiting time target was now in the upper quartile)
- The format, and intended audience, was being finalised, but this would include the persons referred to in AK's report
- The coverage of the audience was important, and needed to include the full range of local elected representatives, who were anticipated to welcome a proactive briefing process

KT offered to share the details of a method of communication he recommended. JL acknowledged the offer, and then continued by noting that the Trust had invested in the 'Listening into Action' initiative. JL added that it was also important to ensure the Trust developed its own strategy, and not be preoccupied with the strategies of others. KT agreed. GD referred to this last point, and elaborated that the Trust was close to being able to describe a future that was based on the Trust's continued viability, notwithstanding the need to collaborate with others. JL agreed and noted that this had been positively affected by being placed into Financial Special Measures. SO agreed.

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

KR referred to the circulated Terms of Reference and highlighted that the annual review was now due, and had resulted in a small number of proposed minor changes. Questions or comments were invited. PM referred to paragraph 6.1, which stated that one of the general responsibilities of the Trust Board was "To work in partnership with all stakeholders others to provide safe, accessible, effective and well governed services for the Trust's patients", & asked whether the wording was adequate. KT proposed that the wording be approved for the time being, but that KR liaise with PM to consider whether it should be amended. This was agreed.

Action: Liaise with the Medical Director to consider whether the wording of paragraph 6.1 of the Trust Board's Terms of Reference ("To work in partnership with all stakeholders others to provide safe, accessible, effective and well governed services for the Trust's patients") should be amended to better reflect the Board's responsibility (Trust Secretary, March 2017 onwards)

GD proposed that paragraph 27 be amended to state "The Trust Secretary will normally attend each meeting". This was agreed.

Action: Amend the Trust Board's Terms of Reference to reflect the change to paragraph 27 that was agreed at the 'Part 1' Trust Board meeting on 29/03/17 (Trust Secretary, March 2017 onwards)

The Trust Board approved the revised Terms of Reference subject to this amendment.

3-23 To consider any other business

The Trust Board delegated the authority to consider & approve proposals regarding the Managed Laboratory Service contract to the 'Part 2' Trust Board meeting scheduled for later that day.

3-24 To receive any questions from members of the public

There were no questions.

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

The motion was approved.

Trust Board Meeting – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
3-8 (Mar 2017)	Submit a report on the outcome of the current investigations regarding mortality/increased HSMR to the Trust Board in April 2017	Medical Director	April 2017	A report has been submitted to the April 2017 Trust Board
3-9 (Mar 2017)	Schedule a further update on the Workforce Transformation Programme at the Trust Board in June 2017	Trust Secretary	March 2017	The item has been scheduled for June 2017
3-22i (Mar 2017)	Liaise with the Medical Director to consider whether the wording of paragraph 6.1 of the Trust Board's Terms of Reference ("To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients") should be amended to better reflect the Board's responsibility	Trust Secretary	April 2017	Liaison occurred, and after discussion it was agreed to leave the wording unchanged
3-22ii (Mar 2017)	Amend the Trust Board's Terms of Reference to reflect the change to paragraph 27 that was agreed at the 'Part 1' Trust Board meeting on 29/03/	Trust Secretary	March 2017	The Terms of Reference were amended

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 – April 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

4-7 Chief Executive's Report — Chief Executive

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

1. Our teams of dedicated healthcare professionals have provided care and treatment on an unprecedented level in the last 12 months. We have over 800,000 recorded episodes of patients being seen by our teams in 2016/17, covering various stages of their care. That's around 50,000 more episodes of patient care than the previous year and is the equivalent of at least one person in Kent and Medway or north East Sussex seeking our help every minute of every day.

   We are reviewing our patient experience during 2016/17 to help ensure we are in the best possible position to respond to the very real potential of a further increase in patients requiring non-planned care this year. This work will specifically look at elderly care given the increasing age and acuity of our emergency patients and their prolonged length of stay that is changing the face of healthcare locally and nationally.

   Similar work carried out at the start of 2016 benefited patients requiring both planned and non-planned care during the winter, but the challenges we face are now year-round and increasingly involve both ourselves and our partners in health and social care.

   We have met many, but not all of our waiting time standards during 2016/17, and where this has not been the case actions are well underway to ensure steady and sustainable improvement over the coming months. Despite the huge numbers of patients seen, we have also met many of our key quality and safety standards, which is a credit to our hardworking colleagues across the Trust.

   We are also making steady and sustained progress in reducing our financial deficit. The actions we have taken in the last 12 months have resulted in millions of pounds of efficiencies that we can continue to build on this year without effecting, and wherever possible improving, standards of care.

2. We are joining forces with our NHS partners across Kent for a day of shared learning and celebration in June.

   Working with Kent Community Health NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust and Kent and Medway NHS & Social Care Partnership Trust, we will be hosting a conference where nurses, midwives and allied health professionals from across Kent can come together, share best practice, talk about the challenges they face and how we can work together in the best interests of our patients. Confirmed guests include Chief Nurse for England Jane Cummings and Shelagh Morris, Deputy Chief Allied Health Professions Officer.

3. A new project aimed at raising awareness around the importance of basic oral care for our patients could help to reduce length of stay and even reduce hospital mortality in the long-term.

   'Mouth Care Matters' has been initiated and is supported by Health Education England following findings from the Care Quality Commission that oral health can deteriorate in hospitalised patients and, in some cases, lead to a range of other health-related issues, including hospital acquired pneumonias.

The project aims to deliver practical ward-based mouth care training to hospital staff, to improve the general health and well-being of patients. It's funded by Health Education England and is currently being rolled out in NHS Trusts across Kent, Surrey and Sussex.

At MTW, we have welcomed Anita Stanforth who has just started as our Mouth Care Matters Associate Lead. Anita will be making her way round the wards cross-site to introduce herself and to let you know about training programmes that are due to commence. She joins us with a wealth of experience from a background in dental nursing and oral health education and promotion

4. We have launched a new booklet to make sure that mothers-to-be are aware of their choices when it comes to giving birth. This comprehensive booklet highlights the different options to help women make an informed choice.

   This will be piloted initially by two community midwifery teams from April 2017 in two locations: Maidstone Town and Crowborough. We will then be able to evaluate the difference this booklet has made in helping women to make a decision. If it is well received, the booklet will be rolled out across the area.

   The work is part of a national pilot programme we are helping spearhead (with NHS West Kent CCG and NHS High Weald Lewes Havens CCG), to open up choice in maternity care. Pioneers are working to widen and deepen choices available to women by enabling women to make choices across CCG boundaries, seeking to attract new providers into the area and by empowering women to take control of decisions about the care they receive.

   Maternity services provided by MTW continue to go from strength to strength with more babies born at Tunbridge Wells Hospital and the Maidstone Birth Centre in 2016/17 than ever before. We see Crowborough Birth Centre as another excellent choice for women and will be promoting this facility throughout the year.

5. Teams from MTW have worked with colleagues from other emergency services to hone our skills and preparedness. Critical care doctors and porters at Tunbridge Wells Hospital worked with HM Coastguard Lydd Rescue Helicopter to practice critical care transfers. Kent Fire and Rescue Service held an equally realistic exercise at Maidstone Hospital involving smoke-filled corridors.

6. Our specialist gynae-oncology nurses helped promote Ovarian Cancer Awareness Month during March, urging women to be mindful of the symptoms. We run a Gynae-Oncology Support and Help group (GOSH) from Maidstone Hospital – the only support group of its kind in Kent.

7. I would like to publicly recognise the on-going support we receive from our local communities. We have recently received donations of equipment for Oncology from Malling Lions Club, and Easter eggs from Maidstone Methodist Scout Group for our young patients.

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 – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

4-8	Board Assurance Framework (BAF) 2016/17: Year-end review	Trust Secretary

The objectives for 2016/17 and the Board Assurance Framework (BAF)

In July 2016, the Trust Board approved a deliberately small number of higher-level objectives for 2016/17 to act as proxy indicators (i.e. a 'litmus test') for broader performance. 7 objectives were selected, covering 5 key risks. The BAF is the document through which the Trust Board identifies the principal risks to the Trust meeting those agreed objectives, and to ensure adequate controls and measures are in place to manage those risks. The BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure that the document is updated throughout the year. The status of the BAF was reviewed by the Trust Management Executive, Finance Committee, Audit and Governance Committee, and Trust Board at regular intervals in 2016/17.

Year-end position

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

Objective		Achieved?
1.a.	To reduce the falls rate to less than 6.2 per 1,000 occupied bed days	Yes, fully
2.a.	To achieve an average maximum Length of Stay (LOS) for elective care of 3.2 days	Partially
2.b.	To achieve an average maximum LOS for non-elective care of 6.8 days	Partially
3.a.	To reduce the vacancy rate to 8.5%	Yes, fully
4.a.	To maintain operational liquidity whilst reducing working capital (from the planned level for 16/17)	Yes, fully
4.b.	To deliver the control total for 2016/17	No
5.a.	To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target	No

The Board is invited to review the content of the report and consider the following questions:

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

The enclosed report was discussed at the Trust Management Executive on 19/04/17, and will be reviewed at the Audit and Governance Committee on 04/05/17. The content of the enclosed report will also be reported (in a different format) within the Trust's Annual Report for 2016/17 (which will be submitted to the Audit and Governance Committee and Trust Board in May 2017).

Proposed objectives for 2017/18

Board Members will recall that the objectives for 2016/17 were not finalised until July 2016, and therefore the Trust Board is asked to agree the objectives for 2017/18 now. The proposed objectives have been agreed with each relevant Executive Director, and are as follows:

	Proposed objective	Rationale
1	To reduce mortality (HSMR) in line with the national average	This is a key priority for the Trust, a good 'litmus' test/proxy for wider quality issues, and features as a quality objective in the 2016/17 Quality Accounts
2	To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target	This is a key priority for the Trust, and a good 'litmus' test/proxy for wider issues relating to patient flow. This replaces the LOS objectives in 2016/17, as reducing LOS is an enabler to increase capacity, whilst the A&E 4-hour performance is a more recognisable end goal
3	To maintain a vacancy rate of no more than 8.5%	The vacancy rate is a key 'litmus' test/proxy for broader workforce issues
4	To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m)	The overall financial position is considered to be the best overall indicator of financial performance
5	To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target	This is a key priority for the Trust (and for NHS Improvement)

Agreeing the objectives now does not prevent amendments or additions in future months, nor prevent the overall approach being amended (e.g. once the new Chair of the Trust Board starts).

The Board is also asked to consider whether it wishes to set specific in-year milestones for the 2017/18 objectives. This approach is not recommended, as the BAF already provides in-year updates on performance, as well as a confidence rating of the objective being achieved by year-end, so it is not believed any additional benefit will be achieved by setting in-year milestones. However, the Trust Board is asked to confirm whether it agrees or disagrees.

Format of the BAF for 2017/18

When the BAF was last reviewed by the Trust Board, on 22/02/17, a query was raised as to whether the continued inclusion of the "Are the actions that had been planned for this point been taken?" rating was confusing, in the light of the more pertinent "How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?" rating. Having considered this, and discussed the matter as part of the annual Internal Audit "Review of Assurance Framework and Risk Management", it is proposed that the "Are the actions that had been planned for this point been taken?" rating be removed from the BAF for 2017/18. The Trust Board is asked to approve the proposal.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/04/17 (the year-end position for 2-16/17 only)
- Finance Committee, 24/04/17 (the year-end position for objectives 4.a. and 4.b. only)

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

1. To review the year-end position for the 2016/17 objectives
2. To agree the objectives for 2017/18
3. To consider the proposal not to set specific in-year milestones for the 2017/18 objectives
4. To consider the proposal to remove the "Are the actions that had been planned for this point been taken?" rating from the BAF for 2017/18

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

Board Assurance Framework 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

1 The Trust fails to improve key aspects of clinical care and safety

What did the Trust want to achieve? [2] *Objective*

1.a To reduce the falls rate to less than 6.2 per 1,000 occupied bed days

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

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

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2016/17? [3]

September 2016	November 2016	February 2017
☒ ☐ ☐	☒ ☐ ☐	☒ ☐ ☐

Explanation of any "Amber" or "Red" rating (at February 2017): N/A

Year-end position: Was the objective achieved by the end of 2016/17?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of rating / detailed status of current position:

The rate for the year was 6.07 (which compared to 6.7 for 2015/16).

[2] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

Board Assurance Framework 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

2 The Trust is unable to manage (either clinically or financially) during the winter period

What did the Trust want to achieve?[4] *Objective*

2.a To achieve an average maximum Length of Stay for elective care of 3.2 days

2.b To achieve an average maximum Length of Stay for non-elective care of 6.8 days

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

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

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2016/17?[5]

September 2016	November 2016	February 2017
☐ ☒ ☒	☐ ☒ ☒	☐ ☒ ☒

Explanation of any "Amber" or "Red" rating (at February 2017):

An 'Amber/Red' rating has been selected, as for the year to date (month 10), the "Average LOS Elective" is 3.33 days, whilst the "Average LOS Non-Elective" is 7.73 days. However there were mitigating circumstances, including December 2016 seeing the highest level of Delayed Transfers of Care (DTOCs), at 8%. Ambulatory pathways were rolled out at Tunbridge Wells Hospital in July 2016, led by the Directorate, but due to high escalation these were not been optimised. Pathways are in place at Maidstone but these need further embedding. The actions taken and/or planned are therefore felt to be the correct actions required, but achieving the average LOS targets listed above may not be achieved until the end of Quarter 2, 2017/18. This level of confidence is affected by the fact that there has been no reduction in non-elective demand. However, despite this, measures have been constantly applied to ensure patient flow continued during recent weeks.

Year-end position: Were the objectives achieved by the end of 2016/17?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of rating / detailed status of current position:

2.a. The average Length of Stay for elective care for the year was 3.28 days
2.b. The average Length of Stay for non-elective care for the year was 7.74 days

Delayed Transfers of Care (DTOCs) and the sustained increased in non-elective activity have contributed to the underlying position.

[4] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

Board Assurance Framework 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

3 The Trust does not have the correct level of substantive workforce for effective delivery

What did the Trust want to achieve?[6] *Objective*

3.a To reduce the vacancy rate to 8.5%

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

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

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2016/17?[7]

September 2016	November 2016	February 2017
☒ ☐ ☐	☒ ☐ ☐	☒ ☐ ☐

Explanation of any "Amber" or "Red" rating (at February 2017): N/A

Year-end position: Was the objective achieved by the end of 2016/17?

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

Explanation of rating / detailed status of current position:

The vacancy rate for the year was 8.3% (which compared to 9.3% for 2015/16).

[6] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

Board Assurance Framework 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

4 The Trust fails to demonstrate an ability to achieve future financial viability

What did the Trust want to achieve?[8] *Objective*

4.a To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17)

4.b To deliver the control total for 2016/17 (N.B. Until Nov. '16, this was "To improve on the Trust's Income and Expenditure plan for 2016/17")

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

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

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2016/17? [9]

September 2016	November 2016	February 2017
☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☒

Explanation of any "Amber" or "Red" rating (at February 2017):

1. There remains a significant amount of risk to the delivery of the control total. The deficit at month 10 was £14.1m, against a planned deficit of £9.9m i.e. £4.2m adverse to plan

Year-end position: Were the objectives achieved by the end of 2016/17?

☐ Fully achieved ☒ Partially achieved ☐ Not achieved

Explanation of rating / detailed status of current position:

4.a. For operational liquidity, this was fully achieved, as the Trust managed its liquidity during the financial year through the delivery of the actions within its Financial Recovery Plan. This meant that no significant additional borrowing has been necessary, while the Trust has also significantly reduced its 90 days and over aged debt profile.

4.b. In relation to the control total for 2016/17 (which was to achieve a deficit, before Sustainability and Transformation Fund (STF) monies of no more than £4.7m), the Trust ended 2016/17[10] with a deficit of £17.6m (although the deficit was £11.9m once Sustainability and Transformation Fund (STF) monies were taken into account), which meant the Trust did not meet its control total for the year. A significant factor in the size of the deficit was the fact that the Trust was not allowed to undertake the Capital to Revenue Transfer (of £4.2m) it had planned (although £900k of revenue was able to be capitalised once this decision had been confirmed).

The "partially achieved" rating reflects the different achievements of the 2 objectives.

[8] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

[10] This position has been determined prior to the submission of the draft Accounts for 2016/17 and is therefore subject to change

Board Assurance Framework 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

What was the key risk? *Main risk*

5 The Trust fails to maintain and improve its reputation as a Cancer provider

What did the Trust want to achieve?[11] *Objective*

5.a To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

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

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

In-year ratings: How confident was the Responsible Director that the objective would be achieved by the end of 2016/17? [12]

September 2016	November 2016	February 2017
☒ ☐ ☐	☒ ☐ ☐	☐ ☐ ☒

Explanation of any "Amber" or "Red" rating (at February 2017):

- At month 9, 2016/17, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 70.3%, but for MTW patients only was 76.3%. This compared to the target performance of 85.2% & 85% respectively
- Performance will not reach the target level by April 2017, and the trajectory therefore needs to be re-assessed to determine when the required level of performance will be achieved. There has however been 4 months of stable performance against the 2-week waiting time target, which is a good 'launch pad' for the 62-day target.

Year-end position: Was the objective achieved by the end of 2016/17?

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

Explanation of rating / detailed status of current position:

The full 2016/17 performance on the 62-day Cancer waiting time target (for first definitive treatments) is not yet known, as the data for Cancer targets runs one month behind. However, at month 11 (February 2017), performance was 68.7% (which compares to the standard of 85%). The key issue to address is with the Lower Gastrointestinal (GI) pathway (which has the lowest performance among all Tumour Sites).

A detailed report on Cancer performance was considered by the Trust Management Executive (TME) and Trust Board in March 2017, which described the resources in place, the actions that had been taken, and those planned to be taken, and noted that a recovery trajectory to achieve the 62-day standard has been submitted to NHS Improvement which anticipates achievement in September 2017.

[11] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

Trust Board meeting – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

4-9 Integrated performance report for March 2017 — Chief Executive

The enclosed report includes:

- The 'story of the month' for March 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, 19/04/17 (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 March 2017

Responsiveness

At the end of month 12 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 March (calendar) improved to 89.6% (including MIU) which was much improved from the previous 2 months, with the greater level of improvement at Maidstone. The year came in at 87.1%, just slightly above the limit set for us by NHSI of 87%. As of next month, we will be judged against a new set of targets, where Q1, Q2 and Q3 must score 90% or above, then 95% in March. The Information Department has agreed a set of monthly targets what should facilitate that, starting with 87.3% for April.

- A&E Attendances remain high. They seem to have settled down to a ‘new normal’, conforming very closely to the model until January, when it started to come in below model. Whether this is an easing off of attendance pressure, or last winter’s anomalously high attendances affecting the model too much is not yet clear. Full year attendances are 4.2% higher than last year, and A&E admissions 17.6% higher. Mar type 1 attendances were 4.7% down on last March.
- Non-Elective Activity was 17.7% higher than plan for Mar and 11% higher than March last year. For the year activity is 12.4% higher than plan and 11.3% higher than last year. More of these patients are coming in through A&E than last year.
- There were 1,409 bed-days lost – 6.19% of occupied beds in March due to delayed transfers of care, a slight improvement on recent trends.
- Non-elective LOS increased to 7.83 days for March discharges, after spiking at 8.68 in Jan. This reflects the increased number of very elderly patients admitted throughout winter 2016/17.
- Average occupied bed days dropped slightly to 733 in March, down from February’s 748.

As reported previously the Urgent Care Division remain focused on improving the flow at the front door, ambulatory, frailty & 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

Count of Hospital ID																									
Row Labels	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	Mar-17
A : Awaiting Assessment	17	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14
B : Awaiting Public Funding	2	2		1	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3
C : Awaiting Further Non-Acute NHS Care	28	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16
Di : Awaiting Residential Home	6	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35
Dii : Awaiting Nursing Home	30	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76
E : Awaiting Care Package	10	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38
F : Awaiting Community Adoptions	8	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13
G : Patient of Family Choice	60	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28
H : Disputes		2	1			1	3	1	1		1				3	1	1				1			1	1
I : Housing	1	3	4	3	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4
Grand Total	162	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228
Trust delayed transfers of care	**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%**	**6.2%**

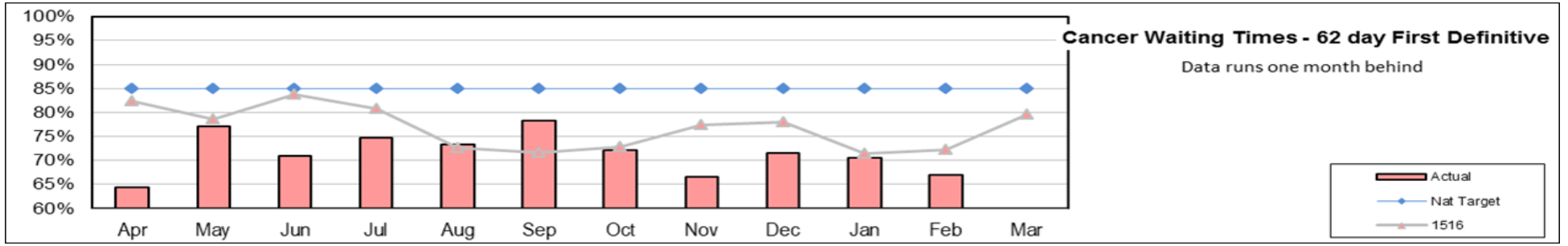
2. Cancer 62 day FDT

Performance for 62 day First Definitive Treatment (data runs a month behind) - Feb 17: 67.0% which is below the national target of 85%. Performance for the 62 Day Screening (data runs one month behind) - Feb 17: 71.4%.

62 FDT for February: 35 breaches, 26 of these were MTW only patients. 11 patients from other Trusts to MTW and 7 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 2 patients from Medway, 2 patients from Darent Valley, 5 patients from East Kent and 2 patients from Queen Victoria (Patients shared across Trusts = 0.5 of a breach).

- The size of the backlog at the end of February was 63 patients (patients waiting over 62 days for treatment with a diagnosis of cancer). For the MTW only patients the backlog was 28. This is a 4 patient decrease compared to December for all patients and a decrease of 9 patients for MTW only. The sustained size of the backlog was due to on-going delays in diagnostic pathways, medically unfit patients and late referrals from other Trusts. Specific issues in tumour sites included administrative delays for lower GI and a large number of complex patients in Urology.
- Urology contributed the largest number of breaches in February (9.0 breaches – 6 MTW only patients). Patient fitness to proceed with diagnostics tests was the most common contributory factor to breaches.
- Lower GI contributed the second largest number of breaches in February (6 breaches – 4 MTW only patients). Complex diagnostic pathways and patient delays were the primary reasons for breaches.
- Lung contributed the third largest number of breaches at 4.5 (4 MTW only patients).
- Current forecast 62 day position for March = 71.6% (which is undergoing validation).

2. Cancer 62 day FDT (cont)



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

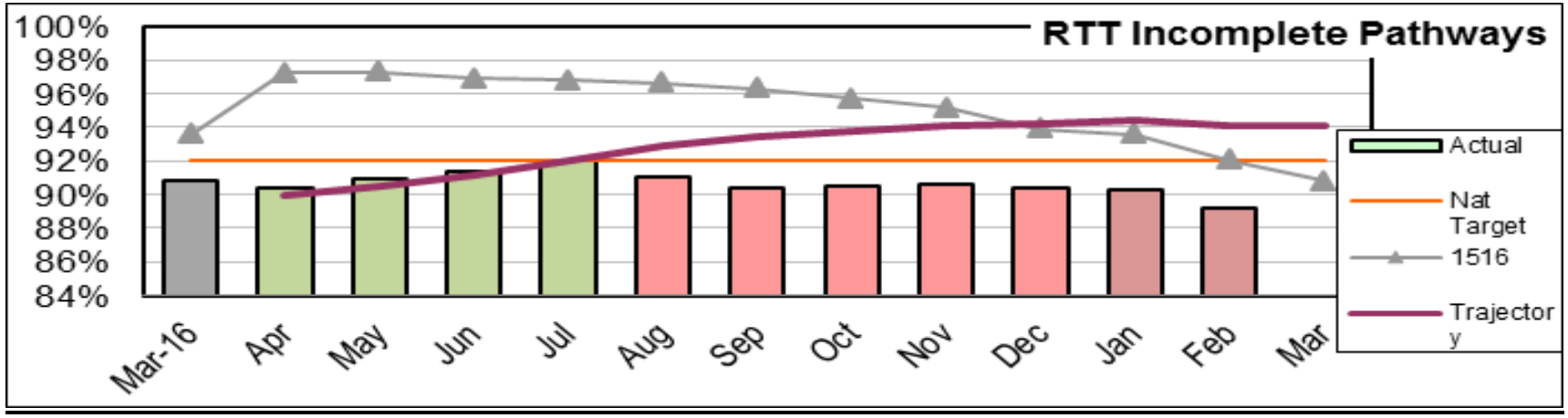
Performance: March performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 88.3%. This is due to a number of surgical cancellations that occurred during Q4.

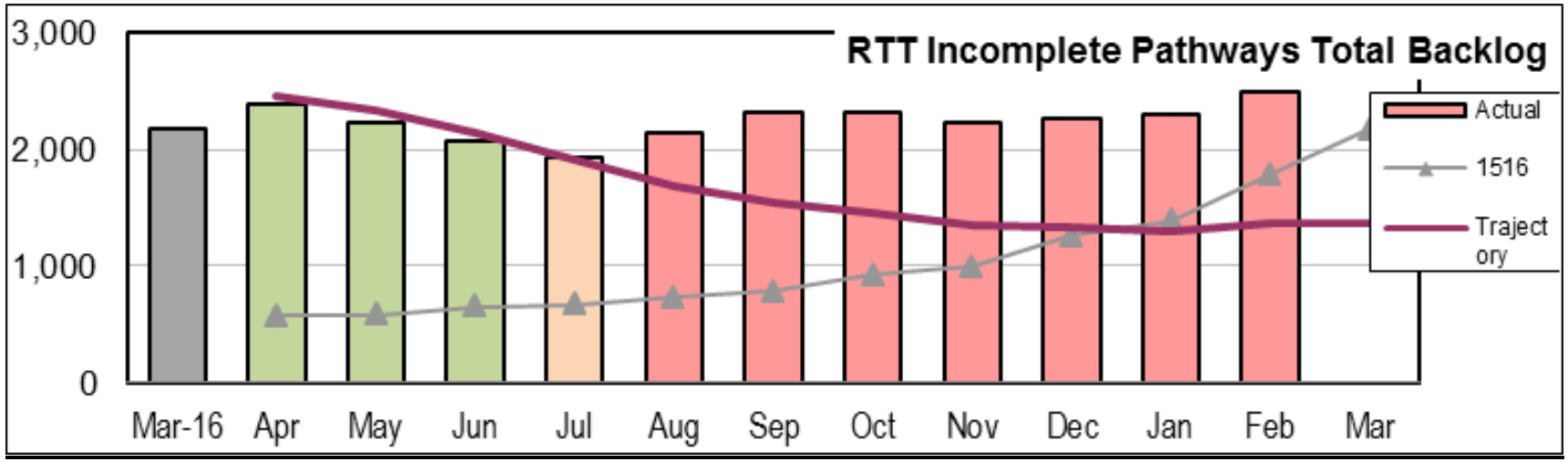
The Trust continues to be non-compliant at a speciality level for T&O, Gynae, ENT, Surgery and Urology and the majority of the backlog is concentrated in these five-all of which are being carefully monitored against action plans put in place to reduce their longest waiters. Cardiology has also seen a slip in performance during March.

- ENT, T&O, Surgery, Urology & Gynae are trying to continue to reduce their backlogs despite cancellations by moving lists to Maidstone and focusing capacity on booking patients within the backlog to all available lists. Extra Saturday sessions are being planned when current escalation reduces. The criteria for the Maidstone Orthopaedic Unit have been reviewed to maximise utilisation.
- 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 continues to remain below the RTT performance trajectory submitted for 16/17. The Trust has now resubmitted the RTT trajectory for 17/18 which shows aggregate compliance by Nov 17.

3. RTT and Elective Activity (cont.)





Workforce

As at the end of March 2017, the Trust employed 5,066.6 whole time equivalent substantive staff. Overall temporary staffing increased from February 2017, although this was as a result of bank rather than agency use.

Sickness absence in the month (February 2017) reduced by 0.4% to 4.2% from a high in January 2017. The most significant sickness reason is cold/flu illnesses, typical for the season. However sickness absence management remains a key area of focus for the HR and operational management teams to drive the rate down.

Statutory and mandatory training compliance is broadly unchanged from February at 90.2%, and has remained 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:** **31 March 2017**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
1-01	*Rate C-Diff (Hospital only)	4.38	13.1	7.4	10.5	3.1	0.4	11.5	10.5	
1-02	Number of cases C.Difficile (Hospital)	1	3	18	28	10	1	27	28	
1-03	Number of cases MRSA (Hospital)	0	0	1	2	1	2	0	2	
1-04	Elective MRSA Screening	99.0%	98.0%	99.0%	98.0%		0.0%	98.0%	98.0%	
1-05	% Non-Elective MRSA Screening	98.0%	97.0%	98.0%	97.0%		2.0%	95.0%	97.0%	
1-06	**Rate of Hospital Pressure Ulcers	2.0	1.3	2.7	2.6	- 0.1	- 0.4	*3.0*	2.6	3.0
1-07	***Rate of Total Patient Falls	6.5	6.22	6.7	6.07	- 0.6	- 0.1	*6.20*	6.07	
1-08	***Rate of Total Patient Falls Maidstone	5.5	4.8	6.1	5.3	- 0.8			5.3	
1-09	***Rate of Total Patient Falls TWells	7.2	7.3	7.2	6.6	- 0.5			6.6	
1-10	Falls - SIs in month	2	4	43	38	- 5				
1-11	Number of Never Events	0	0	2	3	1	3	*0*	3	
1-12	Total No of SIs Open with MTW	17	28			11				
1-13	Number of New SIs in month	6	8	101	112	11	- 8			
1-14	**Serious Incidents rate	0.26	0.35	0.42	0.42	0.00	0.36	*0.0584 - 0.6978*	0.42	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.63	0.69	1.09	0.75	- 0.34	- 0.48	*0 - 1.23*	0.75	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.4%	95.6%	95.3%	95.4%	0.1%	0.4%	95.0%	95.4%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.0%	97.3%	96.6%	96.6%	0.0%	1.6%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.39%	2.56%	2.56%	3.12%	0.56%	0.1%	*3.00%*	3.12%	
1-20	C-Section Rate (non-elective)	15.9%	11.9%	15.9%	12.9%	-2.95%	-2.1%	*15.0%*	12.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		102.6	110.0	7.4	10.0	*Lower confidence limit*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 14 to Sept 15		108.8	110.0	1.2	10.0	*to be <100*		100.0
2-03	Crude Mortality	0.9%	1.1%	1.2%	1.3%	0.1%				
2-04	****Readmissions <30 days: Emergency	11.4%	11.8%	11.4%	11.7%	0.3%	-1.9%	*13.6%*	11.7%	14.1%
2-05	****Readmissions <30 days: All	10.7%	11.2%	10.7%	10.9%	0.2%	-3.7%	*14.7%*	10.9%	14.7%
2-06	Average LOS Elective	3.16	2.97	3.17	3.28	0.11	0.08	*3.20*	3.28	
2-07	Average LOS Non-Elective	8.20	7.83	7.33	7.74	0.42	0.90	*6.84*	7.74	
2-08	******FollowUp : New Ratio	1.26	1.59	1.27	1.59	0.32	0.07	*1.52*	1.59	
2-09	Day Case Rates	84.2%	85.8%	84.4%	85.7%	1.3%	5.7%	80.0%	85.7%	82.2%
2-10	Primary Referrals	9,116	9,571	105,518	107,966	2.3%	3.0%	104,825	107,966	
2-11	Cons to Cons Referrals	3,086	3,651	41,308	43,301	4.8%	6.4%	40,698	43,301	
2-12	First OP Activity	10,706	14,199	138,804	152,119	9.6%	1.2%	150,356	152,119	
2-13	Subsequent OP Activity	20,872	27,929	270,809	293,125	8.2%	0.5%	291,660	293,125	
2-14	Elective IP Activity	575	601	7,487	7,333	-2.1%	-9.9%	8,139	7,333	
2-15	Elective DC Activity	2,956	3,791	38,611	40,597	5.1%	-0.4%	40,746	40,597	
2-16	Non-Elective Activity	4,229	4,378	45,607	50,059	9.8%	0.7%	49,709	50,059	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	14,112	13,277	156,117	159,009	1.9%	-0.8%	164,376	159,009	
2-18	Oncology Fractions	5,888	6,365	69,304	70,927	2.3%	-3.6%	73,613	70,927	
2-19	No of Births (Mothers Delivered)	460	495	5,742	5,977	4.1%	1.5%	5,888	5,977	
2-20	% Mothers initiating breastfeeding	73.0%	82.9%	77.2%	81.9%	4.7%	3.9%	78.0%	81.9%	
2-21	% Stillbirths Rate	0.9%	0.59%	0.45%	0.35%	*-0.1%*	*-0.1%*	*0.47%*	0.35%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	6	12	6	12	0	12	
3-02	*****Rate of New Complaints	1.66	1.53	1.69	1.25	-0.4	- 0.07	*1.318-3.92*	1.25	
3-03	% complaints responded to within target	82.2%	68.8%	71.9%	69.0%	-2.9%	-6.0%	75.0%	69.0%	
3-04	****Staff Friends & Family (FFT) % rec care	83.3%	76.6%	83.3%	76.6%	-6.7%	-2.4%	79.0%	76.6%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	96.2%	94.9%	96.4%	95.5%	-0.9%	0.5%	95.0%	95.5%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	86.1%	92.6%	88.4%	90.7%	2.3%	3.7%	87.0%	90.7%	85.5%
3-07	Maternity Combined FFT % Positive	91.2%	91.5%	94.7%	93.6%	-1.1%	-1.4%	95.0%	93.6%	95.6%
3-08	OP Friends & Family (FFT) % Positive	80.7%	84.1%	80.1%	83.0%	3.0%			83.0%	

* 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*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	86.6%	89.6%	89.4%	87.1%	-2.3%	-3.9%	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	257	New						
4-04	Ambulance Handover Delays >60mins	New	3	New						
4-05	RTT Incomplete Admitted Backlog	1,585	2240	1,585	2240	655	1,324	916	2240	
4-06	RTT Incomplete Non-Admitted Backlog	589	645	589	645	56	186	459	645	
4-07	RTT Incomplete Pathway	90.8%	88.3%	90.8%	88.3%	-2.6%	-5.9%	92%	88.3%	
4-08	RTT 52 Week Waiters	2	0	7	6	- 1	6	*0*	6	
4-09	RTT Incomplete Total Backlog	2,174	2885	2,174	2885	711	1,510	1,375	2885	
4-10	% Diagnostics Tests WTimes <6wks	95.34%	99.0%	98.8%	99.0%	0.2%	0.0%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	4	3	4	2	- 2	- 7	9	3	
4-12	*Cancer two week wait	93.0%	95.3%	92.0%	95.3%	3.3%	2.3%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	81.0%	91.1%	85.6%	88.1%	2.5%	-4.9%	93.0%	88.1%	
4-14	*Cancer 31 day wait - First Treatment	96.4%	95.5%	96.4%	94.1%	-2.4%	-1.9%	96.0%	94.1%	
4-15	*Cancer 62 day wait - First Definitive	72.2%	67.0%	74.3%	68.7%	-5.6%	-12.3%	85.2%	68.7%	
4-16	*Cancer 62 day wait - First Definitive - MTW	76.5%	71.7%	79.5%	73.7%	-5.7%		85.0%		
4-17	*Cancer 104 Day wait Accountable	8.0	11.0	43.5	101.0	57.5	101.0	*0*	101.0	
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%	6.2%	6.2%	6.7%	0.5%	3.2%	3.5%	6.7%	
4-21	% TIA with high risk treated <24hrs	76.0%	72.7%	71.0%	81.7%	10.6%	21.7%	60%	81.7%	
4-22	*******% spending 90% time on Stroke Ward	89.3%	87.7%	81.7%	88.3%	6.6%	8.3%	80%	88.3%	
4-23	*******Stroke:% to Stroke Unit <4hrs	44.9%	69.1%	44.9%	54.2%	9.3%	-5.8%	60.0%	54.2%	
4-24	*******Stroke: % scanned <1hr of arrival	49.0%	76.4%	54.6%	58.8%	4.2%	10.8%	48.0%	58.8%	
4-25	*******Stroke:% assessed by Cons <24hrs	70.1%	80.0%	72.6%	68.0%	-4.6%	-12.0%	80.0%	68.0%	
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	9	1	16	30	14	30	*0*	30	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

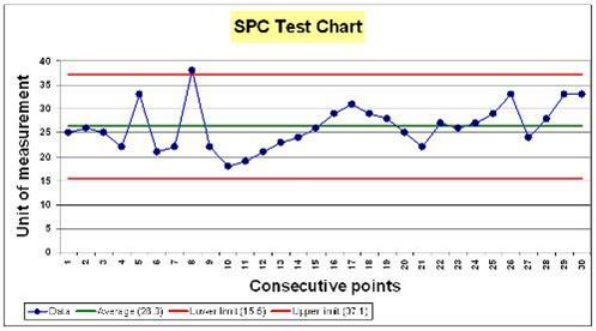
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	36,441	39,634	400,930	428,676	6.9%	-2.8%	440,817	428,676	
5-02	EBITDA	1,765	6,772	8,061	17,943	122.6%	-52.4%	37,717	17,943	
5-03	Surplus (Deficit) against B/E Duty	1,335	4,216	(23,416)	(11,954)			4,675	(11,954)	
5-04	CIP Savings	1,797	3,846	20,764	24,555	18.3%	-20.7%	32,065	24,555	
5-05	Cash Balance	3,796	1,420	3,796	1,420	-62.6%	42%	1,000	1,420	
5-06	Capital Expenditure	4,084	5,153	15,358	9,175	-40.3%	-39.6%	*15,188*	9,175	
5-07	Establishment (Budget WTE)	5,702.9	5,605.4	5,702.9	5,605.4	-1.7%	0.0%	5,605.4	5,605.4	
5-08	Contracted WTE	5,170.1	5,066.6	5,170.1	5,066.6	-2.0%	-1.0%	5,116.5	5,066.6	
5-09	***Contracted not worked WTE	(114.6)	(99.8)	(114.6)	(99.8)	-13.0%		0.0	(99.8)	
5-11	Bank Staff (WTE)	304.6	476.6	304.6	476.6	56.5%	43.0%	333.3	476.6	
5-12	Agency & Locum Staff (WTE)	361.8	160.3	381.3	160.3	-58.0%		155.6	160.3	
5-13	Overtime (WTE)	46.0	37.9	46.0	37.9	-17.7%		-	37.9	
5-14	Worked Staff WTE	5,767.9	5,641.7	5,767.9	5,641.7	-2.2%	0.6%	5,605.4	5,641.7	
5-15	Vacancies WTE	532.8	462.8	532.8	462.8	-13.2%	12.1%	412.9	462.8	
5-16	Vacancy %	9.3%	8.3%	9.3%	8.3%	-1.1%	-5.3%	8.7%	8.3%	
5-17	Nurse Agency Spend	(1,030)	(609)	(10,409)	(8,242)	-20.8%				
5-18	Medical Locum & Agency Spend	(1,064)	(1,630)	(12,362)	(15,004)	21.4%				
5-19	Temp costs & overtime as % of total pay bill		13.3%		13.3%					
5-20	Staff Turnover Rate	9.9%	11.5%	9.8%	10.5%	1.5%	1.0%	*10.5%*	10.5%	11.05%
5-21	Sickness Absence	3.7%	4.2%	3.9%	4.2%	0.6%	0.9%	*3.3%*	4.2%	4.3%
5-22	Statutory and Mandatory Training	90.2%	90.2%	90.2%	90.2%	0.0%	5.2%	85.0%	90.2%	
5-23	Appraisal Completeness	80.0%	86.9%	62.9%	86.9%	6.9%	-3.1%	90.0%	86.9%	
5-24	Overall Safe staffing fill rate	101.6%	98.5%	101.6%	98.8%	-3.1%		93.5%	98.8%	
5-25	****Staff FFT % recommended work	56.9%	63%	56.9%	63%	6.1%	1.0%	62.0%	63%	62.9%
5-26	***Staff Friends & Family -Number Responses	253	422	253	422	169				
5-27	*****IP Resp Rate Recmd to Friends & Family	28.1%	25.2%	25.3%	23.3%	-2.0%	-1.7%	25.0%	23.3%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	13.9%	27.2%	13.1%	15.5%	2.4%	0.5%	15.0%	15.5%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	14.8%	27.7%	19.8%	26.6%	6.8%	1.6%	25.0%	26.6%	24.0%

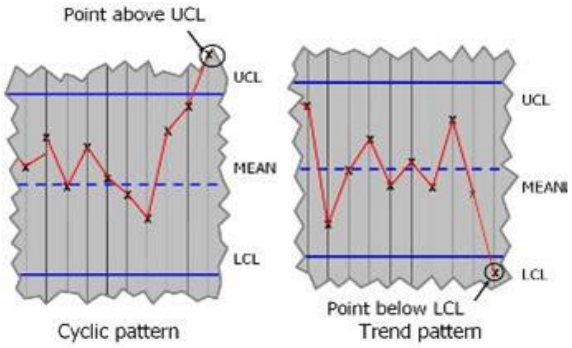
Explanation of Statistical Process Control (SPC) Charts

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

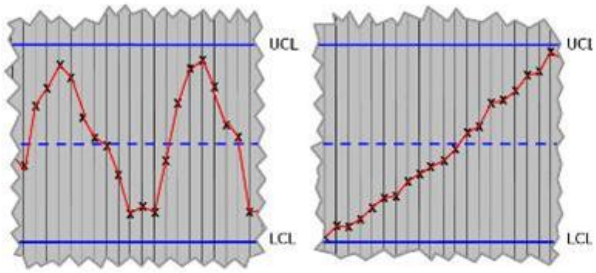


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

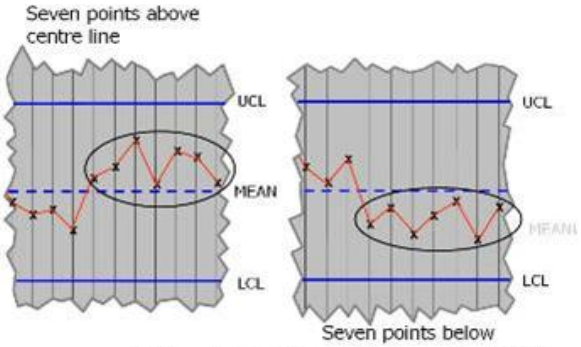


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

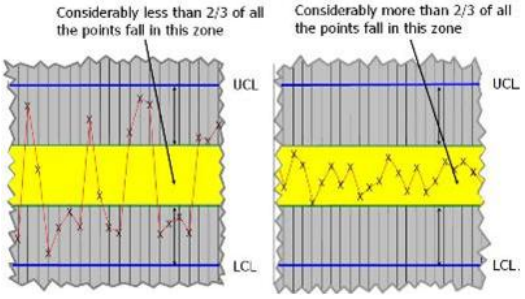


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

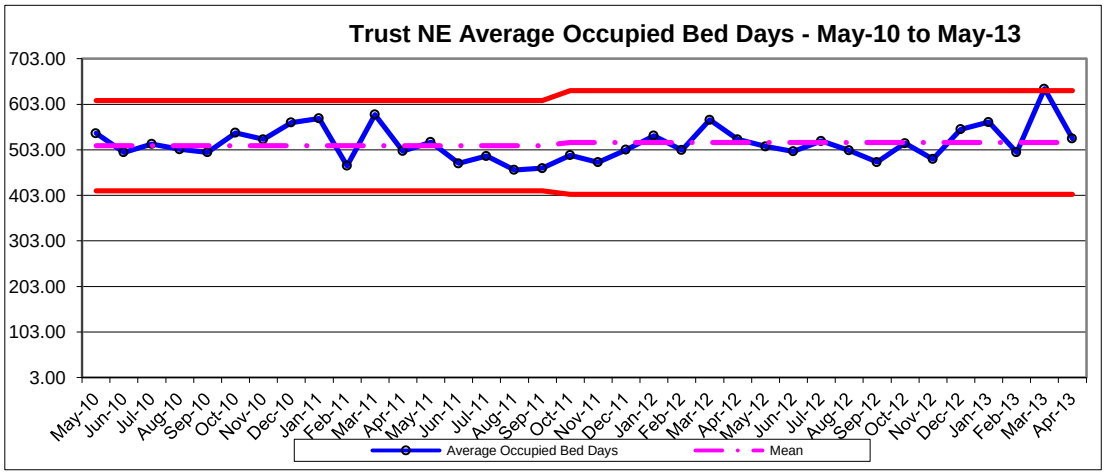


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

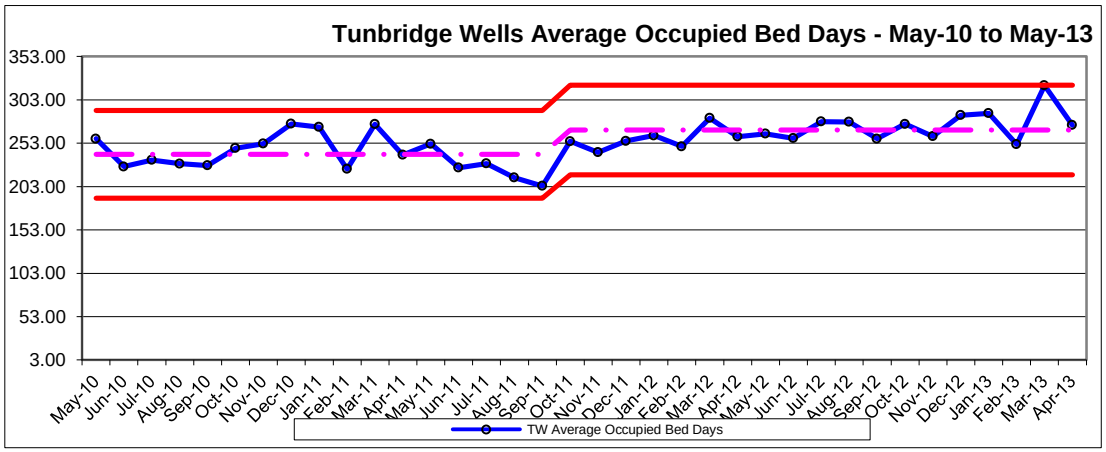


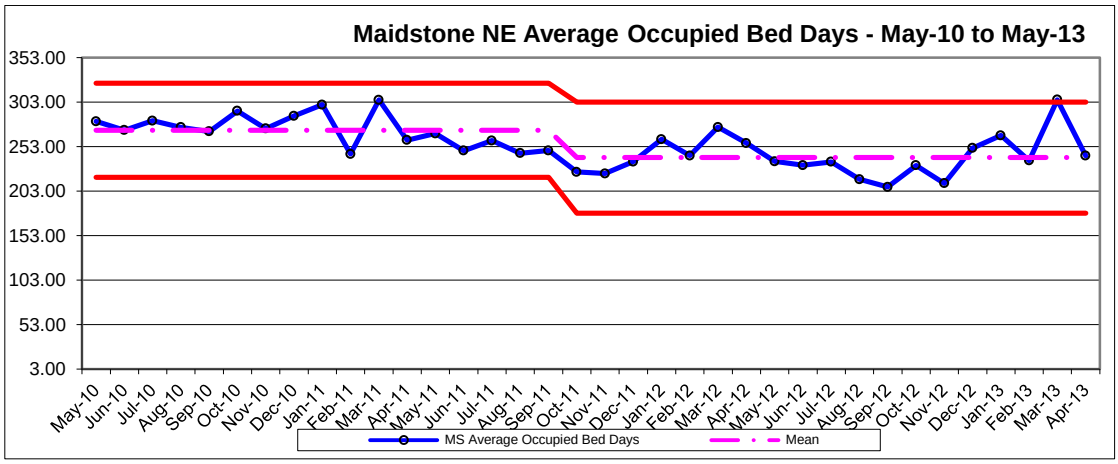
Changes to Control Lines

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



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

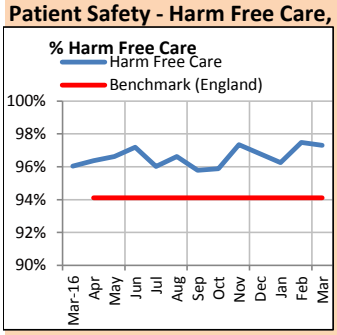


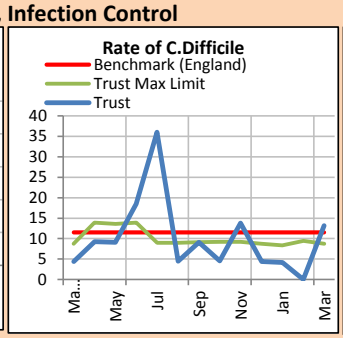


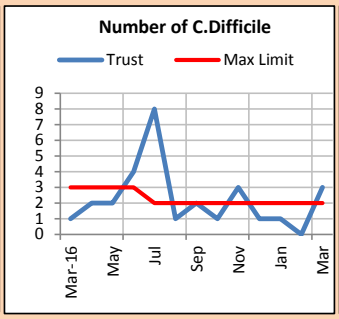
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

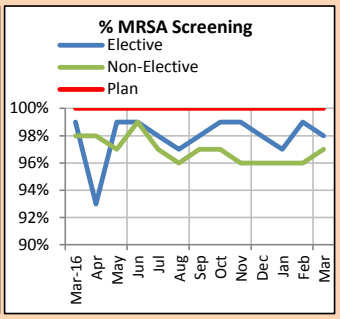
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

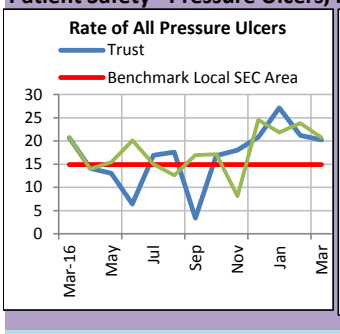


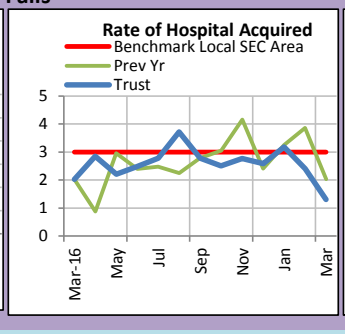


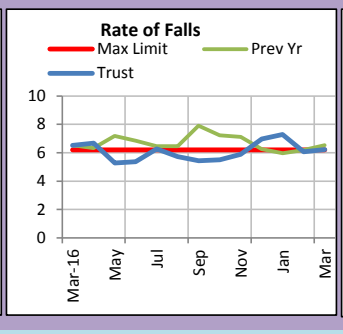


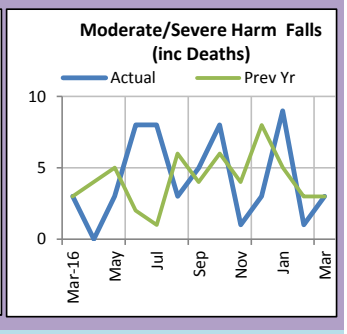


Patient Safety - Pressure Ulcers, Falls

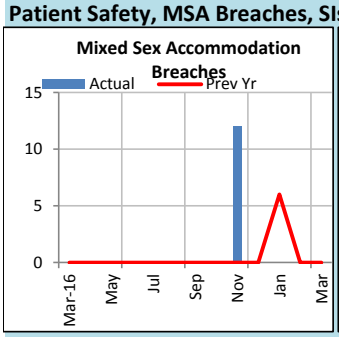


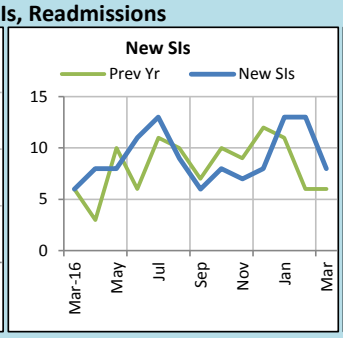


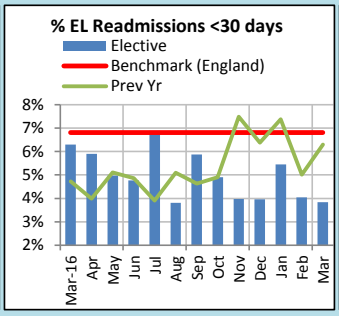


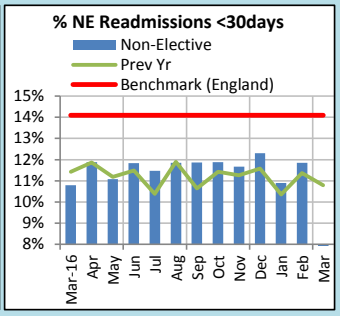


Patient Safety, MSA Breaches, SIs, Readmissions

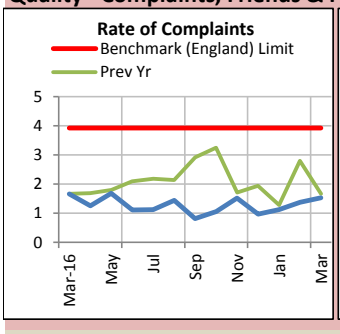


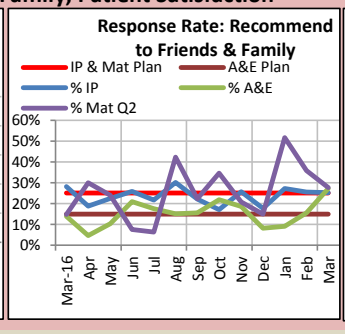


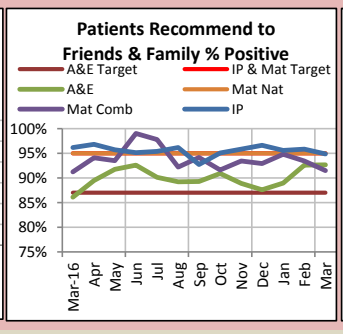


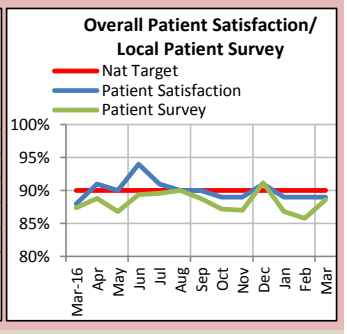


Quality - Complaints, Friends & Family, Patient Satisfaction

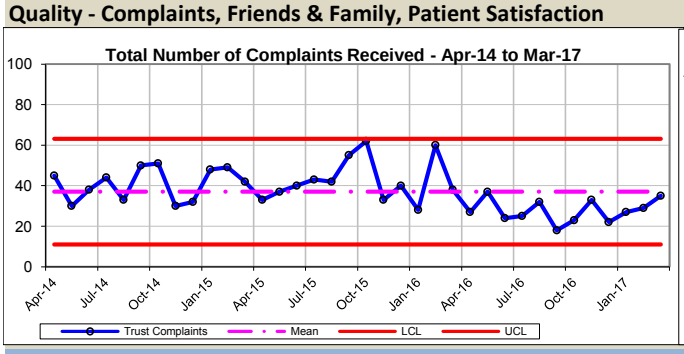


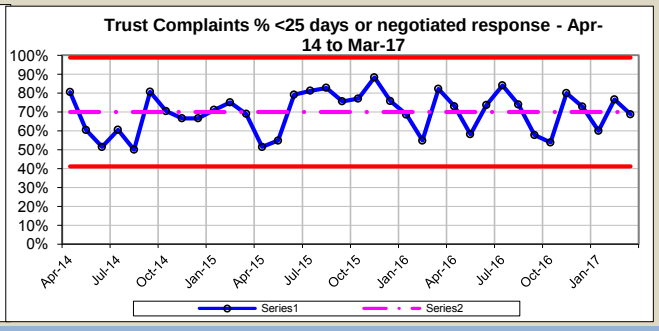




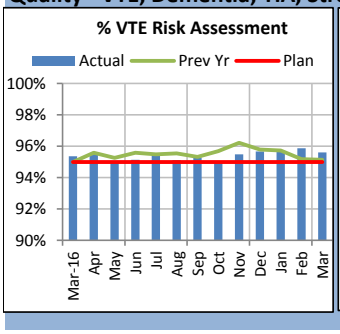


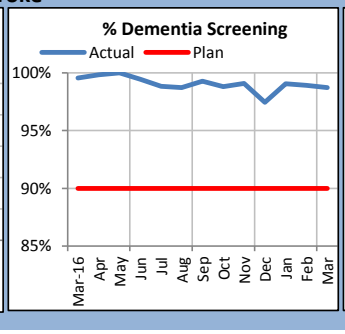
Quality - Complaints, Friends & Family, Patient Satisfaction

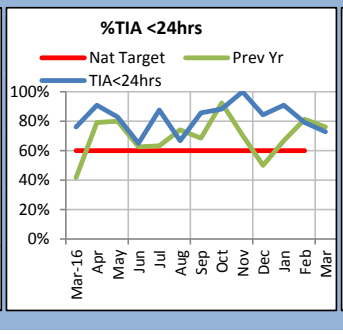


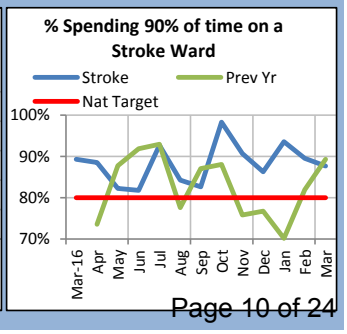


Quality - VTE, Dementia, TIA, Stroke



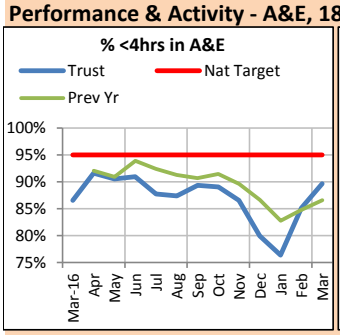


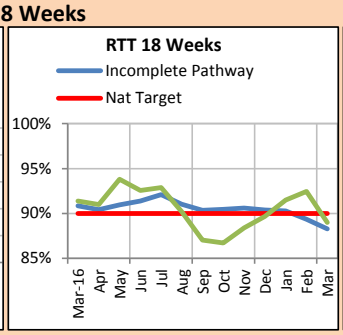


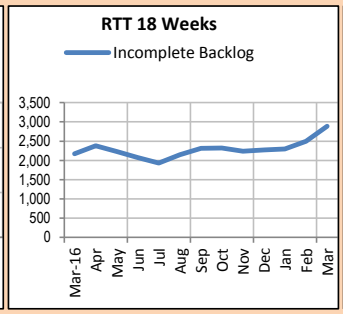


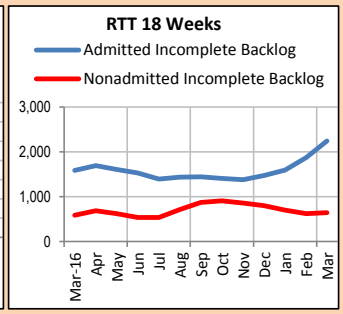
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

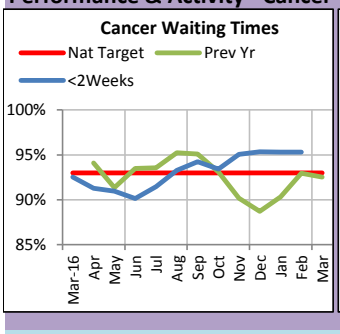


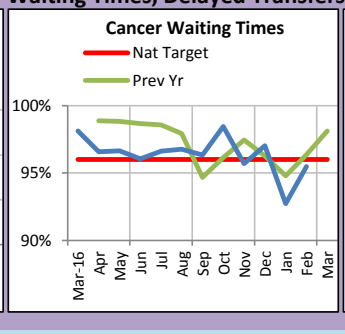


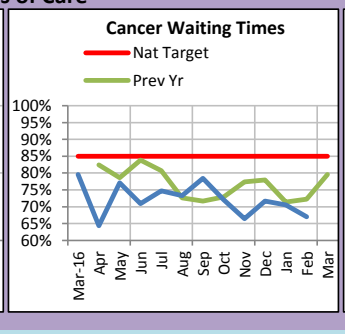


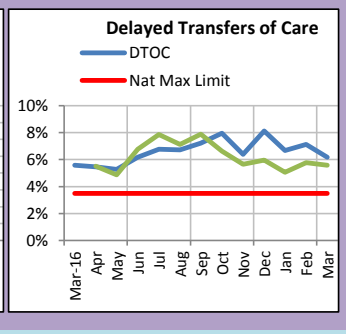


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

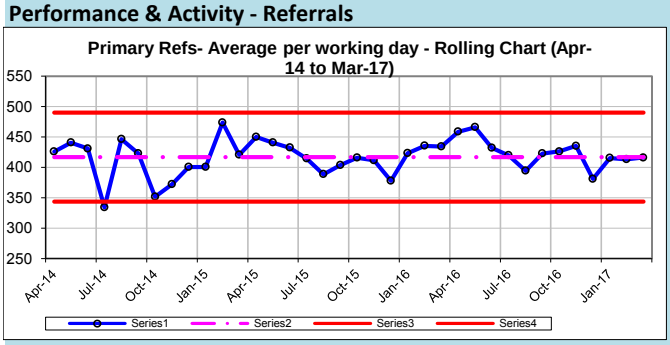


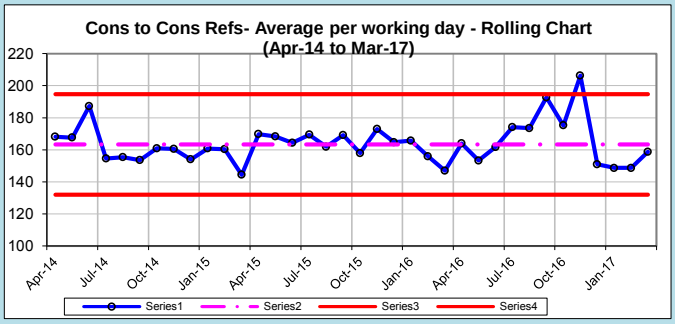




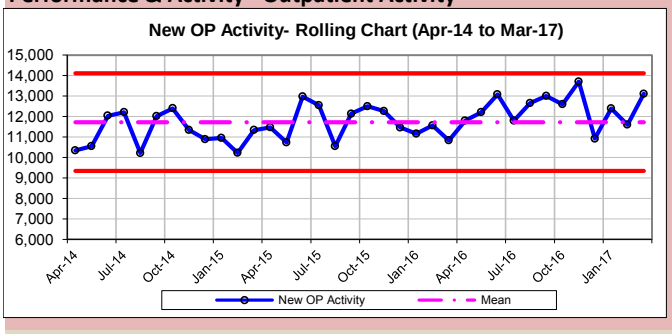


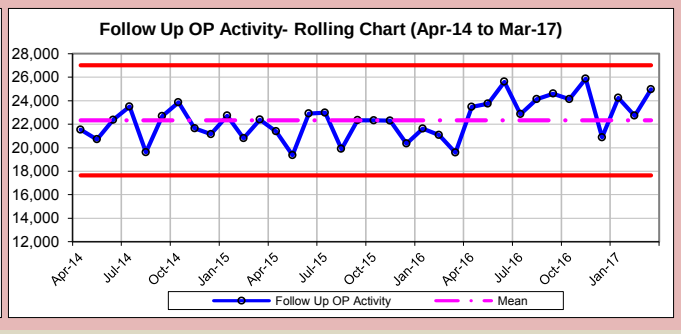
Performance & Activity - Referrals



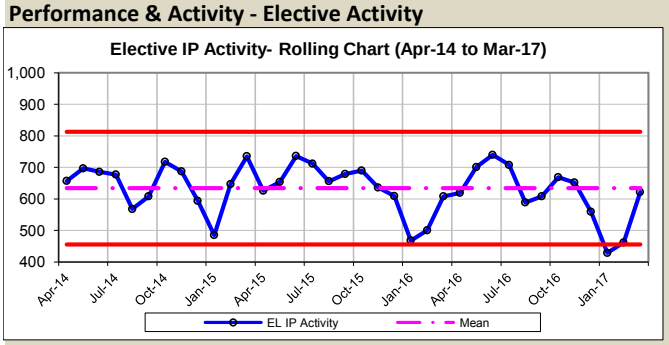


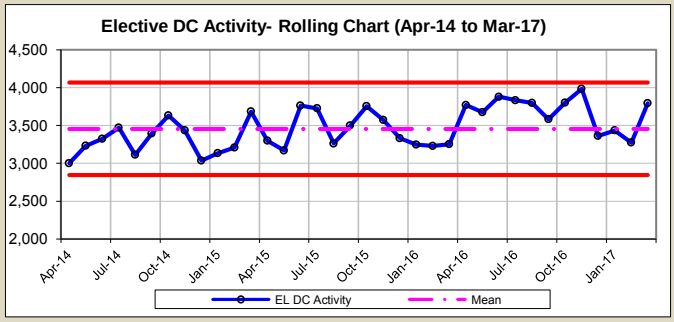
Performance & Activity - Outpatient Activity



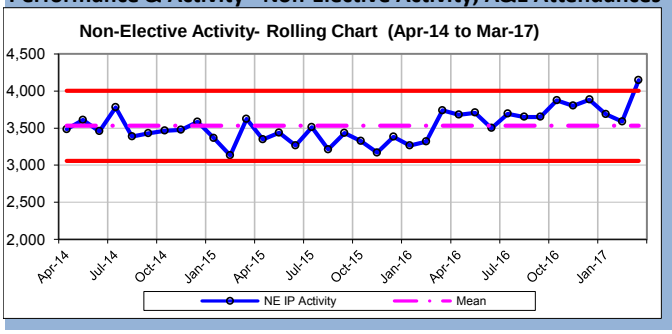


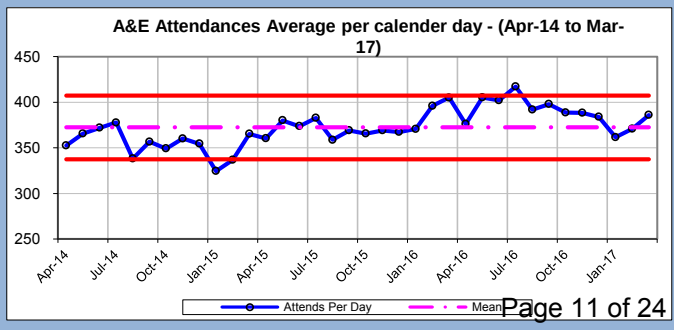
Performance & Activity - Elective Activity





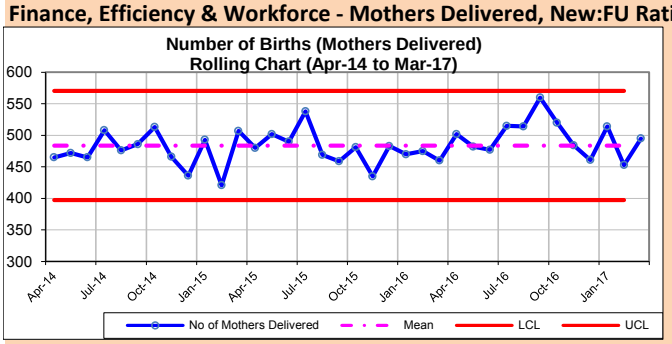
Performance & Activity - Non-Elective Activity, A&E Attendances

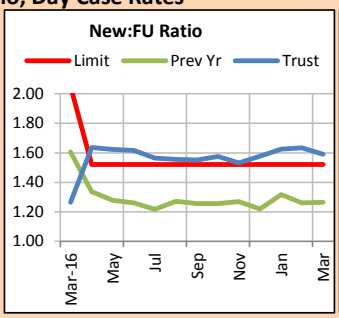


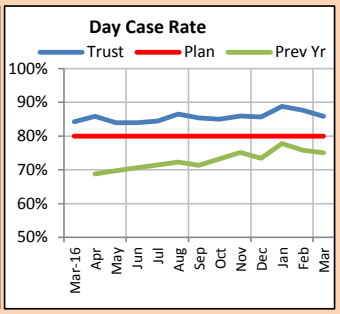


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

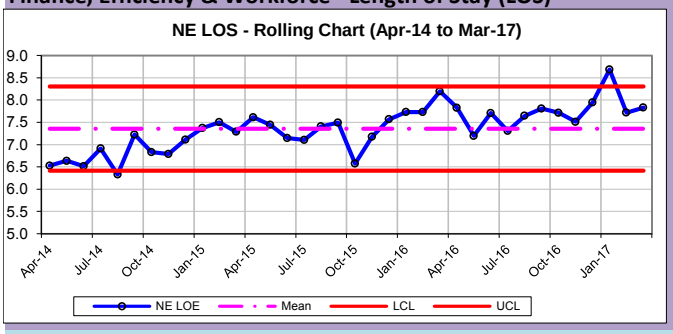
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

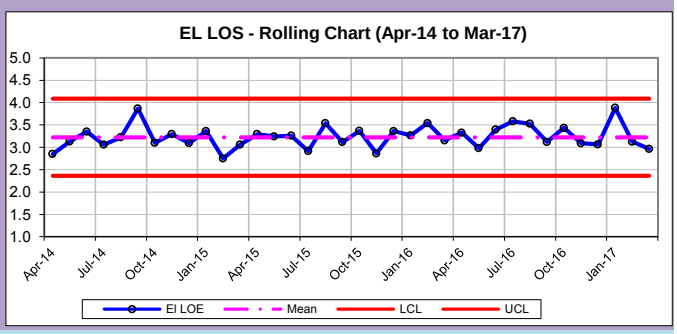




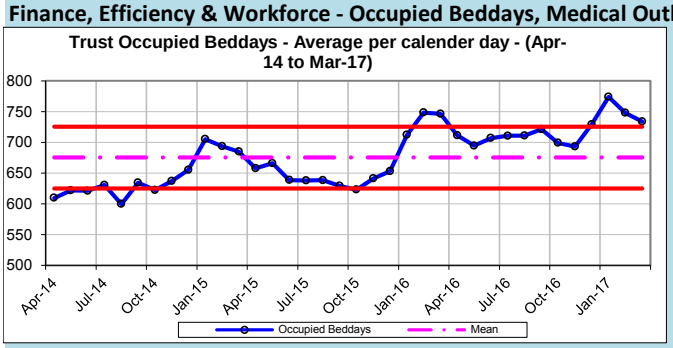


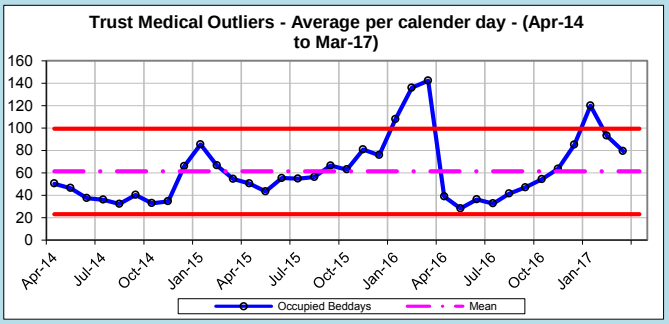
Finance, Efficiency & Workforce - Length of Stay (LOS)



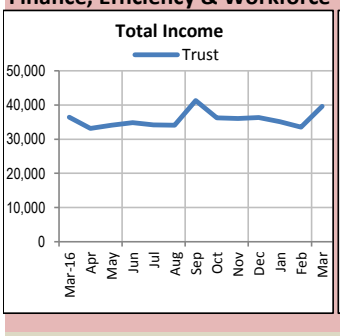


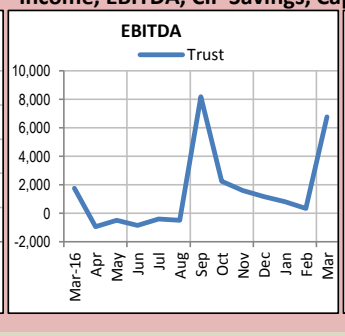
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

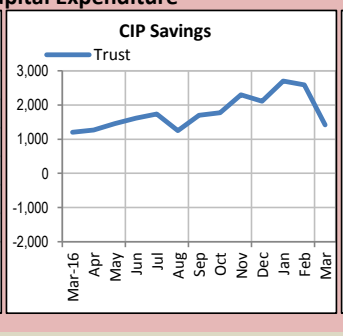


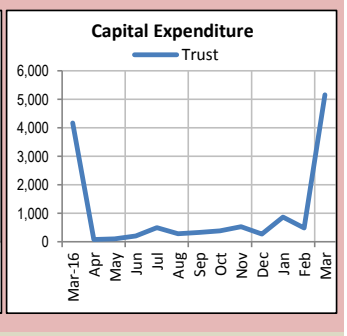


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

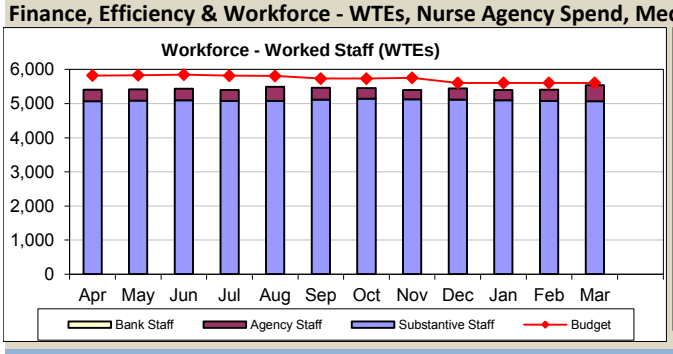


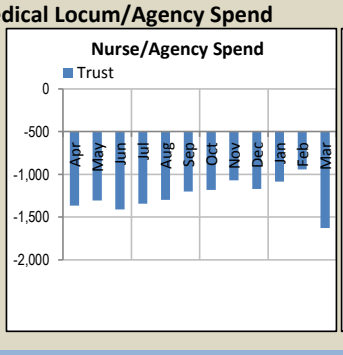


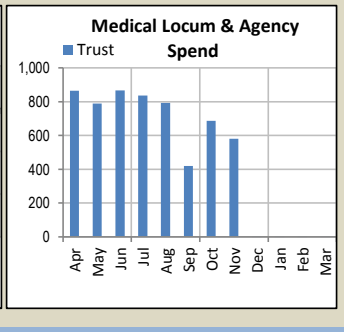




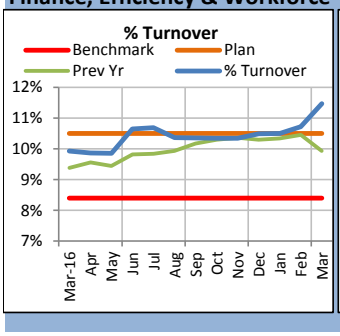
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

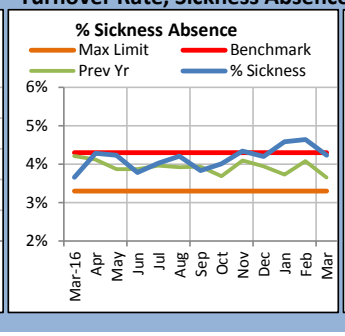


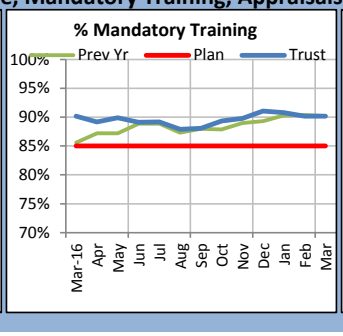


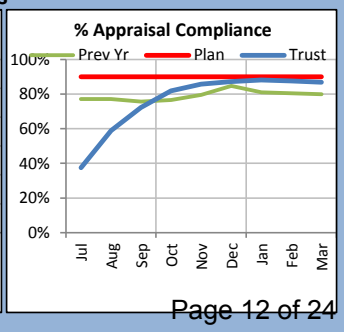


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Trust Board meeting – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

4-9 Review of Latest Financial Performance — Director of Finance

- The Trust had an adverse variance against plan in March 2017 of £6.9m including STF. The in month surplus was £4.2m.
- The Trust's net outturn deficit (including technical adjustments) is £12m against a planned surplus of £4.7m, therefore £16.6m adverse to plan. The Trusts outturn pre STF was £17.6m which was £3.3m adverse to the likely forecasted outturn, the main reason for this adverse movement us due to the Capital to Revenue transfer not going ahead of £4.2m, the Trust did capitalise £0.86m of PAS implementation costs to reduce the impact.
- In March the Trust operated with an EBITDA surplus of £6.8m - £7.7m adverse to plan.
- The key variances in the month are as follows:
    - Total income was £4.9m adverse in the month, £4.2m adverse due to capital to revenue transfer not taking place, Clinical income was £1.8m adverse in the month however elective activity increased by £1m between months, key favourable variances in the month relate to High Cost drug income (£0.5m) and provider to provider SLA (£0.4m)
    - Pay was £1.3m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs increased by £0.9m between months, £0.3m due to increase in number of calendar days. The main increase in temporary staffing costs was within Medical Staffing which increased by £0.7m, mainly within Acute and Emergency directorate (£0.35m) due to a catch-up in in the period after a full reconciliation of temporary staffing usage, Critical Care (£75k) due to a agency consultant supporting obstetrics and a catch-up in internal locum claims relating to previous months.
    - Non Pay was overspent by £1.6m in the month which included £1m unidentified savings. The main area of overspend in the month was Drugs (£1.4m) which included an adverse impact of £0.2m stock movement and supplies and services clinical which overspent by £0.9m, £0.2m due to stock reduction (Theatres £0.1m and Materials Management £0.1m), increase in Cardiology devices (£0.15m) and a catch-up in Theatre consumable purchases £0.4m. .
- The CIP and FRP performance in March delivered efficiencies of £3.8m which was £1.7m adverse to plan. The Trust saved £24.6m which was £7.5m adverse to plan. The majority of this variance was driven by the Urgent Care Division (£5.9m).
- The Trust held £1.4m of cash at the end of March which is in line with the forecast value. Within March the Trust received PDC funding of £1.702m in respect of the Linac machine, £2.2m quarter 3 STF funding and an additional £2.8m over the forecast NHS income expected to be received reducing outstanding debtor invoices. Receiving this income enabled the Trust to pay £1.1m PDC, £2.3m monthly unitary invoice, £1.3m loan and interest repayments along with the statutory commitments of Tax, NI and NHS Pensions. In April the Trust will be repaying the uncommitted loan balance of £2.458m, interest link to the loan of £63k and the invoice relating to the linac machine £1.7m.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/04/17 (performance dashboard)

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

To discuss the March financial position

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

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 12
2016/17

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for March 2017

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4. Cost Improvement Programme / Financial Recovery Plan
- a. Current Month Savings by Directorate
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1.Executive Summary

Maidstone and Tunbridge Wells NHS

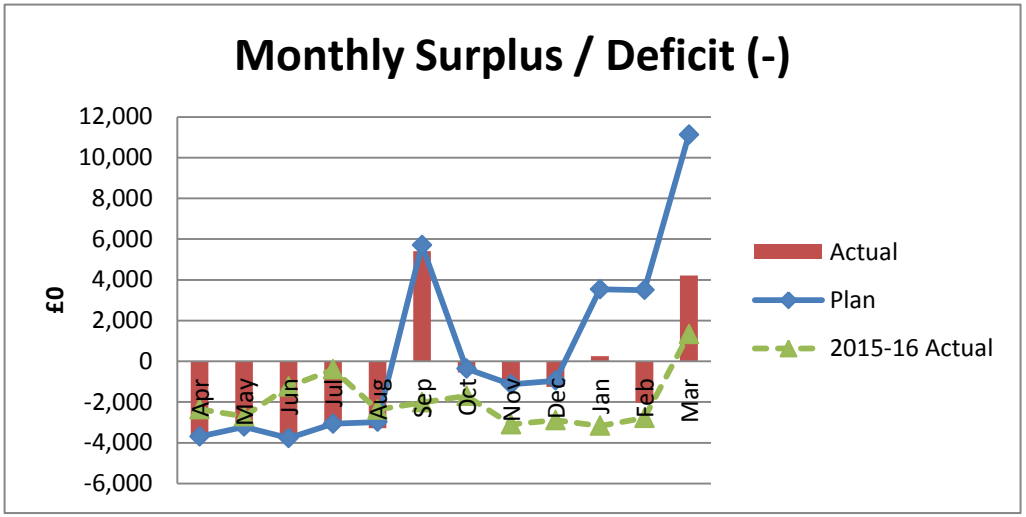
1a. Executive Summary March 2017

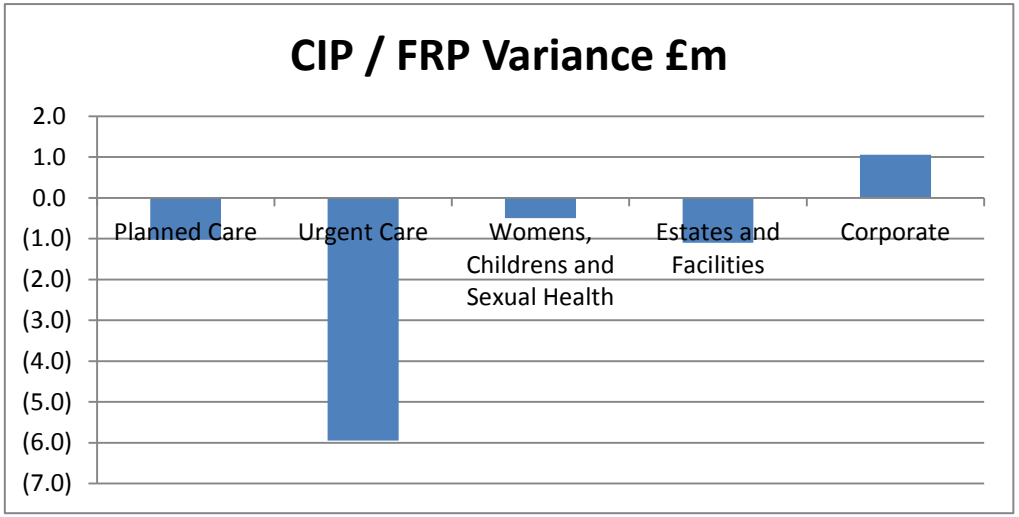
Key Variances £m

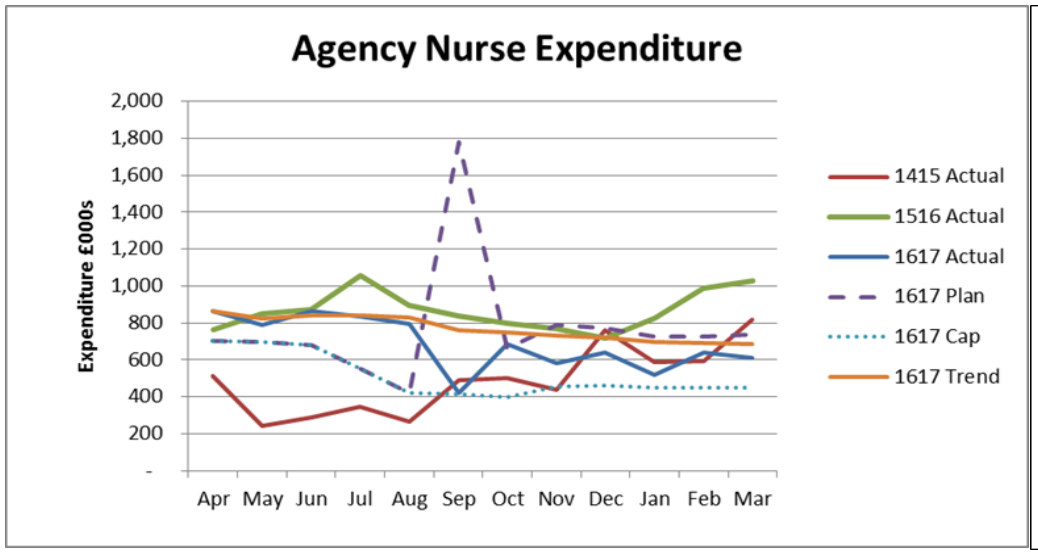
	March	YTD		Headlines
Total Surplus (+) / Deficit (-)	**(6.9)**	**(16.6)**	**Adverse**	The reported Trust position for March is a surplus of £4.2m which is £6.9m adverse to plan with a year end deficit of £12m including STF, £16.6m adverse to plan. The Trust was forecasting a likely pre STF deficit of £14.3m, the Trusts outturn position was a pre STF deficit of £17.6m, £3.3m adverse to forecast. The key reason for this variance was due to the capital to revenue transfer of £4.2m not going ahead as planned although the Trust did capitalise £0.86m of PAS implementation costs.
Clinical Income	**(1.8)**	**(9.6)**	**Adverse**	Clinical Income in March was £2m higher than February, which was mainly due a £1.1m benefit relating from 2015/16 contract negotiations which was released in line with the FRP plan, £1m increase in Elective DC and IP activity within Surgery (£0.4m) Specialty Medicine (£0.2m) and Head and Neck (£0.2m), an Increase in Non elective activity (£0.5m net of Non Elective Threshold) and an increase in partially completed spells between years (£0.2m).
Pay	**(1.3)**	**(1.5)**	**Adverse**	Pay was £1.3m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs increased by £0.9m between months, £0.3m due to extra calendar days in the month. Medical Staffing increased by £0.7m in the month, the main areas of increase related to Emergency and Acute (£350k), Critical Care (£75k), Private Patient Unit (£50k), T&O £30k and Sexual Health £30k. STT Agency costs in March increased by £80k this was mainly within Diagnostics (£50k) specifically relating to Blood sciences and Pharmacy due to high vacancy rates. A review of the bank recharge process was undertaken which provided a £180k 'one off' benefit in March.
Non Pay	**(1.6)**	**(6.1)**	**Adverse**	Non Pay was overspent by £1.6m in the month which included £1m unidentified savings. Drugs £1.4m adverse to plan, £0.2m relating to a Stock adjustment with the remainder offset by HCD income. Clinical Supplies overspent by £0.9m, £0.2m relating to stock adjustment within Theatres (£0.1m) and Materials Management (£0.1m), increase in Cardiology activity (£0.15m), increase in facilities costs (£0.2m) and catch-up in Theatre consumables (£0.4m). Other non pay costs £0.5m favourable in the month, £1m reduction between months, £0.75m relating to capitalisation of PAS costs, £0.1m reduction in STP costs and £0.1m credit relating to UV cleaning machines.
Elective IP	**(0.5)**	**(3.1)**	**Adverse**	Elective Income increased by £1m between months (1,045 cases) mainly within Surgery (£0.4m), Specialist Medicine (£0.2m) and Head and Neck (£0.2m).
Sustainability and Transformation Fund	**(0.3)**	**(3.7)**	**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 was successful in appealing quarter 3 RTT and A&E access targets which resulted in £0.8m, the Trust did not achieve STF in March.
CIP / FRP	**(1.7)**	**(7.5)**	**Adverse**	The FRP plan in March included £3.2m unidentified cost reduction savings

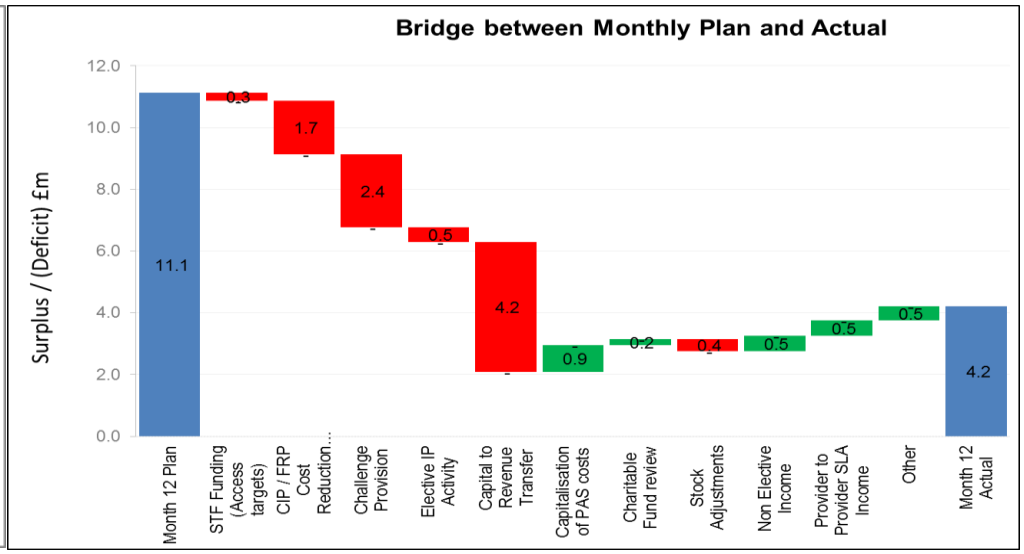
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's March 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure March 2016/17

		Current Month			Year to Date		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Revenue							
	Clinical Income	29.1	30.8	(1.8)	338.8	348.3	(9.6)
	STF	0.8	1.0	(0.3)	5.7	9.4	(3.7)
	High Cost Drugs	3.2	2.7	0.5	35.0	32.6	2.4
	Other Operating Income	6.6	9.9	(3.4)	49.2	50.5	(1.3)
	Total Revenue	39.6	44.5	(4.9)	428.7	440.8	(12.1)
Expenditure							
	Substantive	(17.3)	(17.1)	(0.2)	(214.6)	(214.3)	(0.3)
	Bank	(1.0)	(0.7)	(0.3)	(10.2)	(8.9)	(1.4)
	Locum	(1.6)	(0.7)	(0.9)	(13.0)	(10.8)	(2.3)
	Agency	(1.0)	(1.1)	0.1	(14.3)	(16.4)	2.1
	Pay Reserves	0.0	(0.0)	0.0	0	(0.3)	0.3
	Total Pay	(20.8)	(19.5)	(1.3)	(252.2)	(250.7)	(1.5)
	Drugs & Medical Gases	(5.1)	(3.7)	(1.4)	(51.7)	(48.3)	(3.4)
	Blood	(0.2)	(0.2)	(0.0)	(2.5)	(2.4)	(0.1)
	Supplies & Services - Clinical	(3.1)	(2.4)	(0.8)	(32.3)	(30.5)	(1.9)
	Supplies & Services - General	(0.6)	(0.5)	(0.1)	(5.6)	(5.5)	(0.1)
	Services from Other NHS Bodies	(0.5)	(0.7)	0.2	(7.7)	(8.6)	1.0
	Purchase of Healthcare from Non-NHS	(0.5)	(0.7)	0.2	(8.7)	(9.5)	0.8
	Clinical Negligence	(1.5)	(1.5)	0.0	(18.2)	(18.3)	0.1
	Establishment	(0.3)	(0.2)	(0.1)	(3.8)	(3.3)	(0.4)
	Premises	(1.7)	(1.6)	(0.1)	(20.4)	(20.5)	0.2
	Transport	(0.1)	(0.1)	(0.1)	(1.6)	(1.3)	(0.4)
	Other Non-Pay Costs	0.3	(0.2)	0.5	(6.0)	(4.2)	(1.9)
	Non-Pay Reserves	1.3	1.3	0.0	0	(0.0)	0.0
	Total Non Pay	(12.1)	(10.5)	(1.6)	(158.5)	(152.4)	(6.1)
	Total Expenditure	(32.9)	(30.0)	(2.8)	(410.7)	(403.1)	(7.6)
EBITDA	**EBITDA**	6.8	14.5	(7.7)	17.9	37.7	(19.8)
		0.0	*0.0*	*0.0*	*4.2%*	*8.6%*	*162.9%*
Other Finance Costs							
	Depreciation	(1.2)	(1.6)	0.4	(13.3)	(15.7)	2.5
	Interest	(0.1)	(0.1)	0.0	(1.1)	(1.1)	(0.0)
	Dividend	0.1	(0.4)	0.4	(1.9)	(3.4)	1.5
	PFI and Impairments	(1.2)	(14.6)	13.4	(54.8)	(27.0)	(27.8)
	Total Finance Costs	(2.4)	(16.7)	14.2	(71.0)	(47.2)	(23.8)
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	4.3	(2.2)	6.5	(53.1)	(9.5)	(43.6)
Technical Adjustments	**Technical Adjustments**	(0.1)	13.3	(13.5)	41.1	14.2	26.9
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	4.2	11.1	(6.9)	(12.0)	4.7	(16.6)
	Surplus/ Deficit (-) to B/E Duty Excl STF	3.4	10.1	(6.6)	(17.6)	(4.7)	(12.9)

Commentary

The Trusts surplus including STF was £4.2m in March which was £6.9m adverse to plan with a pre STF adverse variance of £6.6m.

The Trusts year end outturn was a deficit of £12m, £16.6m adverse to plan with a pre STF deficit of £17.6m, £12.9m adverse to plan.

Clinical Income (Excluding STF) was £1.8m adverse to plan in month (£9.6m adverse YTD), Clinical Income in March was £2m higher than February which was mainly due a £1.1m benefit from 2015/16 contract negotiations released in line with the FRP plan, £1m increase in Elective DC and IP activity within Surgery (£0.4m) Specialty Medicine (£0.2m) and Head and Neck (£0.2m). An increase in Non elective activity (£0.5m net of Non Elective Threshold) and a increase of value of partially completed spells between years (£0.2m) .
The key variances within Clinical Income in the month were, IP activity £0.5m adverse , HCD income £0.3m adverse partly offset by £0.5m Non Elective favourable variance .

Other Operating Income £3.4m adverse to plan, £4.2m adverse due to the capital to revenue transfer not going ahead, additional income above plan relating to STP funding of (£0.4m) offsetting expenditure incurred in the month, Private Patient Income unallocated credits (£0.1m) and Sexual Health out of area activity (£0.1m). Deferred income of £1.35m (£0.85m R&D and £0.5m Medical Education) was released in March which was in line with the Financial recovery plan.

Pay was £1.3m adverse in the month which included £2m unidentified CIP. Temporary Staffing costs increased by £0.9m between months, £0.3m due to extra calendar days in the month. Medical Staffing increased by £0.7m in the month, the main areas of increase related to Emergency and Acute (£350k), Critical Care (£75k), Private Patient Unit (£50k), T&O £30k and Sexual Health £30k. STT Agency costs in March increased by £80k this was mainly within Diagnostics (£50k) specifically relating to Blood sciences and Pharmacy due to high vacancy rates. A review of the bank recharge process was undertaken which provided a £180k 'one off' benefit in March.

Non Pay was overspent by £1.6m in the month which included £1m unidentified savings. Drugs £1.4m adverse to plan, £0.2m relating to a Stock adjustment with the remainder offset by HCD income. Clinical Supplies overspent by £0.9m, £0.2m relating to a stock adjustment within Theatres (£0.1m) and Materials Management (£0.1m), increase in Cardiology devices (£0.15m), increase in facilities costs (£0.2m) and catch-up in Theatre consumables (£0.4m). Other non pay costs £0.5m favourable in the month, £1m reduction between months, £0.75m relating to capitalisation of PAS costs, £0.1m reduction in STP costs and £0.1m credit relating to UV cleaning machines.

3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

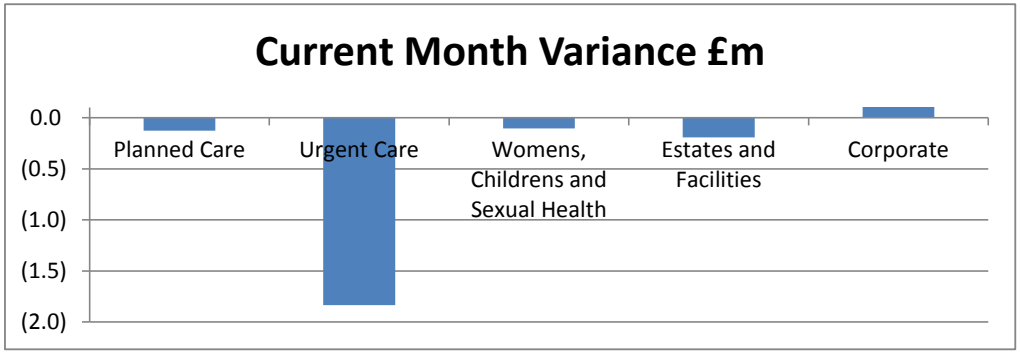
		Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Change between Months
Revenue	Clinical Income	26.9	26.6	27.7	28.4	27.6	27.8	32.0	28.5	28.6	28.1	27.5	27.0	29.1	2.1
	STF	0	0	0	0	0	0	2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.8
	High Cost Drugs	3.1	2.8	2.6	2.8	2.6	2.7	2.9	2.9	2.8	3.8	3.1	2.7	3.2	0.6
	Other Operating Income	6.5	3.8	3.8	3.6	4.0	3.6	3.7	4.0	3.9	3.9	4.5	3.9	6.6	2.7
	Total Revenue	**36.4**	**33.2**	**34.1**	**34.8**	**34.2**	**34.1**	**41.3**	**36.2**	**36.1**	**36.3**	**35.1**	**33.5**	**39.6**	**6.1**
Expenditure	Substantive	(18.1)	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	0.5
	Bank	(1.1)	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.1)
	Locum	(0.6)	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(0.6)
	Agency	(1.9)	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.1)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(21.8)	(21.2)	(21.2)	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(0.4)
Non-Pay	Drugs & Medical Gases	(4.0)	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(1.1)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.3)	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(0.6)
	Supplies & Services - General	(0.7)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.2)
	Services from Other NHS Bodies	(0.7)	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	0.2
	Purchase of Healthcare from Non-NHS	(1.1)	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.0)
	Clinical Negligence	(1.4)	(1.5)	(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)	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(1.1)	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	0.1
	Transport	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.8)	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	0.3	1.1
	Non-Pay Reserves	0	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	0	0	0	0	1.3	1.3
	Total Non Pay	(12.9)	(12.9)	(13.4)	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.1)	0.7
	Total Expenditure	(34.7)	(34.1)	(34.6)	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(32.9)	0.3
EBITDA	EBITDA	1.8	(1.0)	(0.5)	(0.8)	(0.4)	(0.5)	8.2	2.2	1.6	1.2	0.8	0.3	6.8	6.4
		5%	*-3%*	*-1%*	*-2%*	*-1%*	*-1%*	*20%*	*6%*	*4%*	*3%*	*2%*	*1%*	*17%*	
Other Finance Costs	Depreciation	0.9	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(0.2)
	Interest	(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)	0.1
	Dividend	0.1	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.7)
	PFI and Impairments	(14.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	41.1
		(13.3)	**(2.9)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**40.3**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(11.5)	(3.8)	(3.3)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(1.3)	(1.2)	0.1	(42.4)	4.3	46.7
Technical Adjustments	Technical Adjustments	12.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	(40.4)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	5.4	(0.5)	(1.2)	(1.3)	0.3	(2.0)	4.2	6.3
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	2.7	(1.4)	(1.9)	(1.9)	0.3	(2.0)	3.4	5.5

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	0.5	0.3	0.2	0.6	0.4	0.2
Critical Care	0.1	0.1	(0.0)	0.1	0.1	(0.0)	0.2	0.2	(0.0)
Diagnostics	0.1	0.1	0.0	0.2	0.3	(0.1)	0.3	0.5	(0.1)
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	0.2	(0.1)	0.2	0.3	(0.1)
Trauma and Orthopaedics	0.0	0.0	0.0	0.3	0.4	(0.0)	0.4	0.4	(0.0)
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)**	**1.4**	**1.5**	**(0.1)**	**1.9**	**2.0**	**(0.1)**
Urgent Care	**0.3**	**0.3**	**(0.0)**	0.6	2.4	(1.8)	0.8	2.7	(1.8)
Womens, Childrens and Sexual Health	**0.1**	**0.1**	**(0.0)**	0.3	0.4	(0.1)	0.4	0.5	(0.1)
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)**	0.5	(0.0)	0.5	0.6	0.1	0.5
Total	**1.0**	**1.1**	**(0.1)**	**2.9**	**4.5**	**(1.6)**	**3.8**	**5.6**	**(1.7)**



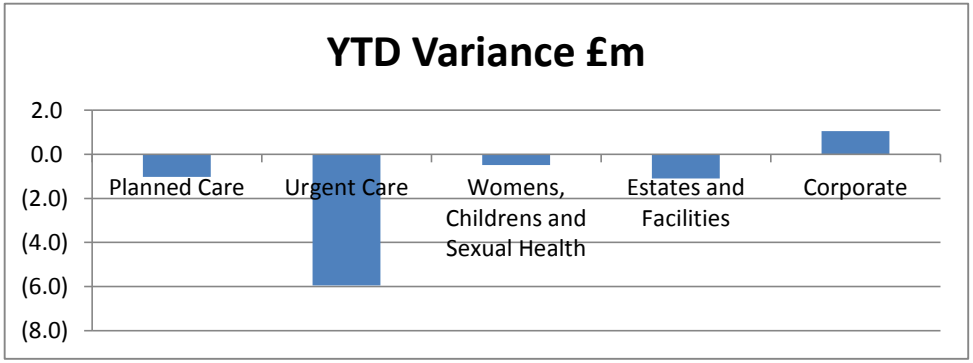
Savings of £3.9m were delivered in March, £1.2m higher than February. Savings were £1.7m adverse to plan. The majority of the underperformance was within Urgent care.

The main movement between months relate to:
- Oncology Provider to Provider SLA £0.5m
- Sexual Health out of area (£60k) and North Kent Contract (£80k)
- Revenue to Trust fund expenditure review £0.2m
- St Jude product recall £0.1m

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	2.2	2.2	0.0	0.9	0.5	0.4	3.2	2.7	0.4
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	(0.3)	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)**	**4.2**	**5.0**	**(0.9)**	**12.0**	**13.0**	**(1.0)**
Urgent Care	**3.5**	**3.7**	**(0.2)**	**2.3**	**8.1**	**(5.8)**	**5.8**	**11.8**	**(5.9)**
Womens, Childrens and Sexual Health	**1.1**	**1.1**	**0.0**	**0.8**	**1.3**	**(0.5)**	**1.9**	**2.4**	**(0.5)**
Estates and Facilities	**1.2**	**2.1**	**(0.8)**	**0.9**	**1.2**	**(0.3)**	**2.2**	**3.3**	**(1.1)**
Corporate	**0.9**	**1.0**	**(0.1)**	**1.7**	**0.6**	**1.2**	**2.7**	**1.6**	**1.1**
Total	**14.6**	**15.9**	**(1.2)**	**9.9**	**16.2**	**(6.3)**	**24.6**	**32.1**	**(7.5)**



The Trust delivered £24.6m savings in 2016/17, £7.5m adverse to the plan of £32.1m

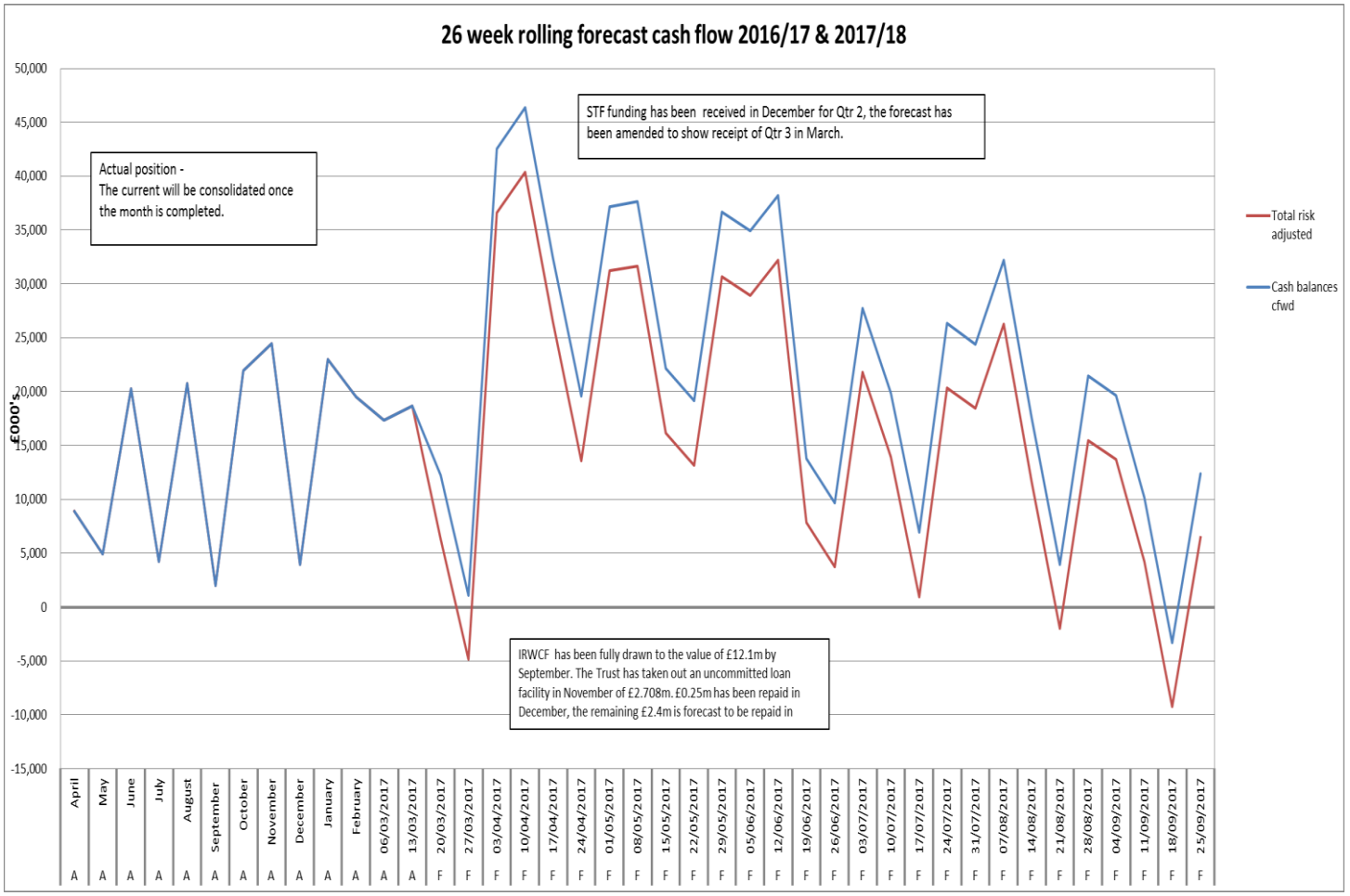
The CIP plan which was used for the resubmitted plan included savings for energy and rates. However this was not included in the I&E forecast therefore has no bottom line impact, this will be a £0.75m shortfall at the year end. Planned savings of £340k associated with the new Patient Transport contract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

The year end FRP gap was £6.3m, the majority of this is within Urgent Care (£5.8m).

5. Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

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, due to uncertainty in timing of receipt of the STF income the Trust has deferred repayment until April .

The Trust received the anticipated £2.2m qtr. 3 STF funding late in March.

The Trust also received £1.7m PDC funding for a linac machine which was delivered on the 31st March 2017.

Other cash receipts were primarily from the recovery of outstanding debts.

A number of large payments were made in March, which include loan repayments including interest of £1.3m and £2.3m PFI unitary payment and PDC £1.1m.

The Trust also paid its statutory commitments of Tax, NI and Pensions before year end.

Maidstone and Tunbridge Wells NHS Trust

5b. Balance Sheet

March 2017

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

	March			February	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	280.3	335.3	(54.9)	276.7	335.3	330.2
Intangibles	3.1	1.5	1.6	2.7	1.5	2.0
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.2	0.3	1.2	1.2	1.2
Total Non-Current Assets	**284.9**	**338.0**	**(53.1)**	**280.6**	**338.0**	**333.4**
Current Assets						
Inventory (Stock)	7.9	8.3	(0.3)	8.3	8.3	8.3
Receivables (Debtors) - NHS	33.9	22.8	11.2	34.7	22.8	21.5
Receivables (Debtors) - Non-NHS	10.0	7.8	2.2	9.7	7.8	9.4
Cash	1.4	1.0	0.4	13.6	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**55.0**	**39.9**	**15.2**	**68.0**	**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	(50.5)	(21.8)	(28.7)	(63.9)	(21.8)	(21.7)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(5.0)	0.3	(4.8)	(5.0)	(5.0)
Provisions for Liabilities and Charges	(1.8)	(1.0)	(0.7)	(1.8)	(1.0)	(1.0)
Total Current Liabilities	**(63.3)**	**(35.1)**	**(28.3)**	**(76.8)**	**(35.1)**	**(34.9)**
Net Current Assets	(8.3)	4.8	(13.1)	(8.8)	4.8	5.3
Finance Lease - Non- Current	(198.5)	(198.2)	(0.3)	(198.7)	(198.2)	(198.2)
Capital Loan - (interest Bearing Borrowings)	(12.3)	(16.4)	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)	(0.7)	(0.5)	(1.2)	(0.7)	(0.7)
Total Assets Employed	**33.0**	**98.4**	**(65.3)**	**27.0**	**98.4**	**98.4**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(203.3)	(1.7)	(203.3)	(203.3)	(203.3)
Revaluation reserve	(30.3)	(53.8)	23.5	(30.3)	(53.8)	(53.8)
Retained Earnings Reserve	202.2	158.7	43.6	206.6	158.7	158.7
Total Capital & Reserves	**(33.0)**	**(98.4)**	**65.4**	**(27.0)**	**(98.4)**	**(98.4)**

Commentary:

The balance sheet is less than plan, primarily due to the revaluation of PPE assets. Key movements to March are in working capital where the stock, cash, debtors and creditors balances are decreasing from the February's position. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets (PPE)- The value of PPE has increased from the February's position as assets which were under construction have been additioned. The Trust worked with Montagu Evans and revalued its Land, Building and Dwellings at 30th September under the Modern Equivalent Asset Valuation method (MEA). For the period from October to March the Trust used BCIS indices to access if there has been any material movement in values, the percentage increase was 0.69% yielding an I&E impact of £30k, which is therefore not a material number .

Current Assets Inventory has decreased slightly from the reported February's position, mainly due to decrease in pharmacy stock from £3.9m to £3.3m, materials management stock from £1m to £0.9m, and other general stocks. Cardiology stocks increased £1m to £1.3m. Inventory reduction is a cash management strategy.

NHS Receivables have decreased since February, remaining significantly higher than the plan value. Of the £33.9m balance, £16.2 relates to invoiced debt of which £2.7m is aged debt over 90 days. Debt over 90 days has decreased since February as a result of receiving 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 increased by £0.3m from February's position, and is above plan by £2.2m. Included within this balance is trade invoiced debt of £2.4m and private patient invoiced debt of £0.6m (consistent with £0.7m in February).

Current Liabilities NHS trade payables has remained consistent with the February reported position and is above plan. Non-NHS trade payables has decreased by £13.4m, still remaining significantly above plan.

Of the £50.5m trade creditor balances, £25.1m relates to invoices, £5.7m is deferred income primarily relating to PAS AllScript and Maternity Pathway. The remaining £20.2m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

The Public Dividend Capital reserve has increased by £1.7m as a result of funding received for a linac machine.

6. Capital

6a. Capital Programme

Capital Projects/Schemes

	Year to Date		
	Actual	*Plan*	*Variance*
	£000	£000	£000
Estates	2,403	9,384	6,981
ICT	3,086	2,671	-415
Equipment	3,439	2,581	-858
PFI Lifecycle (IFRIC 12)	247	553	306
Donated Assets	362	800	438
Total	**9,537**	**15,989**	**6,452**
Less donated assets	-362	-800	-438
Asset Sales (net book value)	-8	0	8
Contingency Against Non-Disposal	0	0	0
Adjusted Total	**9,167**	**15,189**	**6,022**

The total resource approved by the Trust board for the 2016/17 capital programme was £15.989m, including PFI lifecycle and donated assets. The Trust subsequently 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 year-end outturn therefore takes into account the reductions of £4.188m for the capital to revenue transfer, although it has since been agreed with NHSI to reutilise £850k of this for the PAS project (revised reduction £3.338m).

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. Therefore the outturn variance of £6m below plan results from 1. the net capital to revenue transfer value (-£3.338m); 2. the deferral of the Radiotherapy scheme (-£4.1m); 3. the addition of the Linac purchase funded from unplanned central PDC (+£1.7m). The PFI Lifecycle spend also was lower than planned for the year (-£0.3m).

The donated spend was £0.4m in the year, approximately half of the planned level, as a result of unspent legacy funding due for utilisation in 2017/18.

Trust Board meeting – April 2017

Maidstone and Tunbridge Wells NHS Trust

4-10	**Outcome of the current investigations regarding mortality / increased HSMR**	**Medical Director**

This report is submitted following a request from the Trust Board on the 29th March 2017 for a further update into the investigations being undertaken to understand the anomalies reported nationally in regard to the increased Hospital Standardised Mortality Rates (HSMR).

This report outlines the outcome of those investigations, their findings and further actions that are subsequently required.

Which Committees have reviewed the information prior to Board submission?
None

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

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

TRUST MORTALITY REVIEW

1. Introduction

A Mortality 'deep dive' Report was previously prepared by the Medical Director for a subgroup of the Quality Committee and presented in January 2017. That report outlined a variety of potential causal factors which had been highlighted through analysis undertaken internally as well as by Dr Foster to explain the Trust's 'higher than expected' levels of mortality reported by Dr Foster using the Hospital Standardised Mortality Ratio (HSMR).

That report highlighted a number of areas for action and further analysis and investigation and an action plan was developed to cover those points (see Appendix 1).

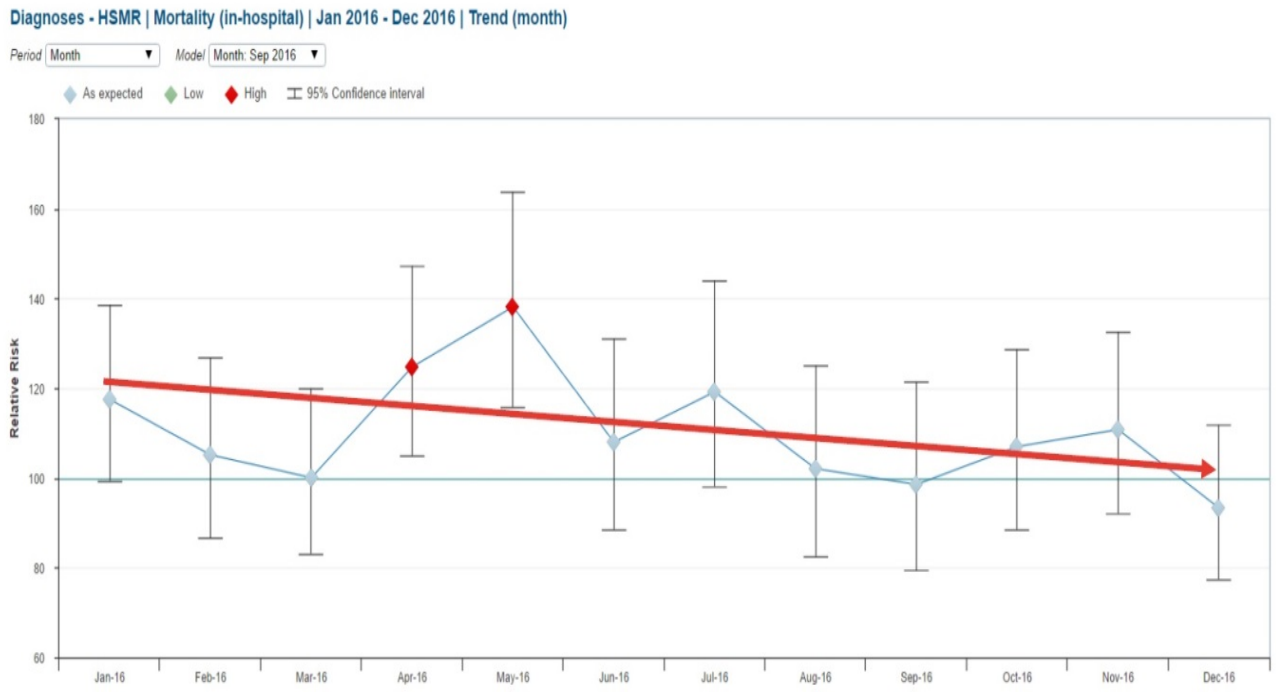
In summary the themes to be followed up fell into the following categories:

- Improve the visibility of mortality data across the Trust
- Verify the risk rating associated with fractured NOF specifically
- Ensure mortality is fed into the 7 Day Services programme to reduce any variation across the week
- Improve data quality and Clinical Coding associated with mortality to ensure the expected level of mortality used by Dr Foster is reflective
- Implementation of Early warning reporting / alerting using the latest Dr Foster tools

HSMR is calculated using a rolling 12 months' worth of data, therefore, it should be highlighted that any improvements in operational practice, clinical coding and/or data quality will not be seen for some considerable time.

2. Current Status

Figure 1.0 – Monthly Trend



Overall the HSMR figure for the rolling period January to December 2016 is 110.1 using the latest September 2016 benchmark, which remains higher than expected. As previously identified, two months during this period were statistically significant April and May 2016 (see Appendix 2). As shown in Fig. 1.0 the linear trend shows a decreasing month on month trend, which if this continues, will translate into an improvement in the rolling 12 month performance used for the HSMR.

Figure 2.0 – Rolling 12 month Trend

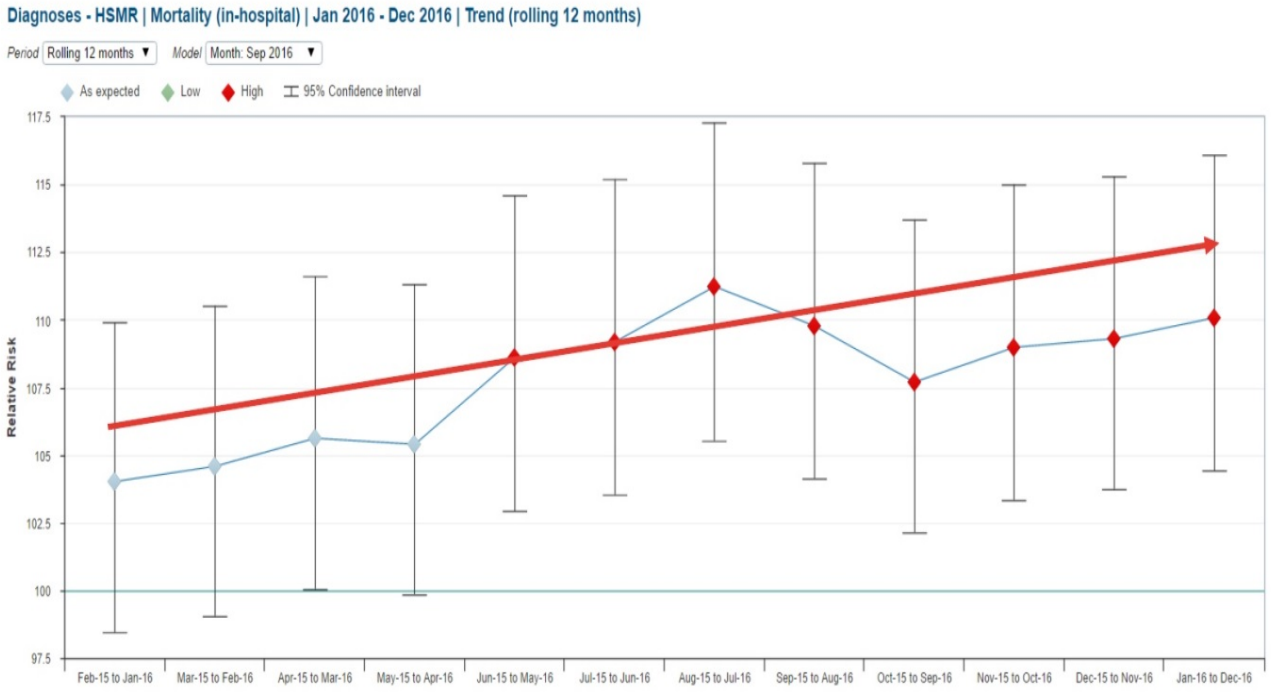


Figure 2.0 however, shows an increasing trend due to 8 of the last 12 data periods (using a rolling 12 month period), having a 'higher than expected' level of mortality. This continues to be impacted by the two statistically significant months (April and May 16).

The latest report from Dr Foster highlights that the Trust admits significantly more non-elective patients than elective compared to our regional peers. Equally, more patients aged 85 years+ are admitted than for our peers. Also statistically evident is that our Trust continues to have a higher rate of admissions for patients with zero co-morbidities than for our peers.

Figure 3.0 - Palliative Care Coding

Trend (Financial Year)	Spells	Observed	Rate (%)	National Rate (%)	Peer Group Rate (%)
2013/14	22,567	169	0.75	2.95	2.50
2014/15	23,619	314	1.33	3.19	3.29
2015/16	21,026	599	2.77	3.42	3.64
2016/17	16,792	549	3.27	3.53	3.65

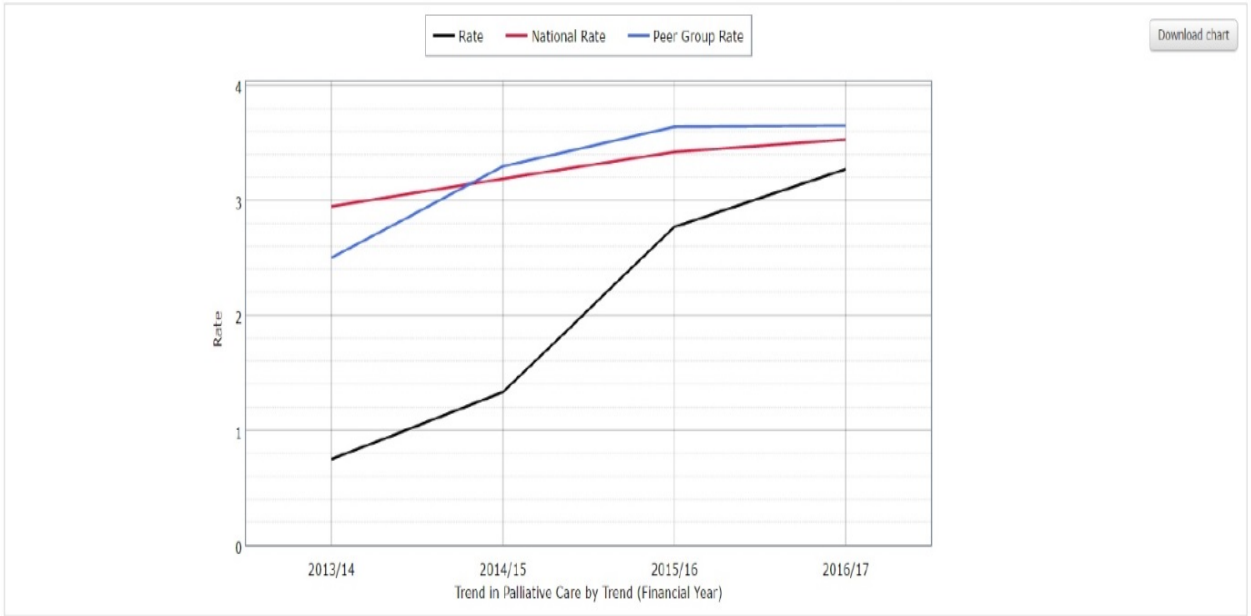


Figure 3.0 shows that the Trust's palliative care coding continues to improve and is closing the gap with the regional and national levels, but there is still room for improvement.

3. Fractured Neck of Femur (NOF)

The Mortality rates associated with patients admitted with a fractured NOF was an area highlighted for further investigation and a records audit was undertaken to look at 48 patients who died under the Trust's care during September 15 to October 16. Due to the availability of notes, it was only possible to audit a sample of these cases.

A detailed report from the audit is being prepared for the Quality Committee, but in summary the following themes were observed from the audit are possible contributing factors:

- Time to surgery seems to be a possible factor, as approximately a third of patients audited had not been operated on, on the day of admission or on the following day (as per the standard of less than 36hrs)
- The NOF Nurse reported delays are due to theatre availability and the need for sub-specialisation, availability of those specialist surgeons and the associated challenges with timely scheduling of operations with competing clinical needs. An audit is taking place to validate this.
- The general coding, including co-morbidities, within the records audited was found to be of good quality.
- The coding of the reasons for procedures not taking place was highlighted as an area for improvement. This requires a change in practice for consultants in their record keeping.
- The Trust was found to have a higher proportion of 85+ year old patients than its local peers.
- The Trust was found to have a higher rate of non-elective activity levels at the Trust when compared to local peers.
- Queries were raised over the impact of having our rehabilitation pathways for fractured NOF's integral to Maidstone & Tunbridge Wells hospitals, rather than discharged to Community hospitals or Nursing home etc.

The level of mortality reported by Dr Foster had previously been questioned as the National Hip Fracture Database (NHFD) appeared to demonstrate a conflicting picture of the Trust's performance with this group of patients. Part of the audit and follow-up included a session with Dr Foster to try to explain the discrepancy between the two data sources. These differences were explained by the following factors:

- Dr Foster uses primary diagnosis for HSMR not the procedure whereas the NHFD is based on procedures (so Dr Foster will include patients not operated on and NHFD will not).
- NHFD is focused on patients over 60 only – Dr Foster uses all patients (so Dr Foster has a larger sample).
- NHFD incorporates deaths within 30 days of discharge following procedure – Dr Foster uses in-hospital deaths and is not limited to 30 days post discharge (so Dr Foster has a larger sample).
- NHFD based on crude numbers whereas HSMR is a risk score made up of 12 factors including - Age, Sex, Method of admission (Elective or Non-Elective), Socio-economic deprivation, Diagnosis CCS subgroup, Co-morbidity, Source of admission, Number of emergency admissions in last 12 months, Palliative care, Year and Month of admission (therefore the results will be different).

4. Data Quality and Clinical Coding

A further area previously highlighted was the depth of Coding for deceased patients. According to Dr Foster the Trust admits a higher proportion of patients with zero co-morbidities than our local peers. Analysis of admissions with zero co-morbidities by specialty, shows that Care of the Elderly and General Medicine have the highest proportion of deceased patients that fall into this category.

It has been agreed that some focussed work will take place with these specialities to increase awareness of how recording co-morbidities clearly and accurately will impact positively on mortality reporting.

The coding of deceased patients will also be allocated to the senior coders within the Coding team, to ensure that our most experienced and qualified coders manage these records, reflecting the complexity of the cases appropriately.

Medway Foundation Trust had similar challenges with their mortality data and has gone a long way to addressing these. Representatives from the two Trust's information and quality teams have planned to meet to share experience and learning.

5. Increasing awareness and improving the use of mortality data

One of the actions agreed at the deep dive meeting in January was to increase the visibility of mortality data within services, by improving the reporting and its circulation throughout the Trust. Since the meeting, additional KPIs have been added to the directorate and divisional dashboards as well as to the EPR packs that are used to performance manage services by the Executive Team.

Further work is being undertaken with the Mortality Surveillance Group to review the use of Dr Foster and mortality reporting, to ensure that any trends and themes are highlighted, understood and followed up in a timely manner by the right group of staff and that the learning is documented and shared.

The data supplied by Dr Foster is several months behind due to the data flows that feed into it. In response to this, Dr Foster has created an early warning tool, which uses data sent directly from the Trust (rather than data made available to them from national commissioning data flows). Since the January meeting, the Trust has now operationalised this with Dr Foster and data is being submitted monthly to enable a more timely view of performance in this area.

6. Mortality Reviews and associated learning

The Mortality Surveillance Group has been developing systems and processes over the last year, focussed around Mortality Review and any derived learning from these reviews. All deaths should be reviewed by the Trust and the results of these reviews should be documented and shared.

The completeness of the Mortality Reviews has improved over the last year and to support the continued improvement of completion of these reviews, this has been added as a KPI on the EPR scorecards for the Executive Team to monitor. The Trust is currently liaising with other local providers to enable some benchmarking of the completion of reviews for context.

7. Summary

As can be seen from the report, there are various strands of work in progress to support improvements in the reporting of the Trust's mortality and to understand what lessons can be learnt from deaths occurring at the Trust. Progress against these actions will continue to be reported to the Medical Director and mortality performance will continue to be monitored by the Mortality Surveillance Group (which the Medical Director chairs).

8. Appendices

Name	Content	File
Appendix 1	Updated Action Plan created following January's Quality Committee deep dive	Mortality Data - Action Plan 20170418.
Appendix 2	Latest Dr Foster Dashboard	Dr Foster Quality - Mortality Dashboard 2

Appendix 1

Mortality Data - Action Plan - Produced in January 2017

No.	Item	Action	Action Owner(s)	Original Deadline	Current Deadline	Status	Update
1	**Improve the visibility of mortality data within the Operations Directorate / Trust**	Design an internal Mortality dashboard by specialty and circulate to Ops managers monthly	James Jarvis	31/01/2017		Completed	Information Team has designed the new scorecards. Copies set to AG and PM. These have been circulated to Ops leads by AG.
		Share the Dr Foster standards dashboards with Ops managers e.g. CDs, Matrons and Directors of Ops, on a monthly basis.	James Jarvis	31/01/2017		Completed	Copies set to AG and PM. These have been circulated to Ops leads by AG
		Promote the use of the Dr Foster tools for services to self-serve to access mortality data.	James Jarvis / Dr Foster	31/03/2017	30/05/2017	Action Delayed	
		Explore the inclusion of mortality review completeness on the EPR scorecards to raise the profile of the requirement to complete these and the associated benefits.	James Jarvis / Lynne Sheridan	31/03/2017		Completed	To be agreed by Jim Lusby as chair of the EPR Meetings and Exec Lead. Done - Jan-17 EPR Packs.
		Review the data supplied to the Mortality Surveillance Group in light of the recent deep dive and ensure this is appropriate to provide a focus on the key areas highlighted.	James Jarvis / Peter Maskell	28/02/2017		Completed	Dr Foster reports by Spec and Trust-level PLUS new scorecards sent to PM & AG.
2	**Verify the risk rating associated with Fractured NOF reported by Dr Foster**	Set up a half day session to review the relevant deaths with the lead consultant, Dr Foster and other internal supporting staff e.g. analysts and quality team.	James Jarvis / Wendy Glazier	28/02/2017		Completed	Session held - 1st Feb abd follow up on the 8th Feb.
		Review the information reported from other sources e.g. the National Hip Fracture Data Base and try to reconcile to the Dr Foster data / understand the differences.	James Jarvis / Dr Foster	28/02/2017		Completed	Review of both data sources completed and the differences highlighted.
		Produce a report to explain the results of the audit and an action plan to address and issues found for either Ops, Information or third parties e.g. Dr Foster.	James Nichol	31/03/2017	21/04/2017	Action Delayed	Peter Maskell has requested this to be completed by the 21st April.
3	**Ensure that mortality data is fed into the 7 Day Services project to reduce variation**	Provide baseline reports to the 7 Day Service programme board on mortality by day of the week by specialty, diagnosis and procedure - for Stocktake review for Clinical Directors Presentation.	James Jarvis	31/01/2017		Completed	Shared variety of Mortality reports with LS and PS for presentation to CDs.
		Set up and provide regular reports to the 7 Day Service programme board on mortality by day of the week by specialty, diagnosis and procedure.	James Jarvis / Lynne Sheridan	15/03/2017		Completed	JJ on Steering Group. Report added to Info Kiosk with Mortality by day of the week.
		Ensure reducing variation in mortality across the week is a key focus of the 7 Day Services programme.	James Jarvis / Lynne Sheridan	31/03/2017		Completed	JJ on Steering Group. Reports to included on the agenda.
4	**Ensuring the Trust's 'expected' level of mortality is as accurate as possible**	Review the resourcing of the Clinical Coding function and ensure this is in line with national benchmarks and produce a business case to cover any changes required.	Bernice Lloyd	31/01/2017		Completed	Business Plan went to Execs 31st Jan. Approved.
		Implement the plan when the business case has been finalised and approved.	Bernice Lloyd	31/03/2018		Action On Track	
		Provide guidance and training for Ops staff on the importance of clinical coding and the impact on mortality reporting.	Bernice Lloyd	31/03/2018		Action On Track	Ongoing training and support to staff.
		Provide focussed support for the Specialties identified as recording below expected levels of comorbidities.	Bernice Lloyd	31/03/2017	30/06/2017	Action Delayed	
		Monitor the levels of comorbidities recorded by specialty and highlight variation by exception.	James Jarvis	28/02/2017	30/06/2017	Action Delayed	Some adhoc reports have been produced, but need to agree a
		Ensure data quality for demographic data is as expected and monitor via DQ group.	James Jarvis	31/03/2018		Action On Track	Ongoing reporting and monitoring of DQ.
5	**Set up Early Warning Alerting**	Share mortality reports by specialty, diagnosis and procure to provide early warning alerting via the Dr Foster tools.	James Jarvis	28/02/2017		Completed	
		Set up the new Early Warning reporting on Dr Foster - using local data feeds, to provide more timely mortality reporting.	James Jarvis	31/03/2017		Completed	IG Committee have signed off the PIA. Data Sharing Agreement Signed. Information Team are working on data feeds.
		Once set up ensure the new Early Warning reports are shared with the Mortality Surveillance Group and other appropriate forums and managers / Ops staff.	James Jarvis	31/03/2017	30/05/2017	Action Delayed	The tool has been set up and access granted to the Trust. We can now look at how we use the new tool and share access / reports.

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Appendix 2

Organisation Maidstone and Tunbridge Wells NHS Trust
Site All sites selected
My Group All diagnoses & procedures
Report date 18 Apr 2017
Time period 12 months (Jan 2016 to Dec 2016)

Dashboards

Mortality

Alerts view: Negative alerts – all

CUSUM detection threshold: 99.0

Relative risk and CUSUM

Title	Cusum	Observed	Expected	Rate (%)	Relative Risk	Trend	LOS	Readm.	Peers
Diagnosis group	10↑	576	436.1	5.2	**132**				
HSMR Basket of 56 Diagnosis Groups	6 4↑	1,394	1,265.4	4.3	**110**				
Residual codes, unclassified	4↑	55	26.6	1.9	**206**				
Congestive heart failure, nonhypertensive	1↑	89	61.8	16.3	**144**				
Multiple myeloma	1↑	6	3.8	6.3	160				
Non-Hodgkin's lymphoma	1↑	19	9.5	7.1	**201**				
Other gastrointestinal disorders	1↑	15	12.8	0.4	118				
Phlebitis, thrombophlebitis and thromboembolism	1↑	3	0.6	3.3	478				
Skin and subcutaneous tissue infections	1↑	17	12.1	1.5	140				
Fracture of neck of femur (hip)		54	36.7	8.9	**147**				
Pneumonia		318	272.3	17.2	**117**				
Procedure group	3↑	506	416.9	3.0	**121**				
Chemotherapy	1↑	7	5.1	2.4	137				
Diagnostic imaging (except heart)	1↑	488	408.5	5.1	**119**				
Rest of Urinary (diagnostic/minor)	1↑	1	0.1	4.3	894				
Diagnostic endoscopic procedures on lower GI tract		8	3.0	0.1	**268**				
Diagnostic endoscopic retrograde exam of bile duct and pancreatic duct		2	0.2	10.5	**991**				

Most observed exceeding

Title	Rel. Risk	Volume	Observed	Expected	Obs.-Exp.
Diagnostic imaging (except heart)	**119**	9,491	488	408.5	**79.5**
Pneumonia	**117**	1,845	318	272.3	**45.7**
Residual codes, unclassified	**206**	2,958	55	26.6	**28.4**
Congestive heart failure, nonhypertensive	**144**	546	89	61.8	**27.2**
Fracture of neck of femur (hip)	**147**	608	54	36.7	**17.3**

Highest crude

Title	Rel. Risk	Volume	Observed	Rate (%)
Shock	212	1	1	100.0
Cardiac arrest and ventricular fibrillation	109	27	17	63.0
Amputation of leg	447	2	1	50.0
Aspiration pneumonitis, food/vomitus	102	176	54	30.7
Respiratory failure, insufficiency, arrest (adult)	95	43	12	27.9

**** Data suppressed in accordance with the HSCIC HES Analysis Guide (2014)

Trust Board meeting – April 2017

Maidstone and Tunbridge Wells NHS Trust

4-11 Planned and actual ward staffing for March 2017 Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of March 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 fairly static at 7.6 compared to 7.5 for February. For Tunbridge Wells it increased to 9.8 compared to 8.9 for 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, Cornwallis, John day, and Ward 20

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

Escalation areas account for over-fill on Maidstone AMU (UMAU), and TWH AMU, and Hedgehog. 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 reduced fill rate across registered and unregistered staff groups. There was an increase in the number of support staff at night 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 and the site practitioners.

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.

Maidstone Accident & Emergency (A&E) Department had acceptable levels of staffing. Tunbridge Wells A&E had reduced fill rates during the day. This was managed with support from the Matron, and close working relationships with the Medical Assessment Unit. There continues to be 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 provides support to the escalated beds in Recovery. The ITUs will move staff between sites according to the acuity levels on each site. Cross-cover support was also provided to wards 2, 21, 30, and 31.

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.

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

Assurance

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

March '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	92.3%	109.7%	102.4%	119.4%	8.0	40.0%	95.0%	9	0		13 episodes of enhanced care needs at night. 10 shifts uncovered by temporary staffing. Supported by divert of stroke bleep to TWH	118,486	133,704	-15,218
MAIDSTONE	Foster Clark	95.8%	98.4%	100.0%	106.5%	6.3	25.2%	75.8%	1	0			98,543	104,921	-6,378
MAIDSTONE	Cornwallis	108.6%	93.5%	100.0%	113.0%	6.7	29.9%	95.5%	0	0		CSW fill rated reflects need on 3 occasions to have a support worker on a Saturday night to meet increased dependency needs.	62,107	69,283	-7,176
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	87.1%	100.0%	N/A	10.7	75.6%	90.3%	1	0			92,404	94,586	-2,182
MAIDSTONE	Culpepper	100.0%	96.8%	100.0%	106.5%	6.8			0	0					
MAIDSTONE	John Day	94.6%	104.8%	100.0%	112.5%	6.0	48.1%	92.3%	7	0		Enhanced care needs for 2 nights. Enhanced care needs assessment undertaken and supported by Directorate	115,419	138,889	-23,470
MAIDSTONE	Intensive Treatment Unit (ITU)	98.0%	N/A	98.4%	N/A	24.6	50.0%	100.0%	0	0			164,702	153,067	11,635
MAIDSTONE	Pye Oliver	93.7%	88.4%	101.1%	101.1%	7.2	42.3%	93.9%	2	0		12 shifts not covered; 2 RNs and 10 support workers	105,945	111,059	-5,114
MAIDSTONE	Chaucer	99.2%	103.9%	100.0%	107.3%	6.3	28.9%	81.8%	7	0			110,176	111,579	-1,403
MAIDSTONE	Lord North	97.4%	116.1%	101.1%	96.8%	6.6	80.0%	100.0%	2	1		6 shifts above plan from within establishment to cover additional ward attenders.	86,241	88,749	-2,508
MAIDSTONE	Mercer	110.5%	96.8%	98.9%	98.4%	7.2	38.6%	95.5%	3	1		Overfill for RNs is from within establishment with minimal leave taken in March.	95,501	80,563	14,938
MAIDSTONE	Edith Cavell (MOU)	95.5%	101.3%	107.1%	92.7%	6.4	81.3%	82.1%	4	0			115,872	66,256	49,616
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	85.6%	94.0%	125.8%	200.0%	11.3	16.7%	98.7%	2	0		High fill rate at night reflects use trolley spaces as escalation capacity. Reduced fill rate during the day an accepted risk to ensure cover at night.	87,800	108,044	-20,244
TWH	Stroke/W22	80.6%	104.5%	96.8%	94.6%	9.6	118.8%	94.7%	18	0		High number of vacancies with registered nurse cohort. A number of shifts downgraded to support worker to ensure sufficient staff to meet fundamental care needs.	172,186	117,636	54,551
TWH	Coronary Care Unit (CCU)	102.0%	61.3%	97.8%	N/A	12.2	73.0%	94.4%	0	0		CSW fill rate an accepted risk. Support gained from Cath Lab and Ward 12 staff as required.	59,081	53,571	5,510
TWH	Gynaecology/ Ward 33	94.7%	88.9%	100.0%	100.0%	7.4	38.7%	95.3%	4	0		14 CSW shifts unfilled	71,112	76,987	-5,875
TWH	Intensive Treatment Unit (ITU)	98.8%	100.0%	100.0%	100.0%	29.6	100.0%	100.0%	0	0			179,176	180,753	-1,577
TWH	Medical Assessment Unit	85.7%	119.4%	119.4%	100.0%	8.0	52.5%	97.4%	2	0		High RN fill rate at night reflects use of ambulatory care bay as escalation capacity. RN:CSW ratio an accepted risk during the day to ensure cover at night.	147,016	202,971	-55,955
TWH	SAU	98.9%	103.2%	100.0%	96.8%	9.4	0.0%	0.0%	0	0			86,568	58,287	28,281
TWH	Ward 32	88.2%	97.8%	101.1%	104.0%	8.5	26.7%	30.0%	4	1		14 RN shifts not covered. Additionally staff moved to assist ward 2 on at least one occasion.	118,550	129,320	-10,770
TWH	Ward 10	94.8%	97.6%	100.0%	114.9%	7.2	0.0%	0.0%	3	0		6 nights of enhanced care needs.	108,759	121,736	-12,977
TWH	Ward 11	99.1%	105.4%	94.4%	117.7%	7.1	0.0%	0.0%	4	0		5 nights of enhanced care needs for a psychiatric patient.	109,499	114,562	-5,063
TWH	Ward 12	86.5%	93.5%	96.8%	97.6%	6.5	28.4%	91.3%	13	0		20 shifts uncovered by bank. Support provided by neighbouring wards and senior nurses.	119,124	111,585	7,539
TWH	Ward 20	96.8%	97.8%	101.1%	137.1%	4.5	18.6%	75.0%	14	0		Enhanced care/co-horting over 20 nights.	86,850	88,959	-2,109
TWH	Ward 21	96.8%	88.2%	87.7%	122.6%	6.5	23.4%	93.3%	7	3		11 shifts unfilled by bank for RNs. 2 shifts RN sent to support Wad 2. Overfill on CSW at night to ensure sufficient staff on ward to meet care needs.	126,492	118,266	8,226
TWH	Ward 2	81.5%	96.1%	103.2%	109.7%	6.6	73.5%	82.0%	11	0		Reduced fill rate during the day for RNs as unable to fill via bank/agency. 13 nights of enhanced care needs for one patient.	81,866	126,638	-44,772
TWH	Ward 30	87.1%	100.9%	100.0%	101.6%	6.3	6.2%	100.0%	7	2		7 RN shifts not covered by bank/agency. RN to cover ward 31 for two shifts.	103,383	106,174	-2,791
TWH	Ward 31	89.2%	100.0%	101.6%	108.6%	7.3	29.6%	100.0%	4	0		8 RN shifts uncovered by bank/agency, 2 shifts agency RN DNA'd.	103,146	135,661	-32,515
Crowborough	Birth Centre	96.8%	83.9%	96.8%	90.3%		27.7%	92.4%	0	0		CSW fill rate an accepted risk as 2 midwives on duty with additional support in adjacent unit if required.	86,692	60,519	26,173
TWH	Ante-Natal	96.8%	90.3%	98.4%	87.1%				0	0		CSW fill rate an accepted risk. Ward function as a unit with staff rotating during shift as required and to follow women through pathway of care. All women in established labour received 1:1 care.	596,709	634,969	-38,260
TWH	Delivery Suite	98.2%	95.2%	94.6%	95.2%				1	0					
TWH	Post-Natal	97.3%	81.7%	100.8%	86.0%				1	0					
TWH	Gynae Triage	95.2%	100.0%	100.0%	96.8%				0	0			12,408	12,929	-521
TWH	Hedgehog	102.2%	61.3%	116.8%	116.1%	9.5	19.7%	93.0%	1	0		Additional capacity at night. Unregistered fill rate during the day an accepted risk to ensure cover for the night.	213,961	168,852	45,109
MAIDSTONE	Birth Centre	96.8%	87.1%	100.0%	80.6%				0	0		CSW fill rate an accepted risk. 2 midwives on duty with on-call arrangement in place if required.	62,135	63,262	-1,127
TWH	Neonatal Unit	108.0%	87.1%	104.3%	103.2%	12.9			0	0			162,269	148,915	13,354
MAIDSTONE	MSSU	105.2%	76.0%	91.3%	N/A	14.3	0.0%	0.0%	0	0		RN:CSW ratio an accepted risk. RN above plan and patient acuity and dependency needs were met.	39,206	38,487	719
MAIDSTONE	Peale	122.6%	59.6%	125.0%	90.3%	7.7	37.5%	93.3%	0	0		Rota changes still in transition. Cover provided to short stay and orthopaedic unit when required.	61,120	64,963	-3,843
TWH	SSSU	100.0%	100.0%	100.0%	100.0%		0.0%	0.0%	2	0			22,982	125,596	-102,614
MAIDSTONE	Whatman	83.1%	82.3%	97.8%	95.2%	4.4	34.6%	77.8%	8	0		Bank/agency unable to fill. 2 new starters commenced in supernumerary role for part of month.	104,187	85,010	19,177
MAIDSTONE	A&E	100.0%	91.4%	99.5%	93.5%		23.0%	92.1%	0	0		Maidstone fill rate according to plan. TWH unable to fill via bank/agency. Support worker gaps particularly hard to fill from bank. Cross cover from MAU as able.	202,541	187,890	14,651
TWH	A&E	89.0%	87.1%	97.9%	65.6%		31.3%	93.0%	0	0			294,413	301,102	-6,689
												Total Establishment Wards	**4,784,627**	**4,896,299**	**(111,672)**
												Additional Capacity beds	40,894	38,725	2,169
												Other associated nursing costs	2,486,248	2,373,810	112,438
												Total	7,311,769	7,308,834	2,935

RAG Key

Under fill

Over fill

Trust Board meeting – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

4-12 Trust Board Members' hospital visits (17/01/17 – 18/04/17) Trust Secretary

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

This quarterly report therefore provides details of the hospital visits reported as being undertaken by Trust Board Members between 17th January and 18th April 2017.

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

In addition, Trust Board Members may have undertaken visits but not registered these with the Trust Management office and/or Programme Management Office (PMO), who oversee the new framework (see below) (Board Members are therefore encouraged to register all such visits).

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, to encourage Board members to continue to undertake visits

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

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

Hospital visits undertaken by Board members, 17th January and 18th April 2017

Trust Board Member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chief Executive (GD)	▪ Maternity (TW) ▪ Crowborough Birth Centre	-
Chief Nurse (CO'B)	▪ Ward 20 (TW) ▪ Special Care Baby Unit (TW) ▪ Endoscopy (MH) ▪ John Day (MH) ▪ Maidstone Orthopaedic Unit (MH)	-
Chief Operating Officer (AG)	▪ X Ray (TW) ▪ Acute Stroke Unit (TW)	-
Deputy Chief Executive (JL)	▪ Health Records (Paddock Wood) ▪ Cornwallis Ward (MH) ▪ Foster Clarke Ward (MH) ▪ Radiotherapy (Canterbury)	-
Director of Finance (SO)	▪ Health Records (Paddock Wood) ▪ Clinical Coding (MH)	-
Director of Infection Prevention and Control (SM)	N/A	-
Director of Workforce (RH)	▪ None	-
Medical Director (PM)	▪ Ward 2 (TW) ▪ AMU (TW) ▪ Acute Stroke Unit (TW)	-
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SDu)	-	-

Trust Board meeting – April 2017

NHS Maidstone and Tunbridge Wells NHS Trust

4-13 Next steps on the NHS Five Year Forward View — Chief Executive

The enclosed "Next steps on the NHS Five Year Forward View" report was published by NHS England on 31/03/17.

The report reviews the progress made since the launch of the NHS Five Year Forward View in October 2014 and sets out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/04/17

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

Discussion

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

NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW

March 2017

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EXECUTIVE SUMMARY

1. Next year the NHS turns 70. New treatments for a growing and aging population mean that pressures on the service are greater than they have ever been. But treatment outcomes are far better - and public satisfaction higher - than ten or twenty years ago.

2. With waiting times still low by historical standards but on the rise, and the budget growing - but slowly - it is the right time to take stock and confront some of the choices raised by this challenging context. This plan is not a comprehensive description of everything the NHS will be doing. Instead, it sets out the NHS' main national service improvement priorities over the next two years, within the constraints of what is necessary to achieve financial balance across the health service. (Chapter One)

3. Perhaps most importantly, we all want to know that the NHS will be there for us and our families when we need it the most - to provide **urgent and emergency care** 24 hours a day, 7 days a week. Staff are working with great skill and dedication to do so, and looking after more patients than ever. But some urgent care services are struggling to cope with rising demand. Up to 3 million A&E visits could have been better dealt with elsewhere. There are difficulties in admitting sicker patients into hospital beds and discharging them promptly back home.

4. That's why over the next two years the NHS will take practical action to take the strain off A&E. Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds. In addition, patients with less severe conditions will be offered more convenient alternatives, including a network of newly designated Urgent Treatment Centres, GP appointments, and more nurses, doctors and paramedics handling calls to NHS 111. (Chapter Two)

5. Most NHS care is provided by **general practice**. One of the public's top priorities is to know that they can get a convenient and timely appointment with a GP when they need one. That means having enough GPs, backed up by the resources, support and other professionals required to enable them to deliver the quality of care they want to provide.

6. We have begun to reverse the historic decline in funding for primary care, and over the next two years are on track to deliver 3,250 GP recruits, with an extra 1,300 clinical pharmacists and 1,500 more mental health therapists working alongside them. As well as improved access during the working week, bookable appointments at evenings and weekends will be available covering half the country by next March, and everywhere in two years' time. (Chapter Three)

7. **Cancer** remains one of the public's most feared illnesses, affecting more than one in three of us in our lifetimes, meaning most of us will face the

anxiety of ourselves or a loved one receiving this diagnosis at some point. Fortunately cancer survival rates are at record highs, and an estimated 7,000 more people are surviving cancer after NHS treatment than would have three years before. Identifying cancer earlier is critical to saving more lives. So we will speed up and improve diagnosis, increase current capacity and open new Rapid Diagnostic and Assessment Centres. Patients will have access to state of the art new and upgraded linear accelerators (LINACs) across the country. By taking these actions we expect at least an extra 5,000 people to survive their cancer over the next two years. (Chapter Four).

8. Increasingly, the public also understand that many of our lives will at some point be touched by **mental health** problems. Historically, treatment options for mental health compare unfavourably with those for physical conditions, particularly for children and young people. The public now rightly expect us to urgently address these service gaps.

9. Substantially increased investment will enable 60,000 more people to access psychological, or 'talking' therapies, for common mental health conditions over the coming year, rising to 200,000 more people in 2018/19—an increase of over 20%. We will also address physical health needs by providing an extra 280,000 health checks in 2018/19 for people with severe mental illness. New mothers will get better care. Four new Mother and Baby Units across the country, more specialist beds and 20 new specialist perinatal mental health teams will provide help to 9000 more women by 2018/19. An extra 49,000 more children and young people will be treated by community services. Both children and adults will benefit from reduced travel distances when they need inpatient care through an expansion and rebalancing of specialist beds around the country. 24-hour mental health liaison teams in A&Es, investing in crisis response and home treatment teams and placing 1,500 therapists in primary care will ensure more people get appropriate care when they need it. (Chapter Five)

10. As people live longer lives the NHS needs to adapt to their needs, **helping frail and older people stay healthy and independent**, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. Early results from parts of the country that have started doing this – our 'vanguard' areas – are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission. (Chapter Six)

11. We now want to accelerate this way of working to more of the country, through partnerships of care providers and commissioners in an area (Sustainability and Transformation Partnerships). Some areas are now ready to go further and more fully **integrate their services and funding**,

and we will back them in doing so (Accountable Care Systems). Working together with patients and the public, NHS commissioners and providers, as well as local authorities and other providers of health and care services, they will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

12. Mirroring this local action, we will also be taking further action nationally to ensure that the NHS can deliver more benefit for patients from every pound of its budget. While the NHS is already one of the leanest publicly-funded health services in the industrialised world, there are still opportunities to do better, as set out in the **NHS' 10 Point Efficiency Plan.** (Chapter Seven)

13. None of this is possible without the outstanding **staff** of the NHS. Although we have 3,000 more doctors and 5,000 more nurses than 3 years ago, and productivity continues to improve, frontline staff face great personal and organisational pressures from rising demand. As a crucial part of delivering the next steps of the Five Year Forward View, we therefore set out in this document how we will continue to support the NHS frontline over the next two years, with Health Education England expanding current routes to the frontline, and opening innovative new ones to attract the best people into the health service, whatever stage of their career they are at. (Chapter Eight)

14. In doing so, the NHS is on a journey to becoming one of the **safest** and most transparent health systems in the world. Chapter Nine describes next steps on this agenda. As well as harnessing people power, the NHS also needs to leverage the potential of **technology and innovation,** enabling patients to take a more active role in their own health and care while also enabling NHS staff and their care colleagues to do their jobs - whether that is giving them instant access to patient records from wherever they are, or to remote advice from specialists. (Chapter Ten)

15. There are considerable risks to delivery of this stretching but realistic agenda, but taken together the measures set out in this plan will deliver a better, more joined-up and more responsive NHS in England. One that is focussed on the issues which matter most to the public. That collaborates to ensure that services are designed around patients. And that is on a more sustainable footing, so that it can continue to deliver **health and high quality care - now and for future generations**. (Chapter Eleven)

CHAPTER ONE

THE NHS IN 2017

Next year marks the 70th anniversary of the National Health Service. Over that period medicine has been revolutionised and lives transformed. The Health Service's founding principles – of care for all, on the basis of need not ability to pay – have stood the test of time. During one of the most vigorous debates our country has seen – over Brexit – the NHS was centre stage.

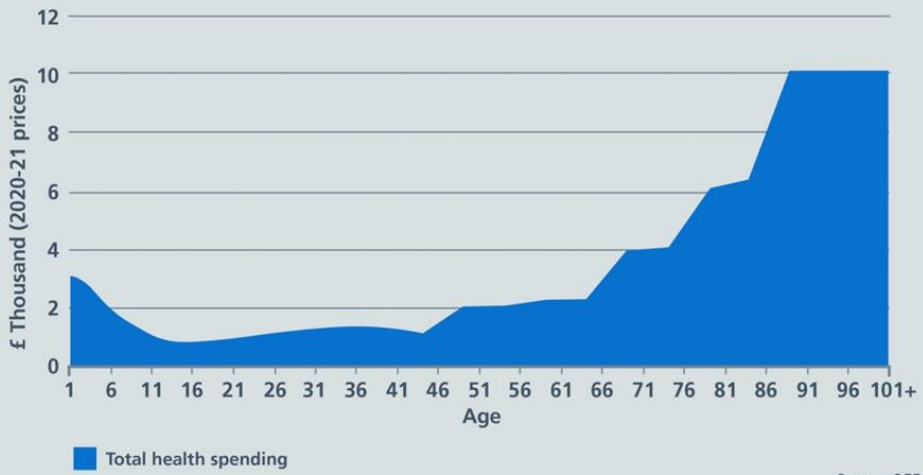
The case for the NHS is straightforward. It does a good job for individual patients, offering high quality care for an ever-expanding range of conditions. It reduces insecurity for families, especially at times of economic uncertainty and dislocation, because access to care is not tied to your job or your income. And as one of the world's most cost-effective health systems, it directly contributes to the success of the British economy.

That's because at a time when the UK is tooling-up for a new trading relationship with the rest of the world, a publicly-funded NHS means British businesses are not on the hook for an inflexible continental-style health 'tax on jobs'. In promoting the health of our children, vulnerable populations, working age adults and retirees, the NHS also helps reduce downstream sickness and unemployment benefits costs. And as the principal domestic customer of the nation's life sciences sector, the NHS helps fuel one of the industrial engines of our future economic growth.

But these are complex and challenging times for our country's most trusted and respected social institution. Pressures on the NHS are greater than they have ever been. The NHS in 2017 confronts five paradoxes:

- *We're getting healthier, but we're using the NHS more*. **Life expectancy has been rising by five hours a day**, but the need for modern NHS care continues to grow.[1] Demand for health care is highly geared to our growing and aging population. It costs three times more to look after a seventy five year old and five times more to look after an eighty year old than a thirty year old.[2] Yet today, there are half a million more people aged over 75 than there were in 2010. And there will be 2 million more in ten years' time. Demand is also heavily impacted by rising public expectations for convenient and personal care, the effectiveness of prevention and public health, and availability of social care. Even more significant is the steady expansion of new treatments and cures, of which the public are often unaware.

Figure 1: Health care spending rises sharply with age



- *The quality of NHS care is demonstrably improving, but we're becoming far more transparent about care gaps and mistakes.* Outcomes of care for most major conditions are dramatically better than three or five or ten years ago. Annual cancer survival rates are up.[3] Heart attack and stroke deaths have tumbled.[4] But greater transparency and rising expectations mean greater awareness of care gaps and variation. And although they are substantially lower than they were a decade ago, waiting times have been edging up.

- *Staff numbers are up, but staff are under greater pressure*. Over the two years from November 2014, there has been an increase of around 8000 more doctors and nurses working in the NHS[5] but there are still gaps in some professions and specialties. Frontline NHS staff say their experience at work continues to improve, with this year's annual staff survey scores at a five year high.[6] Yet only 52% of staff are satisfied with the opportunities for flexible working and 15% have experienced physical violence from patients, relatives or members of the public.

- *The public are highly satisfied with the NHS, but concerned for its future.* Perhaps surprisingly, newly published independent data spanning three decades shows that **public satisfaction with the NHS is higher than in all but three of the past 30 years**.[7] And it reveals public satisfaction with hospital inpatients is at its highest for more than two decades. As a result The King's Fund says that "In 2016 the NHS remained popular with the public, far more so than it was 10 or 20 years ago".[8] Looking internationally, 69% of the public in this country say they get good healthcare, compared with 57% in France and 59% in Germany, and only 47% in 22 other nations. But a higher proportion of our public are worried about the future of the NHS.[9]

- *There is now an underlying consensus about how care needs to change to 'future proof' the NHS, but the ability to do so risks being overtaken by what CQC has called today's 'burning platform'.*[10] That's why in Autumn 2014, in the wake of several years of contentious political and legislative debate, the NHS nationally came together - to chart for the first time its own direction for the years ahead.

The NHS Five Year Forward View[11] crystallised a consensus about why and how the NHS should change. It described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap. It proposed a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services, and of health and social care. And it argued that while much of this lay within the power of the NHS itself to bring about, it was also dependent on well-functioning social care, extra capital investment, transformation funding to support double running costs, and activism on prevention and public health.

Since publication substantial progress has been made, although this year – 2016/17 – only represents Year One of the NHS' five year Spending Review (SR) funding settlement, and demands on the NHS are higher than envisaged when the FYFV was published. Now is therefore an appropriate moment to take stock of what has worked, and what hasn't. And then to make any necessary course corrections accordingly.

Progress since the Forward View – a balanced (but not comprehensive) assessment

Better health

- Action on prevention and public health, including plain packaging for cigarettes, first national diabetes prevention programme, sugar tax agreed to reduce childhood obesity, vaccinating over 1 million infants against meningitis and an additional 2 million children against flu, and public health campaigns including "Be Clear on Cancer" and "Act Fast"

Better care

- Agreed national blueprints for cancer, mental health, maternity, learning disabilities and GP services, backed by targeted initial investment.
- Better clinical outcomes – cancer survival at record high;[12] first ever waiting times targets for mental health treatments introduced and met. Dementia diagnosis rate up from half to more than two thirds.
- Improving experiences of care – overall adult inpatient experience at a record high.[13]
- First phase of fundamental care redesign under way through integrated 'vanguard' new care models.
- 20 hospitals moving out of CQC 'special measures', with 7 moving to a 'good' rating. This includes all 11 hospitals in the original 2013 cohort.
- Action to end inappropriate institutional learning disability services – 12% reduction in inpatients since March 2015.

- Patient safety continues to improve, with the proportion of patients experiencing four major causes of harm (urinary tract infections, falls, deep vein thrombosis and pressure sores) falling by around 8% over the last three years.
- But pressure on waiting times for A&E, routine operations, general practice and other services, with spill-over demand pressures including from preventative services and social care, which CQC warned were approaching a 'tipping point'.[14][15]

Financial sustainability

- SR settlement provides real terms aggregate annual NHS England revenue funding growth, but with pressure on per-person funding levels and on areas such as capital investment.
- Improved financial grip – trust agency/locum staffing bills down by £700 million, and CCGs on track to contribute to an £800 million managed commissioner underspend this year, on top of £600 million last year. £1.8 billion a year from the Sustainability and Transformation Fund mainly deployed to support hospital pressures.
- Fairest ever needs-based NHS funding allocation to different parts of the country – reducing to zero the number of CCGs more than 5% under their target, while including primary and specialised services in a comprehensive inequalities-reducing allocation formula.
- Some areas have not been ambitious enough in their attempts to redesign services and need to raise their game on RightCare allocative efficiency improvement. Arguably too much fragmentation in the oversight and support provided by the various national bodies.

A fair conclusion from the NHS' recent history is therefore that we have a viable and agreed strategic direction, and progress has been made. But we have a Health Service under real pressure from rising demand within a tight funding envelope.[16] [17]

Given the importance of ending years of relative neglect of primary care and mental health, these pressures are confronting us with some difficult choices – about the relative priority of improving A&E services and cancer outcomes versus guaranteeing short waits for routine operations.

But the truth is that many of the wider changes to how NHS services are organised would be needed come what may, even if money were no object. The current pressures simply underline the need to get on with them.

Next steps – delivering for the next two years

The NHS Five Year Forward View set out <u>why</u> improvements were needed on our triple aim of better health, better care, and better value. This Plan concentrates on <u>what</u> will be achieved over the next two years, and <u>how</u> the Forward View's goals will be implemented.

Largely that will rely on effective local action by NHS bodies and their partners across the country. But the NHS' national leadership bodies will also have to step up and play their part, supporting local change with national action.

To that end, NHS Improvement has successfully brought coherence to the provider accountability structure that was previously split between Monitor for foundation trusts and the Trust Development Authority for NHS trusts.

Similarly, NHS England's work has evolved in three distinct phases since its creation. The first phase in the immediate aftermath of the passage of the Health and Social Care Act in 2013 and 2014 was successfully to de-risk the financial and operational transition to a new system, in which Parliament passed control of two-thirds of the NHS budget to over 200 new local groups.

The second phase, mostly in 2015 and 2016, was to use NHS England's independence and system leadership role to chart a consensus-based strategic direction for the NHS. Following the Five Year Forward View, specific national improvement blueprints were developed with key partners for urgent and emergency care, cancer, mental health, primary care, and maternity services. Real gains have since been made in each of them, as is set out in this Plan.

2017 marks the third phase of NHS England's life where the focus shifts decisively to supporting delivery and implementation of those key priorities, as detailed in this Plan. Together with associated documentation it also formally constitutes NHS England's 2017/18 Business Plan.[18]

But it also affirms the **shared vision of the Five Year Forward View and approach to implementing it of the national leadership bodies** of the NHS, including NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England, NHS Digital and NICE, working closely with a number of patient, professional and representative bodies.

Priorities and trade-offs

In setting national priorities and strategic direction, we draw on numerous sources, including but not limited to:

- The annual NHS Mandate[19] framed by the Government. Issues are also identified by Parliamentary select committees.
- NHS England's direct work in multiple venues with the public, patients, staff and stakeholders.[20]
- Healthwatch compiles an annual priorities list of the top five issues citizens want to see improved.[21] For the second year running, mental health services topped the list. Convenient access to GPs, easier hospital discharge and better social care also feature prominently. These priorities are all addressed in this plan.

We also recognise there are benefits from constancy of purpose, not chopping and changing. The challenges we are tackling require sustained action over several years.

This Plan necessarily takes as its starting point the current legislative framework, and the funding the NHS has been allocated. Decisions on both are for government and parliament.

It is not, of course, a comprehensive description of all the good things the NHS will be doing – including on maternity and children's services, diabetes, dementia care, care for people with learning disabilities, tackling inequalities, end of life care, and improving quality in challenged providers. Nor are these all the actions we will be taking to give effect to the Government's 2017/18 Mandate to the NHS.

However within the constraints of the requirement to **deliver financial balance across the NHS**, the main **2017/18 national service improvement priorities** for the NHS are:

- **Improving A&E performance**. This also requires upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services. (We set out the plan for Urgent and Emergency Care in Chapter Two).
- **Strengthening access to high quality GP services** and primary care, which are far and away the largest point of interaction that patients have with the NHS each year. (See Chapter Three).
- **Improvements in cancer services (including performance against waiting times standards) and mental health** – common conditions which between them will affect most people over the course of their lives. (Chapters Four and Five).

Within a given funding envelope there are always limits to what can and cannot be done. While the NHS and the Government remain committed to short waits for routine operations, our new Mandate rightly recognises that there is likely to be continued pressure on waiting times for routine care and some providers' waiting times will grow. Likewise, there is no reason in principle why extra spending on a drug treatment should automatically have a legal override so as to displace community nursing, mental health care or hip replacements – hence the new budget flexibility in the way NICE technology appraisals operate. And in times of modest funding growth, it's right to challenge and tackle areas of waste or low value care, so as to free up investment head-room for the main priorities. (Chapter Seven sets out the details).

In order to deliver these and our wider goals, in 2017/18 we will work to **accelerate service redesign locally**. (Chapter Six sets out next steps on integrating care locally through Sustainability and Transformation Partnerships and Accountable Care Systems). We also intend to focus on the

enablers of the above, namely our **workforce, safer care, technology and innovation** (Chapters Eight, Nine and Ten refer).

These actions comprise the rest of this plan.

CHAPTER TWO

URGENT AND EMERGENCY CARE

Each year the NHS provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital.

Frontline staff have pulled out all the stops, but over this past winter there have been real difficulties. In providing nine out of ten patients with A&E care within four hours over the past year, the UK offers our patients the fastest national A&E treatment of any major industrialised country. However, in recent years the proportion of patients looked after within 4 hours has been falling – caused by rising demand in A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; the need to adopt good practice in hospitals consistently; and difficulties in discharging inpatients when they are ready to go home. So we need to take action to improve services for patients and reduce pressure on our staff.

What's been achieved in England over the past three years?

- Cared for 23 million A&E attendances in 2016/17, 1.2 million more than three years ago.
- Boosted the capacity and capability of NHS 111, which now takes 15 million calls each year, up from 7.5 million three years ago.
- Expanded "Hear and Treat" and "See and Treat" ambulance services so that they now cover 3.5 million people, with the provision of telephone advice and treatment of people in their homes saving needless trips to hospital.
- Developed an integrated urgent care model, offering a single point of entry for urgent care via NHS 111, and rolled it out to 20% of the population.
- Increased NHS staff uptake of winter flu vaccinations from 49% last year to 63% this year – the highest ever.

Key deliverables for 2017/18 and 2018/19

Trusts and CCGs will be required to meet the Government's 2017/18 mandate to the NHS that: 1) in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours – up

from 85% currently; 2) the majority of trusts meet the 95% standard in March 2018; and 3) the NHS overall returns to the 95% standard within the course of 2018. In order to do so:

- Every hospital must have comprehensive **front-door clinical streaming** by October 2017, so that A&E departments are free to care for the sickest patients, including older people.

- By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate **patient flow**, including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities.

- Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care**. They need to:
  - ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby **helping to free up 2000-3000 acute hospital beds** – the equivalent of opening 5 new hospitals – and regularly publish the progress being made in this regard.[22]
  - ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting, by March 2018.
  - Implement the High Impact Change Model[23] for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England.

- Specialist **mental health care in A&Es**: 74 24-hour 'core 24' mental health teams, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and reach nearly half by March 2019, compared with under one-in-ten today.

- Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed.

- NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management.

- Roll out **evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.**

- Strengthen support to **care homes** to ensure they have direct access to clinical advice, including appropriate on-site assessment.

- Roll-out of standardised new **'Urgent Treatment Centres'** which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.

- Working closely with the Association of Ambulance Chief Executives and the College of Paramedics, implement the recommendations of the **Ambulance Response Programme** by October 2017, putting an end to long waits not covered by response targets. Actions taken will be subject to the results of evaluation and approval from Ministers.

How changes will be implemented

- *£100 million in capital funding* will be provided to support modifications to A&Es to enable clincial streaming by October 2017.

- *Clearer local performance incentives*. Previous standard contract fines have been dropped. From April 2017 the rules governing the performance element of the £1.8 billion Sustainability and Transformation Fund (STF) for acute trusts that relates to A&E will be amended in agreement with Department of Health and HM Treasury.[24]

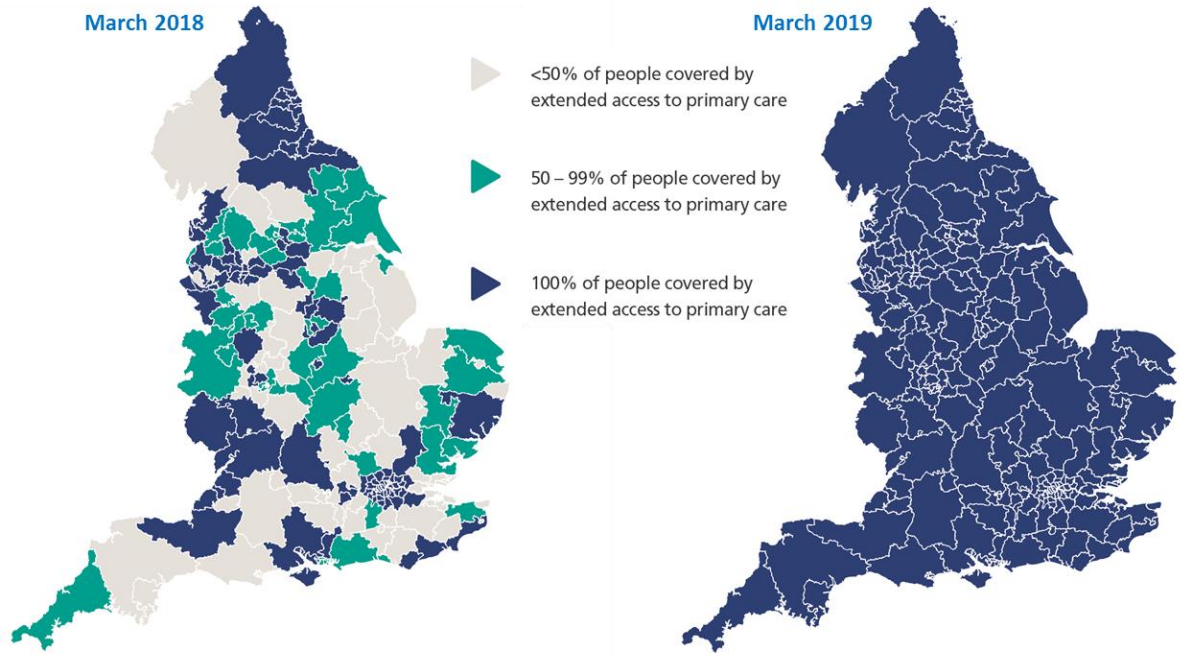
- *Aligned national programme management*. To ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed a single national leader accountable to both NHS England and NHS Improvement. We will also bring together the work of NHS Improvement's and NHS England's national urgent and emergency care teams. From 1st April 2017 a single, named Regional Director drawn from either NHS Improvement or NHS England will hold to account both CCGs and trusts in each STP area for the delivery of the local urgent care plan. Each RD will therefore act with the delegated authority of both NHS Improvement and NHS England in respect of urgent and emergency care.

- *Broader improvement support.* Building on the work of the Emergency Care Improvement Programme and the regional teams of NHS England and NHS Improvement, we will offer a broader range of improvement support to frontline staff to achieve the priorities set out above. This

will include extending to emergency care both the Getting it Right First Time Programme and the Model Hospital, together with joint work with the Royal College of Emergency Medicine and other professional bodies on workforce and a more standardised clinical operating model.

- Detail on the *technology* changes to support these approaches is included in Chapter Nine.

Figure 2: Roll out of extended access to primary care



CHAPTER THREE

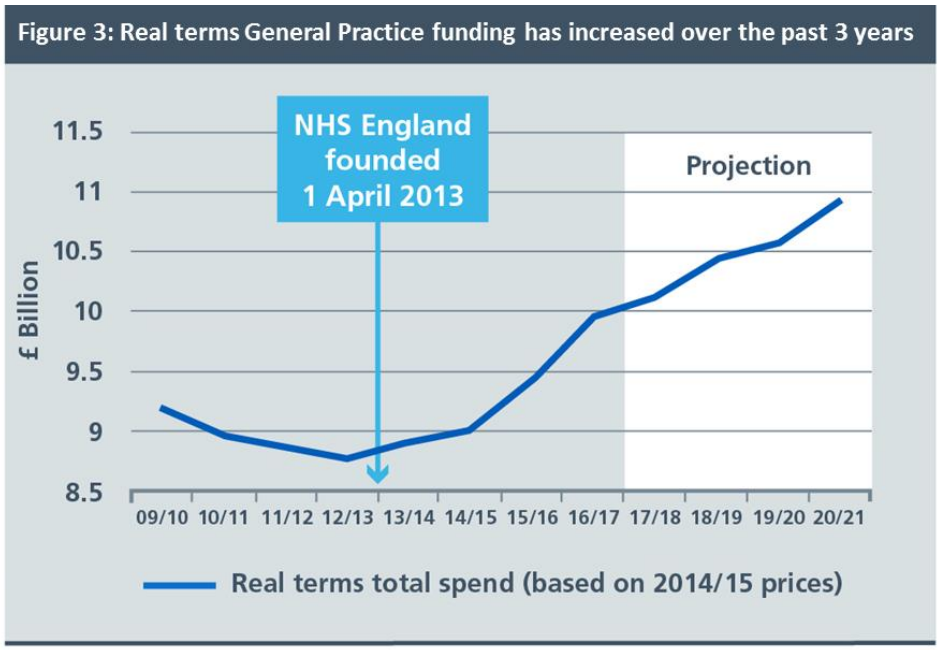
PRIMARY CARE

GPs have one of the highest public satisfaction ratings of any public service, at over 85%,[25] but we know improving access to primary care services is a top priority for patients.[26] General practice is undeniably the bedrock of NHS care and we have more GPs per head than Germany.[27] General practice provides over 300 million patient consultations each year, compared to 23 million A&E visits. So if general practice fails, the NHS fails. Yet a year's worth of GP care per patient costs less than two A&E visits, and we spend less on general practice than on hospital outpatients. For the past decade funding for hospitals has been growing around twice as fast as for family doctor services.

That's why the General Practice Forward View set out a detailed, costed package of investment and reform for primary care now through to 2020. It will mean more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care. In doing so we are working with the Royal College of GPs, the General Practitioners Committee, the National Association of Primary Care, and others. See the General Practice Forward View.[28]

What's been achieved in England over the past three years?

- More convenient access to primary care services, with 17 million people now able to access GP appointments at evenings and weekends.
- First steps to expand the primary care workforce, including an additional 300 GP trainees, and 491 clinical pharmacists. New national mental health service for GPs launched.
- 560 new schemes completed and over 200 in progress to modernise GP surgery buildings, IT and equipment.
- New 'vanguard' models of scaled primary care across 23 areas, covering nearly 10% of the population, which have seen lower growth in emergency hospital admissions than the rest of England.
- In the years prior to the creation of NHS England, investment in general practice was falling in real terms. Each year since the establishment of NHS England we have made sure it has gone up, with real terms funding increasing by 8% over the past 3 years.



Key improvements for 2017/18 and 2018/19

- *More convenient patient access to GP services.* As additional GPs, therapists, pharmacists and nurses come on stream we want to improve access to convenient and needed practice appointments. During daytime surgery hours, practices are increasingly 'streaming' patients so as to offer convenient same day urgent appointments, while preserving continuity of care for patients with more complex long term conditions. During 2017/18 practice profiles will be published including patient survey results and ease of making an appointment. From October 2017 the new agreed GP contract means that practices who shut for half days each week will not be eligible for a share of the £88 million extended access scheme.

- For many people with jobs, particularly self-employed and hourly paid workers, tackling inequalities in access will mean making available bookable evening and weekend appointments. **By March 2018, the Mandate requires that 40% of the country will benefit from extended access to GP appointments at evenings and weekends, but we are aiming for 50%. By March 2019 this will extend to 100% of the country**. This does not require every practice itself to be open each evenings or weekend, but it does mean that patients anywhere will be able to book appointments when they need them. To provide these additional services, general practices will increasingly cooperate with other practices in formal or informal networks.

- *Boost GP numbers.* The Government has set an objective of an extra 5000 doctors working in general practice by 2020. Numbers entering GP training are up by 10% since 2015 and HEE will fill a further 230

places in 2017/18 to ensure they reach 3250 trainees per year. Initial applications for GP training in 2017 are up by 5% on the same time last year. Practical action to boost GP retention, as set out in the GP Forward View, will include:

- The GP Career Plus scheme in 10 sites across the country, supporting retention of experienced doctors by allowing them to continue working without the responsibilities of a partnership.
- The Time to Care programme, investing £30 million to help practices reduce their workload and free up GP time.
- The new NHS GP Health Service, to support doctors suffering from mental ill-health and addiction.

- *Expand multidisciplinary primary care.* We will:
  - increase the number of **clinical pharmacists** working in GP surgeries from the 491 we are co-funding today to over 900 by March 2018 and over 1300 by March 2019. Not only will patients benefit from pharmacy services, but the introduction of clinical pharmacists will also help free up GP time to focus on those patients who need it most, for example, by supporting patients to manage high risk conditions such as high blood pressure earlier and more effectively, preventing cardiovascular disease. Clinical pharmacists and will also help to ensure efficient use of medicines.
  - 800 **mental health therapists** will be placed in primary care by March 2018 rising to over 1500 by March 2019. These therapists will lead the way in how we integrate physical and mental healthcare outside of hospital.
  - HEE is supporting universities to train 3000 **physician associates** by 2020. HEE will work with NHS England to incentivise up to 1000 of these staff to work in General Practice.
  - HEE has also published findings on how to improve the future of **general practice nursing**. NHS England and HEE will work with partners on this, backed by £15m as promised in the GP Forward View.

- *Modernise primary care premises.* We have been investing steadily in upgrading primary care facilities, benefiting both patients and staff. Over **800 further infrastructure projects** are identified for investment by 2019.

How changes will be implemented

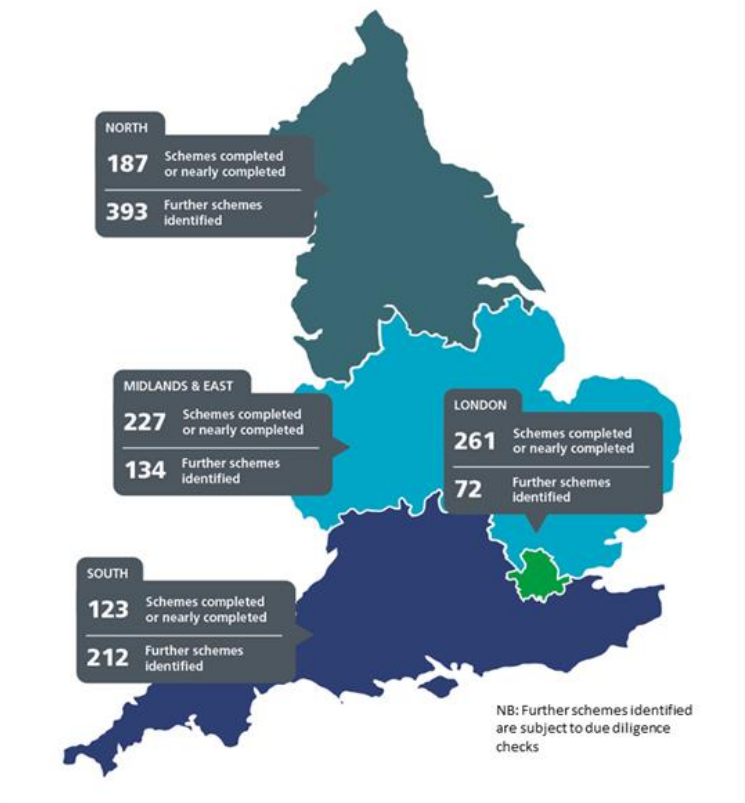
- *Continue to increase investment* in GP services, so that by 2020/21, funding will rise by £2.4 billion, a 14% real terms increase. Targeted national investment in a growing number of clinical pharmacists and mental health therapists embedded in primary care.

- *Encourage practices to work together in 'hubs' or networks.* Most GP surgeries will increasingly work together in primary care networks or hubs. This is because a combined patient population of at least 30,000-

50,000 allows practices to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. They also involve working more closely with community pharmacists, to make fuller use of the contribution they make. This can be as relevant for practices in rural areas as in towns or cities, since the model does not require practice mergers or closures and does not necessarily depend on physical co-location of services. There are various routes to achieving this that are now in hand covering a majority of practices across England, including federations, 'super-surgeries', primary care homes, and 'multispecialty community providers'. Most local Sustainability and Transformation Plans are intending to accelerate this move, so as to enable more proactive or 'extensivist' primary care. Nationally we will also use funding incentives - including for extra staff and premises investments - to support this process.

- *Contract reform.* The 2004 GP contract linked a proportion of practice income to performance against detailed indicators – the Quality and Outcomes Framework (QOF). There is now wide agreement that this particular approach has run its course, and is now partly a tick-box exercise.[29] We will seek to develop and agree with relevant stakeholders a successor to QOF, which would allow the reinvestment of £700 million a year into improved patient access, professionally-led quality improvement, greater population health management, and patients' supported self-management, to reduce avoidable demand in secondary care.

Figure 4: Roll out of primary care Building and Technology improvements



CHAPTER FOUR

CANCER

The NHS Five Year Forward View identified cancer as one of our top priorities because more than one in three of us will get cancer in our lifetimes. Better prevention, earlier diagnosis and innovative new treatments mean we have a realistic opportunity to make major improvements in survival.

But large increases in the number of people being referred for cancer check-ups is placing strain on services, with one of the eight cancer waiting times standards not having been met for several years.

What's been achieved in England over the past three years?

- Highest cancer survival rates ever – latest survival figures show an estimated 7000+ more people surviving cancer after successful NHS cancer treatment compared to three years prior.
- Big expansion in cancer check-ups – over 1.7 million people urgently referred by their GP this year, up by 500,000 people compared to three years ago. 450,000 more people are being seen in under 14 days.
- New fast track funding for the most promising new cancer drugs approved by NICE, matched by rigorous NHS England assessment and price negotiation, has helped eliminate a £125 million overspend in the Cancer Drugs Fund budget. Six new molecular diagnostic tests funded by the NHS this year.
- 300,000 fewer smokers – lowest smoking rate since records began. Plain packaging introduced.
- NHS England's cancer taskforce has agreed a detailed improvement blueprint to 2020, in partnership with patient groups, medical experts and research organisations. See Cancer taskforce report[30] and 'one year on' document.[31]

Key improvements for 2017/18 and 2018/19

- *Better cancer survival.* Within two years, **more than 5000 extra people a year will survive cancer** as compared to now.

- *Expanded screening to improve prevention and early detection of cancer*. Introduction of a **new bowel cancer screening test** for over 4 million people from April 2018. Compared to the old bowel screening test, almost a third of a million more people are expected to complete screening from 2018/19 and a fifth more cancers will be caught earlier. The introduction of **primary HPV testing for cervical screening** from April 2019 will benefit over 3 million women per year and could prevent around 600 cancers a year.

- *Faster tests, results and treatment for people with worrying symptoms.* Expand diagnostic capacity so that England is meeting all 8 of the cancer waiting standards, compared to seven out of eight today. We will focus specifically on the **cancer 62-day from referral to treatment standard** ahead of the introduction of the **new standard to give patients a definitive diagnosis within 28 days** by 2020. Performance incentives for achievement of the cancer 62-day waiting standard will be applied to extra funding available to our cancer alliances. By March 2018, introduce 10 new multi-disciplinary Rapid Diagnostic and Assessment Centres across England, and by March 2019, rollout Centres in each of the 16 cancer alliances. Expand access to the latest molecular diagnostics capability across England, with hi-tech test volumes set to grow from around 55,000 to around 70,000 a year.

- *Access to the most modern cancer treatment in all parts of the country.* Implement the **largest radiotherapy upgrade programme in 15 years** by October 2018, patients will have access to sustainable high-quality, modern radiotherapy treatments wherever they live. The first 23 hospitals have received new or upgraded equipment in early 2017, and over 50 new radiotherapy machines in at least 34 hospitals will be rolled out over the next 18 months, subject to the customary HM Treasury approval of the capital business case (see map). In addition, further modern cancer drugs available thanks to our reshaped cancer drugs fund and the new Accelerated Access approvals process with NICE. Roll out personalised follow up after cancer treatment, starting with half the country's cancer alliances in 2017.

How changes will be implemented

- *Targeted national investment*, including £130 million for a national radiotherapy modernisation fund. £36 million has been spent so far, with a further £94 million planned to be spent over the next 18 months. In addition a National Cancer Diagnostics Capacity Fund is supporting earlier diagnosis and living with and beyond cancer.

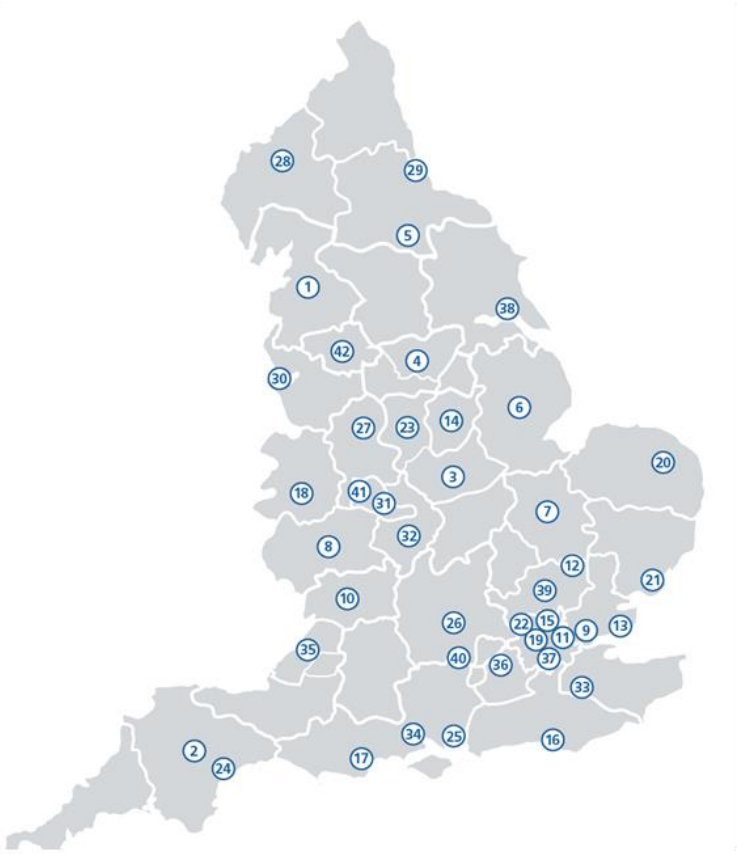
- *Expand the cancer workforce*: HEE to have trained 160 non-medical endoscopists by 2018, alongside 35 more places for ST1 clinical radiology training.

- *Clear accountability and delivery chain*. Performance goals for CCGs and cancer providers, matched by unprecedented transparency using the new cancer dashboard.[32] CCG ratings published in July. Aligned local delivery infrastructure through 16 cancer alliances coterminous with their constituent STPs. Three cancer vanguards creating population cancer budgets so as to integrate commissioning of cancer surgery, radiotherapy and cancer drugs for 9.6 million people. Single national programme management team led by a single national cancer director and national clinical director, aligning the work of NHS England, NHS Improvement, Health Education England, Public Health England, and

other Arm's Length Bodies, and working closely with Cancer Research UK and Macmillan.

- See our full Cancer implementation plan.[33]

Figure 5: Roll out of cancer care Radiotherapy upgrade programme



NHS hospitals that have already received funding for new or upgraded equipment in early 2017

1. Lancashire Teaching Hospitals NHS Foundation Trust
2. Torbay and South Devon NHS Foundation Trust
3. University Hospitals of Leicester NHS Trust
4. Sheffield Teaching Hospitals NHS Foundation Trust
5. South Tees Hospitals NHS Foundation Trust
6. United Lincolnshire Hospitals NHS Trust
7. Peterborough and Stamford Hospitals NHS Foundation Trust
8. Worcestershire Acute Hospitals NHS Trust

NHS hospitals that will receive funding for new radiotherapy machines in the next 18 months

9. Barking, Havering and Redbridge University Hospitals NHS Trust
10. Gloucestershire Hospitals NHS Foundation Trust
11. Imperial College Healthcare NHS Trust
12. Cambridge University Hospitals NHS Foundation Trust
13. Southend University Hospital NHS Foundation Trust
14. Nottingham University Hospitals NHS Trust
15. North Middlesex University Hospital NHS Trust
16. Brighton And Sussex University Hospitals NHS Trust
17. Poole Hospital NHS Foundation Trust
18. Shrewsbury and Telford Hospital NHS Trust
19. The Royal Marsden NHS Foundation Trust
20. Norfolk and Norwich University Hospitals NHS Foundation Trust
21. Ipswich Hospital NHS Trust
22. Royal Free London NHS Foundation Trust
23. Derby Teaching Hospitals NHS Foundation Trust
24. Royal Devon and Exeter NHS Foundation Trust
25. Portsmouth Hospitals NHS Trust
26. Oxford University Hospitals NHS Foundation Trust
27. University Hospitals of North Midlands NHS Trust

NHS hospitals that have already received funding for new or upgraded equipment and will receive funding for new radiotherapy machines in the next 18 months

28. North Cumbria University Hospitals NHS Trust
29. The Newcastle upon Tyne Hospitals NHS Foundation Trust
30. The Clatterbridge Cancer Centre NHS Foundation Trust
31. University Hospitals Birmingham NHS Foundation Trust
32. University Hospitals Coventry and Warwickshire NHS Trust
33. Maidstone and Tunbridge Wells NHS Trust
34. University Hospital Southampton NHS Foundation Trust
35. University Hospitals Bristol NHS Foundation Trust
36. Royal Surrey County Hospital NHS Foundation Trust
37. University College London Hospitals NHS Foundation Trust
38. Hull and East Yorkshire Hospitals NHS Trust
39. East and North Hertfordshire NHS Trust
40. Royal Berkshire NHS Foundation Trust
41. Royal Wolverhampton NHS Trust
42. The Christie NHS Foundation Trust

CHAPTER FIVE

MENTAL HEALTH

The NHS Five Year Forward View pointed out that one in four of us will experience mental health problems, and mental illness is the single largest cause of disability. Yet mental health services have for several decades been the 'poor relation' compared to acute hospital services for physical conditions. Fortunately there is now good evidence that tackling some major mental health problems early reduces subsequent problems, improves people's life chances, and also saves money for the wider economy.

What's been achieved in England over the past three years?

- Decisive investment upturn, with overall mental health funding up £1.4 billion in real terms compared to 3 years ago.
- 120,000 more people getting specialist mental health treatment this year than 3 years ago, including over 20,000 more children and young people.
- The dementia diagnosis rate increased from half of people to more than two thirds, enabling earlier care and support.
- Over two thirds of the country now covered by criminal justice liaison and diversion services, up from under a quarter 3 years ago. Use of police cells as a place of safety for people with mental health problems has seen more than a 3-fold decrease over past 3 years.
- This year the NHS has introduced, and met, the first ever national waiting times standards for mental health services, 25 years after targets were set for surgical operations.
- NHS England's mental health taskforce has agreed a detailed improvement blueprint to 2020, in partnership with patient groups, clinicians and NHS organisations. See Mental Health Taskforce Report,[34] Implementation Plan[35] and One Year On Report.[36]

Key improvements for 2017/18 and 2018/19

With carefully targeted and affordable national funding, supplemented by investment from local CCGs, we are now delivering one of the biggest expansions in access to mental health services currently happening in Europe.

- *Big increase in psychological ('talking') therapies*: 60,000 more people will get treatments for common mental health conditions by the end of 2017/18, rising to **200,000 more people getting care** by the end of 2018/19 – an increase of over 20%. Alongside this, we are working with NICE to help facilitate faster access to new digital therapies.

- *Better mental health care for new and expectant mothers*: **4 new mental health Mother and Baby Units**. In East Anglia, the North West, and

South West and South East. Boost bed numbers in the current 15 units so that overall capacity is up by 49% by 2018/19. And **20 new or expanded specialist perinatal mental health teams**. This will mean being able to provide care and treatment to at least 2000 more women with severe mental health problems in 2017/18 and 9000 more women by 2018/19.

- *Improved care for children and young people*. An extra 35,000 children and young people being treated through NHS-commissioned community services next year compared to 2014/15, growing to an **extra 49,000 children and young people getting the care they need** in two years' time.

- *Care closer to home*. For children and young people, NHS England will fund 150-180 new CAMHS Tier 4 specialist inpatient beds in underserved parts of the country to **reduce travel distances** for treatment, rebalancing beds from parts of the country where more local CAMHS services can reduce inpatient use. For adults, investment in crisis resolution and home treatment teams will reduce the need to inappropriately send people out of area for non-specialist inpatient care - from 2018, it should mean a one third reduction in adults sent out-of-area for inpatient psychiatric treatment.

- *Specialist mental health care in A&Es*: 74 24-hour **mental health teams** at the Core 24 standard, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and nearly half by March 2019, compared to under 10% today.

- *Better physical health for people with mental illness*. An extra 140,000 **physical health checks** for people with severe mental illness in 2017/18, rising to 280,000 health checks in 2018/19.

- New specialist Transition, Intervention and Liaison (TIL) mental health services for **veterans**, accessed through four areas across England from April 2017

- New specifications for mental health provision for people in secure and detained settings to be in place during 2017

- Investment in mental health provider **technology** through Mental Health Global Digital Exemplars (see Chapter Ten)

How changes will be implemented

- Targeted earmarked national investment for expanded services, alongside an overarching CCG 'investment standard' directing growth in mental health funding.

- Expand the mental health workforce – 800 mental health therapists embedded in primary care by March 2018, rising to over 1500 by March 2019.

- Reform of mental health commissioning so that local mental health providers control specialist referrals and redirect around £350 million of funding. Enables expansion of local services and reduction of inappropriate out-of-area placements.

- Mental health providers to work with their local councils in same way as acute hospitals to reduce delayed discharges for people stuck in psychiatric inpatient units.

- Clear performance goals for CCGs and mental health providers, matched by unprecedented transparency using the new mental health dashboard.[37] CCG ratings published in July 2016.

- Support the development of the Children and Young People's Green Paper due for publication in autumn 2017.

- Single national programme management team led by a national mental health director and national clinical director, aligning the work of NHS England, NHS Improvement, Health Education England, Public Health England, and the other Arm's Length Bodies. We will also continue to work closely with our key partners, including Mind, Young Minds, the Mental Health Foundation and the Royal College of Psychiatrists.

- See our full mental health implementation plan.[38]

CHAPTER SIX

INTEGRATING CARE LOCALLY

Next steps for STPs and Accountable Care Systems

The NHS Five Year Forward View said: *"The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."*

To give life to this vision the FYFV argued for a new approach using five rules of thumb:

- Focus on keeping people healthier for longer through *service improvements and outcomes* not just administrative reorganisation per se. Distinguish means from ends, so that systems flex in pragmatic ways to support the work that now needs doing. (Hence taking a permissive approach to parts of the country that wanted to move away from tariff payments, and to those areas that wanted cross-organisational system 'control totals'.)

- *Co-produce major national improvement strategies* with patients' and voluntary groups, staff and other key stakeholders (as for example with the mental health, maternity and learning disabilities taskforces).

- '*Horses for courses*' not 'one size fits all'. Recognise that England is diverse both in its population and care delivery so support and test plural models in different parts of the country. (Hence local STPs to debate and develop locally-grounded proposals and plans.)

- *Evolution not Big Bang* – inevitable if the focus is on continuous improvement, adaptive change and learning by doing (hence the vanguards).

- *Back energy and leadership where we find it* – if in one area that comes from local government or the third sector partnering with the NHS they may take on a wider strategic leadership role for the health and care system, as in Greater Manchester. In other places that leadership role has fallen to CCGs and emerging GP groups, and in yet others it is an NHS trust that has the capability and authority

to take on the convening role for change. The point is to focus on the assets available to catalyse change in given communities.

Across England, commissioners and providers across the NHS and local government need to work closely together – to improve the health and wellbeing of their local population and make best use of available funding. Services that are planned and provided by local government, including housing, leisure and transport as well and public health and social care, impact on the health and wellbeing of local people. Addressing the wider determinants of health affects demand for primary and acute services. Equally, the demand for social care is affected by the availability and effectiveness of NHS services such as stroke rehabilitation and other primary and community services provided to people in their own homes and care homes. Local health and care systems only work smoothly and effectively to provide effective services and minimise delays when there are good relationships and clear joint plans in place locally.

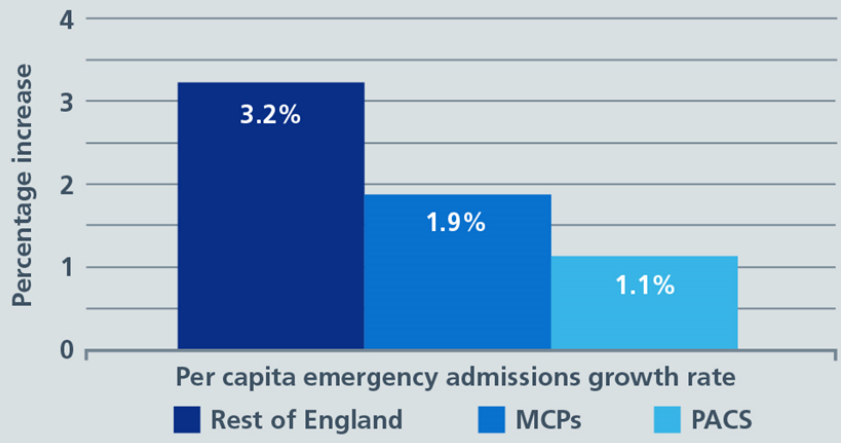
New care models

One way in which this approach has been given expression is through the vanguard programme. Over the past 18-24 months fifty areas around England covering more than five million people have been working to redesign care. They have focused on:

- better integrating the various strands of community services such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals into the community ('Multispecialty Community Providers' or 'MCPs');
- joining up GP, hospital, community and mental health services ('Primary and Acute Care Systems' or 'PACS');
- linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency ('Acute Care Collaborations' or 'ACCs'); and
- offering older people better, joined up health, care and rehabilitation services ('Enhanced Health in Care Homes').

Compared to their 2014/15 baseline **both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England**. Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), **per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%**.

Figure 6: MCP and PACS vanguards have seen lower growth in per capita emergency hospital admissions than the rest of England



NB: This chart compares the most recent twelve months for which complete data are available (January - December 2016) with the twelve months prior to the vanguards commencing (the year to September 2015).

Alternatively taking the full financial year April 2014-March 2015 before the vanguards were selected as the baseline period, per capita emergency admissions growth rates were: PACS 1.7%, MCPs 2.7% and rest of England 3.3%. Vanguards such as Morecambe Bay, Northumberland and Rushcliffe are reporting absolute reductions in emergency admissions per capita. As intended, the benefit has been greatest for older people. The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.

Sustainability and Transformation Partnerships

Our aim is to use the next several years to make the biggest national move to integrated care of any major western country. Why? As the CQC puts it:

> "The NHS stands on a burning platform - the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today's population needs… transformational change is possible, even in the most challenging of circumstances - we have witnessed it, and seen the evidence that it delivers improved care. As the boundaries between organisations and sectors become increasingly porous, peer review and transparency will become ever more important." Prof Sir Mike Richards [39]

This will take the form of Sustainability and Transformation Partnerships covering every area of England, and for some geographies the creation of integrated (or 'accountable') health systems.

STPs began life as pragmatic vehicles for enabling health and care organisations within an area to chart their own way to keeping people healthier for longer, improving care, reducing health inequalities and managing their money, working jointly on behalf of the people they serve. They are a means to an end, a mechanism for delivering the Forward View and the key national priorities in this Plan.

These partnerships are more than just the 'wiring' behind the scenes. They are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most. They are a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them. At their best, they engage front-line clinicians in all settings to drive the real changes to the way care is delivered that they can see are needed and beneficial. And they are vehicles for making the most of each pound of public spending; for example, by sharing buildings or back office functions.[40]

More fundamentally they require engaging with communities and patients in new ways. In order to mobilise collective action on "health creation" and service redesign, we need to recognise that, as the Five Year Forward View argued:

> "One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'. Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and underdeveloped advocacy and action on the broader influencers of health and wellbeing. As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments."

In making this transition to population-based integrated health systems, the NHS will be guided by several principles building on those identified above:

- **STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations**. It's a case of 'both the organisation and our partners', as against 'either/or'.

- **The way STPs work will vary according to the needs of different parts of the country**. Place-based health and care systems should be defined and assessed primarily by how they practically tackle their shared local health, quality and efficiency challenges. We do not want to be overly prescriptive about organisational form. This

approach to health and social care integration, building on the Better Care Fund, is also supported by government who have said:

> "The government will not impose how the NHS and local government deliver this. The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports, including: Accountable Care Organisations such as the one being formed in Northumberland, to create a single partnership responsible for meeting all health and social care needs; devolution deals with places such as Greater Manchester which is joining up health and social care across a large urban area; and Lead Commissioners such as the NHS in North East Lincolnshire which is spending all health and social care funding under a single local plan."[41]

- However to succeed, all STPs need a **basic governance and implementation 'support chassis'** to enable this type of effective working. All NHS organisations will therefore from April form part of a Sustainability and Transformation Partnership, which will:

  - Form an *STP board* drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate. Establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations. (The governance arrangements now in place across Greater Manchester provide one example of how this can be done within the current statutory framework.) In the unlikely event that it is apparent to NHS England and NHS Improvement that an individual organisation is standing in the way of needed local change and failing to meet their duties of collaboration we will – on the recommendation of the STP as appropriate – take action to unblock progress, using the full range of interventions at our disposal.

  - Where this has not already occurred, re/appoint an *STP chair/leader* using a fair process, and subject to ratification by NHS England and NHS Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata.

  - Ensure the STP has the necessary *programme management support* by pooling expertise and people from across local trusts, CCGs, CSUs and other partners. Where CCGs wish to

align their management teams or even governing bodies more closely with those of the STP geography, NHS England will generally now support that. NHS England will also deploy its own local staff under the direction of STPs where appropriate.

- Be able to propose an adjustment to their *geographical boundaries* where that is thought appropriate by local bodies in agreement with NHS England. Over time we expect these may flex pragmatically depending on local circumstances. In any event, patient flows, for example for specialised services, may mean planning across several STP areas.

- We will work with STP leads, NHS Clinical Commissioners, NHS Providers, the NHS Confederation, the Local Government Association and other appropriate bodies in the development of STPs and the policy framework they will operate in

- The corollary to not being prescriptive about STP structures is that **the way to judge the success of STPs - and their constituent organisations - is by the results they are able to achieve**. We will publish metrics at STP level that will align with NHS Improvement's Single Oversight Framework for NHS provider trusts and NHS England's annual CCG Improvement and Assessment Framework, which will be published in July.

Community participation and involvement

Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities. Nationally, we will continue to work with our partners, including patient groups and the voluntary sector, to make further progress on our key priorities.

Locally, we will work with patients and the public to identify innovative, effective and efficient ways of designing, delivering and joining up services. And by prioritising the needs of those who experience the poorest health outcomes, we will be better able to improve access to services, reduce health inequalities in our communities and make better use of resources.

Last year STPs produced and published initial 'Mark 1' proposals covering the next five years. Some of these contained suggestions for major changes in local services that require formal public consultation. All of them require local engagement with patients, communities and staff.

Healthwatch has set out five steps to ensure local people have their say:

1. Set out the case for change so people understand the current situation and why things may need to be done differently.
2. Involve people from the start in coming up with potential solutions.
3. Understand who in your community will be affected by your proposals and find out what they think.
4. Give people enough time to consider your plans and provide feedback.
5. Explain how you used people's feedback, the difference it made to the plans and how the impact of the changes will be monitored. [42]

As STPs move from proposals to more concrete plans, we expect them to involve local people in what these plans are and how they will be implemented.

In addition, where significant hospital bed closures will result from proposed service reconfigurations, NHS England will in future require STPs to meet a 'fifth' new test in addition to the four existing ones put in place in 2010. Under those current rules, planned closures can only go ahead with support from GP commissioners, strengthened public and patient engagement, clear clinical evidence and assurances that they are consistent with patient choice.

From 1 April 2017, NHS organisations will also have to show that proposals for significant hospital bed closures, requiring formal public consultation, can meet one of three common sense conditions:

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

Hospitals will still have the freedom to flex their number of beds throughout the year to manage their budgets, and the responsibility to determine how many beds they can safely staff.

Accountable Care Systems

ACSs will be an 'evolved' version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In

return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital. Specifically, ACSs are STPs - or groups of organisations within an STP sub-area - that can:

- Agree an *accountable performance contract* with NHS England and NHS Improvement that can credibly commit to make *faster improvements* in the key deliverables set out in this Plan for 2017/18 and 2018/19.

- Together manage *funding for their defined population*, committing to shared performance goals and a financial system 'control total' across CCGs and providers. Thereby moving beyond 'click of the turnstile' tariff payments where appropriate, more assertively moderating demand growth, deploying their shared workforce and facilities, and effectively abolishing the annual transactional contractual purchaser/provider negotiations within their area.

- Create an effective *collective decision making and governance structure*, aligning the ongoing and continuing individual statutory accountabilities of their constituent bodies.

- Demonstrate how their provider organisations will operate on a *horizontally integrated* basis, whether virtually or through actual mergers, for example, having 'one hospital on several sites' through clinically networked service delivery.

- Demonstrate how they will simultaneously also operate as a *vertically integrated* care system, partnering with local GP practices formed into clinical hubs serving 30,000-50,000 populations. In every case this will also mean a new relationship with local community and mental health providers as well as health and mental health providers and social services.

- Deploy (or partner with third party experts to access) rigorous and validated *population health management capabilities* that improve prevention, enhance patient activation and supported self- management for long term conditions, manage avoidable demand, and reduce unwarranted variation in line with the RightCare programme.

- Establish clear mechanisms by which residents within the ACS' defined local population will still be able to exercise *patient choice* over where they are treated for elective care, and increasingly using their personal health budgets where these are coming into operation. To support patient choice, payment is made to the third-party provider from the ACS' budget.

In return, the NHS national leadership bodies will offer ACSs:

- The ability for the local commisioners in the ACS to have delegated decision rights in respect of commissioning of primary care and specialised services.

- A devolved transformation funding package from 2018, potentially bundling together national funding for GPFV, mental health and cancer.

- A single 'one stop shop' regulatory relationship with NHS England and NHS Improvement in the form of streamlined oversight arrangements. An integrated CCG IAF and trust single oversight framework.

- The ability to redeploy attributable staff and related funding from NHS England and NHS Improvement to support the work of the ACS, as well as to free up local administrative cost from the contracting mechanism, and its reinvestment in ACS priorities.

This is a complex transition which requires careful management, including of the financial framework so as to create opportunity while also reducing instability and managing risk. That's why ACSs require a staged implementation. This also provides the opportunity to prove their ability to manage demand in ways that other areas can subsequently adopt. We expect that candidates for ACS status to include successful vanguards, 'devolution' areas, and STPs that have been working towards the ACS goal. In Q1 2017/18, NHS England and NHS Improvement will jointly run a light-touch process to encourage other STPs (or coherent parts of STPs) to come forward as potential ACSs and to confirm this list. Likely candidates include:

- Frimley Health
- Greater Manchester
- South Yorkshire & Bassetlaw
- Northumberland
- Nottinghamshire, with an early focus on Greater Nottingham and the southern part of the STP
- Blackpool & Fylde Coast, with the potential to spread to other parts of the Lancashire and South Cumbria STP at a later stage.
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- West Berkshire

In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas (particularly some of the MCP and PACS vanguards) in England are on the road to establishing an ACO, but this takes several years. The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.

CHAPTER SEVEN

FUNDING AND EFFICIENCY

By definition a tax-funded NHS depends on a well-performing UK economy. Over the last seven decades of the NHS' life, growth in NHS funding has closely followed the ups and downs of wider economic cycles. Since the recession of 2008 the economic picture has again become more challenging. Despite real terms protection, NHS funding growth is much slower than the historic long term trend.[43] The NHS Five Year Forward View set out three alternative scenarios for minimum funding levels in the year 2020, but did not specify minimum funding or efficiency requirements for each year in the run up to 2020. NHS funding has fared better than other public services, and the Spending Review provides real terms growth in NHS England revenue funding, although age-weighted real terms funding per person will go down in 2018/19 and 2019/20, and capital investment has been limited in recent years.[44]

At the end of 2016, thanks to the dedicated work of local NHS commissioners and providers the NHS and its partners produced initial STP proposals, followed by operational plans and contracts for 2017/18-2018/19. These initial STP proposals are now being updated in the light of these operational plans. These will set out clear accountabilities for delivering local goals and key national milestones - including better A&E performance, improvements in cancer, mental health and primary care services, and financial balance within agreed local control totals supported by decisive action on major efficiency programmes. Substantial progress has been made but this work is not yet complete so significant risks to delivery remain such as the bed occupancy reductions required, workforce supply, capital requirements and residual financial gaps. NHS England and NHS Improvement will work with local health partners to address these and will then publish a national operational update during the first quarter of 2017/18, setting out final agreed control totals and plans for the year. Under all circumstances the NHS will benefit from creating the maximum 'headroom' from available efficiencies, and this is the approach we will be taking:

The NHS' 10 Point Efficiency Plan

The evidence from multiple sources suggests three truths:

- Overall, the NHS is one of the industrialised world's most efficient health care systems, and substantially lower cost than other advanced European countries such as France, Germany, Sweden or Switzerland. The Germans spend 30 percent more per person on health care than we do.[45] And since 2010 the NHS has been increasing its productivity faster than the rest of the UK economy.[46]

- As the Office for Budgetary Responsibility has projected in their latest Fiscal Sustainability Report, notwithstanding any action to address future cost pressures, health spending is likely to rise significantly as a proportion of GDP over the coming decades, as a result of demographic pressures but also growing technology costs and rising demand.[47] [48]

- BUT despite those two truths, it is also the case that there are still substantial opportunities to cut waste and increase efficiency in the NHS, just as there are in every other country's health care system.[49] In a tax-funded health service, every pound of waste saved is a pound that can be reinvested in new treatments and better care for the people of England. With 2017/18 funding fixed, substantial efficiencies are needed to create funding headroom over and above that.

Most annual efficiency gains will continue to be delivered locally taking account of the specific opportunities in different areas and organisations, for example improving staff retention, reducing sickness absence and ensuring proper staff rostering.

In addition there are some particularly **large efficiency opportunities that now require concerted action right across the NHS**, with national implementation support. These are part – but not the whole – of the efficiencies the NHS will be delivering in 2017/18, alongside local programmes. But they are a critical part of the NHS' ability to 'square the circle' in balancing its budget. Effective delivery against these programmes is therefore no longer optional for each NHS organisation. Instead they are now mandatory requirements for every trust and CCG in 2017/18, and NHS Improvement and NHS England will oversee their delivery.

1. Free up 2000 to 3000 hospital beds (NHS Improvement/NHS England/with local authorities)

At present around 2500 hospital beds are occupied by patients who are fit to leave hospital but are awaiting social care, and an equivalent number are occupied due to delays in community health services. This means we are not providing the most appropriate care for these individuals, who are often frail, older people; we are causing delays for other patients in A&E departments who are waiting to be admitted to a hospital bed; and we are sometimes having to delay routine operations for other patients. That is one reason why the NHS itself supported the call for well-targeted extra social care funding.

The Chancellor used his March Budget to make available an additional £1 billion for local authority-funded adult social care in 2017/18 and a further £1 billion over the following two years. In doing so he made clear that it should in part be used by councils to ensure extra home care and care home places to free up more hospital beds:

> "£1 billion of this will be provided in 2017/18, ensuring councils can take *immediate action to fund care packages for more people*, *support*

> *social care providers, and relieve pressure on the NHS locally*. Building on the approach to the Better Care Fund, *councils will need to work with their NHS colleagues to consider how the funding can be best spent*, and to ensure that best practice is implemented more consistently across the country. This funding will be supplemented with targeted measures to help ensure that those areas facing the greatest challenges make rapid improvement, *particularly in reducing delayed transfers of care between NHS and social care services.*" HM Treasury, March 2017[50]

It is therefore essential that **hospital trusts now work with their local authorities, primary and community services to reduce delayed transfers of care and contribute to freeing up 2000-3000 beds. We have mapped the beds blocked by delayed transfers related to social care to each hospital and responsible local authority. We are now developing improvement trajectories for hospitals to deliver in part by working with their local authorities**, and we will regularly publish the progress being made against these objectives. In addition, hospitals, community services and CCGs are required now to adopt good practice to ensure appropriate patient flow, as set out in the Urgent and Emergency Care section of this Plan.

2. Further clamp down on temporary staffing costs and improve productivity (NHS Improvement lead)

Great progress has been made over the past year in cutting around £700 million from trusts' bills for agency staff, from £3.7 billion in 2015/16 to around £3 billion in 2016/17. Applying caps on hourly rates and use of mandatory pricing frameworks, the effect has been greatest in agency nursing. But around £1 billion is still being spent on agency and locum doctors. Last year five such medical locums billed the NHS more than £2 million between them. To try and pin this on 'shortages' misses the obvious point that these are individuals who are actually available to work and are doing so – but in a way that is unfair to their permanent colleagues and is placing an unacceptable burden on the rest of the NHS.

Trusts are now being set the target of making a **further cut in agency and temporary staffing costs in 2017/18**, of which around £150 million should come from reduction in medical locum expenditure. NHS Improvement now requires public reporting of any individual locum costing the equivalent of over £150,000 a year, and trust chief executives are required to sign off personally on any agency shift costing more than a nationally specified amount per hour. NHS Improvement will be working specifically with the Royal College of Emergency Medicine on ways to convert A&E locums into substantive posts. Similar controls are now in place to cut the use of expensive interim executives – in both providers and commissioners.

3. Use the NHS' procurement clout (NHS Improvement lead)

As part of the 'Carter' programme, NHS Improvement will standardise and improve trust procurement to release £350 million of savings in 2017/18 on a baseline of over £8 billion of annual expenditure on supplies and devices. Smarter and collaborative procurement will mean purchasing certain categories of product on behalf of the whole NHS. **All trusts will be required to participate in the Nationally Contracted Products programme**, by submitting and sticking to their required volumes and using the procurement price comparison tool to switch to better value products.

4. Get best value out of medicines and pharmacy (NHS England lead)

The NHS spends around £16 billion a year on drugs, of which about £9 billion arises from GP prescribing and £7 billion from hospital treatment (of which about half is directly reimbursed by NHS England's specialised services budget). The NHS drugs bill grew by over 7% last year, with particular growth in hospital-driven prescribing. This was considerably faster than growth in the overall NHS budget. In some cases newer medicines displace other hospital costs or older categories of treatment. However within this fast growing pharmaceutical expenditure there are also opportunities for efficiency:

- NHS England is co-funding clinical pharmacists embedded in general practice to support GP prescribing and optimise medicines usage. Formulary decisions will now typically be made regionally rather than by each CCG, as recommended by the Accelerated Access Review.
- NHS RightCare will be used to drive improved uptake of NICE-recommended medicines that also generate downstream savings - for example anticoagulation to reduce strokes.
- Four regional Medicines Optimisation Committees will coordinate the pursuit of medicines optimisation opportunities, including in care homes, multiple prescribing, use of generics and biosimilars, and reducing medicines wastage.
- NHS Clinical Commissioners and CCGs are reviewing the appropriateness of their expenditures on medicines, identifying areas of prescribing that are of low clinical value or are available over-the-counter often at a lower price - such as for minor conditions such as indigestion, travel sickness, cough remedies and upset stomachs. Following consultation, NHS England will support them in taking action on their top medicines of low clinical value that should not normally be prescribed (which cost £128 million a year) by developing national guidance with CCGs. We will also work with CCGs, providers, patients and manufacturers to consider other medicines and products of low clinical value, to ensure that NHS funding is used on those things that have the most impact on outcomes for patients.
- NHS England's new commercial medicines team will directly negotiate with pharma companies, in conjunction with NICE where appropriate,

on new win/win fast track reimbursement arrangements for selected drugs, as recommended by the Accelerated Access Review.

- NHS Improvement will be supporting hospitals to save £250 million from medicines spend in 2017/18 by publishing and tracking the uptake of a list of the top ten medicines savings opportunities. As savings are realised the top ten will be refreshed with further products or switches that deliver best value.
- NHS Improvement is working with hospitals to consolidate pharmacy infrastructure such as medicines stores across wider geographies to deliver further efficiencies and free up pharmacists' time for clinical work.
- Following public consultation, NICE and NHS England have established a £20 million budget impact threshold for further discussion on phasing and affordability of new spending, effective April 2017.
- The Department of Health is continuing to drive important savings in the supply chain for dispensing medicines.

5. Reduce avoidable demand and meet demand more appropriately (PHE and NHS England lead with local authorities)

One of the greatest opportunities for increasing efficiencies in the NHS is the reduction of unwarranted variation in care. Across the NHS there are very large variations in the number of people seeing a GP, being referred to hospital and receiving operations that are not explained by clinical need. In a financially constrained system, unnecessary care given to one patient results in needed care being denied to another. The NHS will, therefore, be increasing its work to reduce this variation and ensure that care is delivered to those most in need and those most able to benefit from it.

Real world examples of the sort of progress that is possible have recently been shown through the RightCare programme. Locally reported results include:

- Bradford CCG – 210 fewer deaths from stroke, 38,000 new people self-caring to manage blood pressure and avoid demand for services. £1.6 million saved.
- Ashford CCG – 30% reduction in acute MSK demand and a 7% reduction in MSK spend through introduction of a triage service.
- North Kirklees CCG – introduced new material for hospital and practice use explaining the cost of over-the-counter prescriptions, leading to £100k annual saving.
- Slough CCG – new complex care case management service reducing targeted demand on A&E by 24% and non-elective admissions by 17%.
- Blackpool CCG – reduced demand from frequent callers by 89% (999 calls), 93% (A&E attends), 82% (admissions). Saved £2 million.

In 2017/18 we will build on these examples, and focus work to scale up demand moderation relating to prevention, emergency care and elective services, as follows:

Prevention

Multiple programmes to prevent illness and support health have been kicked off following the NHS Five Year Forward View. These are diverse and include, for example: falls prevention undertaken by fire services during home visits to older residents; the world's largest evidence-based diabetes prevention programme now covering half of the country; and 150 dementia-friendly communities covering 18 million. We will now take action, including:

- Expand the Diabetes Prevention Programme, a partnership between NHS England, Public Health England, and Diabetes UK, which provides tailored, personalised help to reduce **risk of Type 2 diabetes**, including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes. In 2017/18 this means an estimated 130,000 referrals and around 50,000 people on programmes. In 2018/19 these figures could rise to as many as 200,000 referrals and more than 80,000 people on programmes.

- Tackle **obesity** in particular in children through tougher action on sugar and junk food. Following our public consultation, NHS England will set out action shortly on ensuring NHS premises offer appropriate food and drink options for staff, visitors and patients. In 2017/18, PHE will publish specific targets to reduce the sugar contents of nine food categories. In addition, from 1 April 2018, the Government will introduce a nationwide levy on sugary soft drinks, which is expected to raise £385m in the first year with the proceeds to be invested in encouraging sports and exercise in schools.

- NHS provider trusts will have to screen, deliver brief advice and refer **patients who smoke and/or have high alcohol consumption** in order to qualify for applicable CQUIN payments in 2017/18 and 2018/19. In 2017/18, all mental health trusts will become smoke-free, expanding to all acute trusts in 2018/19, leading to all NHS estates becoming smoke-free by 2019/20.

- By 2018/19, Public Health England will lead work with Local Authorities to reach over 2.8 million more people with an **NHS Health Check.** This will identify around 280,000 people at high risk of cardiovascular disease and facilitate follow up, preventative care; 70,000 patients with high blood pressure, 14,000 patients with type 2 diabetes and over 4,600 patients with chronic kidney disease who will be diagnosed earlier and treated by the NHS.

- In 2017/18, PHE will expand the **childhood flu vaccination** to include children in school year 4, to reduce incidence of disease. This will be delivered as part of the phased roll-out of the children's programme.

- The NHS will **work with employers** to help people with a health condition to stay in work. About half of people with a health condition who fall out of work do so because of mental illness. Working with the West Midlands Combined Authority, we will support the trialling of a "wellbeing premium" that will encourage employers, through a fiscal incentive, to look after their employees' health and wellbeing, and to support those at risk of falling out of work. In addition to this, we are working in partnership with the Work and Health Joint Unit (a partnership between DWP and DH) to test new ways to improve the integration of and access to health and employment support to help people get and stay in work. As part of this we are supporting three trials involving around 12,000 people in Islington, the West Midlands and Sheffield City Region. These trials apply well-evidenced approaches derived from Individual Placement and Support – a model that helps people with severe mental illness return to work – to help people with more common physical and mental health conditions get and stay in work. These randomised control trials will report interim findings in 2018 and final results in 2020, providing a strong evidence base on which to consider wider roll-out.

- Prevention of **cardiovascular disease.** Cardiovascular disease (CVD) mortality has fallen dramatically over the last 30 years, but it remains the second highest cause of premature death, as well as being a major contributor to health inequalities. CVD is highly preventable through proven treatments for high risk conditions, recommended in NICE guidance. For example, anticoagulation for patients with atrial fibrillation (AF) reduces stroke risk by two thirds. Yet half of the people with known AF who suffer a stroke have not received anticoagulants. If everyone diagnosed with AF who could benefit from anticoagulants received them, then 5,000 strokes could be prevented each year.[51] In 2017/18, NHS RightCare will work with CCGs covering an additional 13 million people to identify and implement optimal value CVD interventions, deploying electronic audit tools such as GRASP-AF and new models of care to improve detection and treatment of people with high risk conditions. Public Health England will work with STPs and NHS England, including the RightCare programme, to support the implementation of identified preventative interventions at scale. Effective progress on this will also reduce the risk factors associated with dementia.

- A programme to **promote healthy communities** and support disabled people and those with long-term conditions to manage

their own health, care and wellbeing. Through an extension of the Integrated Personal Commissioning model, we will reach over 300,000 people by the end of 2018/19, including in the best ACS and STP geographies, and then if successful scale it substantially thereafter. We will work collaboratively with the voluntary sector and primary care to design a common approach to **self-care and social prescribing**, including how to make it systematic and equitable.

- Further action to **identify and support carers**. We will develop quality markers for Carer Friendly GP practices that promote carer identification, health checks, flu jabs and referral/signposting to advice and support, in order to reduce carer breakdown and improve carer health-related quality of life. We will also help health and social care organisations to support carers, including young carers, to avoid reaching breaking point, so that they, and the cared-for person, will be less likely to end up in hospital. This is being done in partnership with Greater Manchester Health and Social Care Partnership, West Yorkshire, Surrey Heartlands and others, and with a cohort of 15 new care model vanguards.

- Support **disabled people and people with complex health needs** to benefit from a personal health budget, with expansion to over 20,000 people in 2017/18 and 40,000+ in 2018/19. We will provide 10,000 Personal Maternity Care Budgets to new mothers by end of 2017/18 through the seven Maternity Pioneer areas.

- We will also continue to maintain focus on **diagnosis and post-diagnostic support for people with dementia and their carers**. These are key drivers to keeping in their own homes, preventing crises and avoiding unnecessary admission to hospital.

- We will support eight STP areas to take part in our new one year **Building Health Partnerships programme** to facilitate strong engagement with the voluntary sector and local communities on actions that improve wellbeing and self care.

Reduce avoidable demand for emergency care and meet demand more appropriately

In both 2015/16 and 2016/17, cost-weighted acute activity commissioned by CCGs has grown, at around 2.5% a year. Within that total, emergency admissions and delayed discharges have crowded out inpatient elective activity. While acute hospital bed days are up by about 1% over the latest twelve month period, within that total, non-elective bed days are up by double that at around 2%.

Although these emergency growth rates are in line with the medium term trend, cost growth has exceeded income growth. Additional funding has been provided in the form of £1.8 billion from the STF. Taken together with the £800 million of system reserve which commissioners were required to set aside to cover risks in the provider sector, the NHS has, therefore, been locked into a cycle where the extra funding needed to pay for hospital services could not be used to invest in extra services that could moderate growth in this demand. The NHS is starting to break out of this cycle, both by increasing hospital productivity and – as the new care models are starting to demonstrate – using existing resources more effectively to reduce rates of emergency admissions and lengths of stay.

Looking to 2017/18, it is vital that we accelerate progress in both these areas.

- Chapter Two sets out our **comprehensive plan to reduce the growth in 'minor' cases that present in A&E department**s. This includes: better access to GP care; a more standardised 'urgent treatment centre' offer to the public; a higher proportion of 111 calls handled by a clinician; more flexibility for ambulance services to decide how patients need looking after, including on site by paramedics without the need for conveyance to hospital; better support for frail older people in care homes; GP streaming alongside A&E departments; and beefed up mental health services in A&Es.

- Every part of the country – be it an STP or ACS (see Chapter Six) – will from April be **measuring and managing emergency hospitalisation rates**. There is a meaningful opportunity for improvement. By comparison with other countries, our figures show that "While admission rates for congestive heart failure are around a third of the EU average and point to effective treatment at the primary care level, the same is not the case for asthma and chronic obstructive pulmonary disease, where hospital admissions were well above the average."[52] In July 2017, NHS England will publish metrics for each STP benchmarking their emergency admission rates and bed days. CCGs will be held to account for improvement.

- Vanguards are entering their third year and now need to take clearer financial accountability for reducing emergency hospitalisation growth in their area. To that end, **2017/18 national funding for each PACS, MCP or UEC vanguard will be available to STPs as a funding source to pay for excess emergency admissions growth in their area**. The STP in which they operate will be able to use the vanguard funding provided by NHS England to pay for the lower of a) emergency admissions growth above the vanguard's agreed local emergency 2017/18 contract volumes *or* b) any emergency admissions growth for the vanguard's patients above the 2017/18 national emergency admissions growth rate in 2017/18. That way we can be sure that vanguards are explicitly

focused on demand management and delivering better performance than the rest of the country. They now need to fulfil their early promise and demonstrate how they 'earn their passage'.

Reduce avoidable demand for elective care

30 years ago over 200,000 people were waiting over a year for an operation; today it is well under 2,000. Compared to 15 years ago, the NHS has doubled the number of hip replacements and nearly tripled the availability of knee replacements.[53] And over the past fifteen years the maximum waiting time standard has fallen from 18 months to 18 weeks. Where ten years ago just under half of patients waited more than 18 weeks for treatment, now only around one in ten patients do.

Figure 7: The number of people in England waiting over a year for NHS elective hospital treatment

Looking out over the next two years we expect to continue to *increase* the number of NHS-funded elective operations. However given multiple calls on the constrained NHS funding growth over the next couple of years, elective volumes are likely to expand at a slower rate than implied by a 92% RTT incomplete pathway target. While the median wait for routine care may move marginally, this still represents strong performance compared both to the NHS' history and comparable other countries.

During 2017/18 CCGs and trusts will also step up their work to get more value out of the NHS' growing, multi-billion pound investment in elective care. For GPs and CCGs this will mean tackling clinical practice variation in referrals. For trusts this will mean tackling variation in clinical quality and productivity revealed by the Getting it Right First Time (GIRFT) programme. And for CCGs and trusts jointly it will mean redesigning care pathways to promote optimal patient care in line with RightCare. Specifically:

- Building on recent progress which has seen GP referral growth slow to a modest 1.6% year-to-date, NHS England will work with upper quartile higher referring GP practices and CCGs to **benchmark clinical appropriateness of hospital referrals** using CCG dashboards and a new tool from NHS Digital, and then deploy clinical peer review. In doing so we will look to increase the impact of the Academy of Medical Royal Colleges' 'Choosing Wisely' initiative.[54]

- CCGs will review their **referral management** processes and guidance, where appropriate redesigning patient pathways for example to allow speedier access to physiotherapy for musculoskeletal patients with back pain.

- GPs practices and hospitals are moving to universal use of **e-referrals** by October 2018. This offers a new specialist '**advice and guidance' option** avoiding the need to default to an outpatient referral. It also embeds decision prompts on local providers with the shortest waiting times, to help with **demand/capacity 'smoothing'**.

- GIRFT will work direct with consultants on the appropriateness of certain procedures of **questionable clinical value** such as some spinal surgery procedures.

- Detail on the IT changes to support these approaches is included in Chapter Nine.

6. Reduce unwarranted variation in clinical quality and efficiency (NHS Improvement lead)

The **Getting it Right First Time** (GIRFT) methodology drives quality and productivity improvement in over 30 clinical specialties that cost trusts over £45 billion a year. The primary objective of GIRFT is to improve quality of care and outcomes for patients. By doing this, it will also deliver savings by reducing complications and litigation and improving outcomes, to the value of £400 million in 2017/18.

Since most elective hospital admissions are daycases and so not dependent on beds, hospitals will work to improve **theatre productivity** in line with GIRFT benchmarks. They also need to free up 2000-3000 inpatient beds with local councils which can then partly be used for additional funded elective inpatient admissions.

Subject to appropriate local public consultation, we will in principle support well-designed and affordable STP proposals that seek to **split 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities** so as to allow efficient use of beds for planned surgery, avoiding the risk of cancelled operations from emergency admissions. STP schemes that are proposing this include the South East London elective orthopaedics

centre, the 'restack' of services between Bournemouth and Poole hospitals, and a number of other proposals to redesign services across neighbouring district general hospitals across the country.

Differential availability of services and functions in hospitals and community settings across the week leads to variation in care for acutely unwell patients, and delays in progressing treatment. The Academy of Medical Royal Colleges has endorsed four **priority clinical standards**. The aim is that the proportion of the population for whom they are available seven days a week should reach 50% by April 2018. By November 2017 the whole population should be covered by five specialist services – emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care – meet the standards seven days a week.

Action will continue to be taken to reduce the inappropriate hospitalisation of **people with learning disabilities**. Hospitals are not homes, and the aim is to improve the quality of people's lives, their ability to control the services they are offered, and tackle premature mortality. Since the 'Transforming Care' programme began implementation in Spring 2015 the number of people in inpatient units has fallen by 11%. Over the next two years it will fall at least a further 25% points, as better community alternatives are provided across England.

CCGs commission NHS **Continuing Health Care** for over 150,000 people with long term care needs each year. Together with the Department of Health in 2017/18, we will be consulting on the National Framework, ensuring that assessments and decisions around care packages are taken with patients and their carers within no longer than 28 days.

7. Estates, infrastructure, capital, and clinical support services (NHS Improvement lead and DH lead)

Clinical support services such as **diagnostics laboratories and imaging services** are vital in supporting patient care. The NHS spends over £2.5 billion a year on these services. We need to ensure pathology services across England deliver the fastest and highest quality possible support to trusts. By improving the deployment of pathologists and imaging services, the NHS can both improve services and save up to £130 million annually.

The NHS also needs to protect and improve its **estates and facilities**. Facilities management has a direct bearing on patient experience, for instance by ensuring that premises are safe, warm and clean environments for staff and patients and by preparing high quality and nutritious hospital food. The NHS spends over £6.5 billion maintaining and running its estate and facilities. Here too there are opportunities to achieve efficiency savings, for example through reducing unwarranted variation in energy costs. NHS Improvement will support hospitals to achieve over £100 million in savings in 2017/18.

The NHS and Department of Health are aiming to dispose of **£2bn of surplus assets** over the Spending Review period, so as to create headroom for investment and to free land sufficient for 26,000 homes. The forthcoming **Naylor review will set out the action plan** for doing so. This principally relates to land and assets held by provider trusts and NHS Property Services and Community Health Partnerships, since the majority of premises used by GPs, other family health services, and third party providers are not owned by the NHS. The Naylor review also recommends a new NHS property organisation, a key function of which will be to provide a single, strengthened source of strategic estates planning expertise for the NHS.

In the March 2017 Budget the Chancellor said "At Autumn Budget I will announce a **multi-year capital programme** to support implementation of approved high quality STPs." And "In the Autumn a further round of local [STP] proposals will be considered, subject to the same rigorous value for money tests. Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land to reinvest in the health service." An initial down-payment of £325 million divided evenly over the next three years has been announced for well-developed STPs "where there is the strongest case to deliver real improvements for patients".

8. Cut the costs of corporate services and administration (NHS England and NHS Improvement)

NHS administrative costs are already far lower than other comparable major countries. Latest OECD data show that on a like for like basis we spend only 2p in the pound on administration, compared to 5p in Germany and 6p in France.[55]

Like the rest of the public sector, the health service needs to concentrate its resources on front line service delivery as much as possible. At the same time, administration and back office functions play a vital role in keeping the NHS going, from payroll and HR facilities through to sourcing medical supplies and keeping GP practices and hospitals well stocked.

NHS administration therefore has an important role to play, but its costs need to be managed carefully. The scale of the NHS makes it possible to achieve substantial efficiencies. In 2017/18, we will take action on the following areas:

- NHS provider trusts are spending over £3.2 billion a year on back office administration for finance, payroll and similar services. If all trusts reduced their costs to the current average they could save £400 million a year. NHS Improvement is targeting **savings of over £100 million in 2017/18**, as trusts move to consolidate these services, where appropriate across STP areas. NHS Improvement is

establishing a set of national benchmarks across the key corporate services functions to enable individual trusts to compare their performance and identify where improvements can be made.

- The NHS Litigation Authority, now known as **NHS Resolution**, is also contributing to cost reduction. As part of a new five-year strategy, NHS Resolution will provide support closer to the time of incidents, and facilitate local resolution and learning. For example, NHS Resolution will use an early notification model for cases of severe brain injury at birth from April 2017. NHS Resolution will aim to reduce costs by identifying and investigating these incidents earlier, providing the opportunity to resolve disputes in a less adversarial way, possibly through deploying alternative models for dispute resolution. The approach will also support learning with the aim of reducing the actual incidence of harm and its associated costs to the system. NHS Resolution will also continue to save money for patient care from claims when no compensation is due, and by challenging over-charging, fraudulent and excessive claims. From 2017/18 the NHS Standard Contract is being amended to prevent law firms from operating from or touting for business in NHS premises.

- **NHS England and CCGs have cut more than £250 million in real terms from running costs over the past three years. We will now cut another £150 million** in real terms by the end of 2019/20, in addition to savings made by other ALBs. As STPs and ACSs ramp up we will work with them to make further efficiencies by combining management support across providers, CCGs and CSUs.

- NHS England and NHS Improvement have distinct and enduring statutory responsibilities under current law. In addition to our shared local work with local CCGs and trusts, NHS England's statutory duties include independently allocating £110 billion of NHS resources to different parts of the country and across programmes of care, directly managing £16 billion of national specialised services including pharmaceuticals, and overseeing over 30,000 contracts with GP practices, pharmacists, dentists and opticians. However our ways of working and cultures need to evolve and change. There are opportunities to **streamline aspects of our joint work** in 2017/18:
    - Each Regional Director and their team will act on behalf of both organisations in overseeing implementation of the Urgent and Emergency Care plan in a certain number of STPs.
    - The two organisations will create unified programme management groups to deliver key clinical priorities in this Plan. These will have a single jointly appointed leader, including for urgent and emergency care, mental health,

cancer, maternity, and technology implementation. We also intend to promote closer collaboration between RightCare and the broader Operational Productivity programme, of which GIRFT is a major clinical component. This will better support the shared aim of reducing unwarranted and costly clinical variation across primary and secondary care and strengthen the clinically-led approach that is vital to its success. We will also look to share certain functional resources.

- As STPs become designated Accountable Care Systems, they will - within the scope of current law - have a single 'one stop shop' relationship with NHS England and NHS Improvement.

9. Collect income the NHS is owed (NHS Improvement lead)

In respect of cost recovery from non-UK residents, the National Audit Office says that "the best available estimates suggest that the NHS is recovering significantly less than it could".[56] The Government has set the NHS the target of recovering **up to £500 million a year**, up from £97 million three years ago. Twenty trusts will now pilot new processes to improve the identification of chargeable patients. As agreed with GP representatives, by Autumn 2017 the Department of Health will amend the General Medical Service regulations to require GP practices to ask all new patients whether they hold a non-UK issued EHIC card, and then pass this information to NHS Digital so that these patients can more easily be identified in secondary care and appropriate recharging to other EEA countries can automatically occur.

10. Financial accountability and discipline for all trusts and CCGs (NHS Improvement and NHS England)

The Government's Mandate to the NHS for 2017/18 requires it to "ensure overall financial balance in the NHS" with "all parts of the system – commissioners and providers – meeting their control totals".[57] This is going to require tough decisions and decisive action.

Financial performance has improved across the NHS over the past year. Commissioners have generated an £800 million managed underspend, and most trusts are on track to meet their control totals. But as the NHS goes in to the next two years of intensified financial challenge, financial success will require managing a number of important risks and dependencies, including reducing both NHS-related and social care-related blocked acute beds as set out in the chapter two; the level of emergency admissions growth; effective deployment of available capital to unleash trust efficiencies; and workforce availability in key staff groups. In 2017/18, funding has been allocated up-front to frontline services so there is no substantial national 'bail out' fund that can cover off poor financial control by individual trust boards or CCG governing bodies. The importance of

individual trusts and CCGs meeting their financial control totals and sticking to their budgets is critical. So in 2017/18:

- Each provider trust and CCG will again be set a financial control total (which may by prior agreement be flexed between organisations within an STP or ACS system control total) and which they must meet.
- 70% of the national Sustainability and Transformation Fund will again be tied to delivery against trust-specific financial control totals.
- Provider trusts not agreeing control totals will lose their exemption from the default fining regime in the NHS standard contract, and CCGs missing their financial goals will lose access to the CCG Quality Premium. From August 2017 CQC will begin incorporating trust efficiency in their inspection regime based on a Use of Resources rating.
- Trusts and CCGs missing their individual (or, where applicable, system) control totals may be placed in the Special Measures regime. CCGs in that status will be subject to legal directions and possible dissolution.
- Some organisations and geographies have historically been substantially overspending their fair shares of NHS funding and their control totals, even taking account of access to the STF. In effect they have been living off bail-outs arbitrarily taken from other parts of the country or from services such as mental health. This is no longer affordable or desirable. So going into 2017/18 it is critical that those geographies that are significantly out of balance now confront the difficult choices they have to take. Where necessary this may mean explicitly scaling back spending on locally unaffordable services, so that they go in to the next two years with a viable and balanced income and expenditure plan, delivering locally the Government's Mandate requirement for the NHS to balance its books.

CHAPTER EIGHT

STRENGTHENING OUR WORKFORCE

Despite a growing workforce, NHS staff are under real pressure. The number and complexity of the patients they care for continues to increase. Some geographies and types of job are hard to recruit to. Further challenge arises from ongoing pay restraint and uncertainty for our international staff.

Perhaps surprisingly, given these well understood pressures, frontline NHS staff say their experience at work continues to improve, with overall employee engagement scores now at a five-year high.[58] But there's still much to be done to ensure all staff – including nurses, therapists, doctors in training, support staff, midwives, health visitors and scientists - are properly supported. This chapter of the Plan summarises some of the key actions we will be taking.

What's been achieved in England over the past three years?

- More staff, including 8000 more doctors and nurses and the highest number of GPs in training ever.[59]
- New roles, including 2000 Nursing Associates in training to create both a new role and a career ladder from healthcare assistant to registered nurse, 650 new physician associates in training, and 500 new clinical pharmacists working alongside GPs.
- New routes into the NHS, including new on-the-job apprenticeship route to becoming a registered graduate nurse and over 2000 nurses completing HEE's return to practice programme.
- Frontline staff report improved working conditions. The annual NHS staff survey[60] published in March 2017 shows another year of improvements, with NHS staff engagement scores at their highest level in five years. And across 32 key measures, over 80% were more positive than last year.
- Action taken on workplace culture and employee support. The percentage of staff witnessing potentially harmful incidents is at its lowest in five years, at the same time as the percentage of staff able to report those concerns is at its highest in five years.[61] The new NHS Workforce Race Equality Standard is holding a mirror up to individual employers' practices in supporting Black and Minority Ethnic nurses and other staff.
- The Care Certificate, introduced in 2015 for new healthcare assistants and social care support workers, sets out 15 standards that describe the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care.

- 90% of NHS staff report their organisation takes positive action on staff health and well-being. Feeling unwell as a result of work-related stress is at its lowest reported level in five years, but still stands at 37%. So a new

national 'CQUIN' incentive scheme is promoting workplace health, including musculoskeletal, mental wellbeing, and weight management. 130,000 more NHS staff got flu jabs this winter compared to last, a record high.

Key improvements for 2017/18 and 2018/19

The NHS in 2020 is going to be looking after more patients, better funded and larger than the NHS of today. We are therefore going to need to continue to improve productivity and grow our frontline workforce, especially in priority areas such as nursing, mental health, urgent and primary care**.** Achieving this will require more training, more recruitment, better retention and greater return to practice after time out of the workforce. It will also require flexibility as roles and places of work evolve in line with changes to the practice of medicine and the shape of health care.

More people are training to join the NHS every year than are leaving it. Health Education England forecasts at least 25,000 to 50,000 net additional clinical staff could be available for NHS employment by 2020, partly depending on the NHS holding onto the staff it already has. This will enable the NHS to reduce its dependence on agency and locum staff.

The NHS will need more registered nurses in 2020 than today, as will the social care system**.** HEE forecasts growth of at least 6,000 extra nurses but this could be considerably higher if the NHS successfully focuses on:

- *Education and training*. The number of newly qualified nurses available to be employed will increase by up to 2,200 more per year in 2019, as a result of expansion in nurse training places commissioned by HEE between 2013 and 2016.

- *Retention.* Improving retention to the level of two years ago would mean around 4000 more whole time equivalent nurses per year. A new nurse retention collaborative run by NHS Improvement and NHS Employers will support 30 trusts with the highest turnover.

- *Return to practice.* There are over 50,000 registered nurses in England not currently working for the NHS. It takes three years and £50-70,000 to train a nurse, but only £2000 and three to twelve months to retrain a returning nurse. We will target a further 1500-2000 nurses to be supported to return to work over the next two years.

- *New fast track 'Nurse First' programme*. We will consult on creating a Nurse First route to nursing, similar to the Teach First programme. It will provide financial support for graduates from other related disciplines to undertake a fast track 'top up' programme to become a graduate registered nurse - in the first instance targeting mental health and learning disability nursing.

- *Support new Advanced Clinical Practice (ACP) nurse roles*. These senior nurse roles are valuable in their own right, and also have been shown sometimes to offer a better alternative to medical locums and unstable Tier 1 hospital rotas. Training is typically service-based alongside an accredited university programme. HEE and NHS Improvement will publish a new national ACP framework, and deploy ACPs in trusts in the first instance where they can make a demonstrable impact in high priority areas such as A&E, cancer care, elective services or reducing locum costs by converting medical posts.

- *Use e-rostering and effective job planning* to ensure right staffing at the right time. Building on successful pilot projects for nurses and healthcare support workers in 2016/17, NHS Improvement will publish guidance on electronic rostering to ensure high quality effective care at the bedside (measured by number of care hours delivered per patient according to their clinical needs). This will help further reduce agency spend through more effective deployment of substantive staff, and will make rostering more staff-friendly through use of technology. The benefits of e-rostering and job planning will be promoted for all other staff groups, particularly allied health professionals and pharmacists, to deliver similar benefits for hospitals and their staff. NHS Improvement will focus during 2017/18 on supporting trusts in getting best value from electronic tools to support better job planning for hospital doctors, and implementing newly-issued job planning guidance. The focus will be on maximising direct clinical care time, eliminating unwarranted variation in the number of patients treated per clinic and per theatre list, and reducing extra-duty payments.

In terms of the **medical workforce**, while we still have fewer practicing doctors than the European average (as we also do for nurses), we have seen a 50% increase since 2000[62], and the number of consultants and GPs available to work in the NHS by 2020 is forecast to rise further.

- *Undergraduate medical school places will grow by 25%* adding an extra 1500 places, starting with 500 extra places in 2018 and a further 1000 from 2019. These will be mainly geared to producing more of the doctors the NHS needs such as GPs and psychiatrists. This expansion is currently being consulted upon.

- *Expand GPs numbers.* HEE will train over 15,000 GPs between 2015 and 2020, GP trainee numbers have gone up 10% year on year since 2015, and HEE will target a further 231 places in 2017/18 to ensure the target is met of 3,250 GP trainees per year. The initial round of applications for 2017/18 is 5% up on the equivalent stage last year. (See Chapter Three for more detail on primary care workforce expansion.)

- *Tackle pressures on doctors in training.* **Junior doctors** are a crucial part of the NHS workforce, and the NHS needs to do a better job of engaging with the senior doctors of the future. HEE, NHS Improvement, NHS Employers and their partners are committing to tackle head on non-contractual pressures confronting junior doctors. Following consultation with junior doctors over recent months, action to improve working conditions will include these first steps:
    - Ensure doctors receive their proposed rota a minimum of eight weeks and final rota by six weeks before they start new rotations, as specified in the code of practice agreed by HEE, NHS Employers and the BMA. From October 2017, NHS Improvement will monitor trusts' adherence to the six week standard monthly, with a review after six months. HEE will ensure trusts have trainee details 12 weeks before rotations begin.
    - From this year, provide Specialty Training applicants with an online 'Swap Shop' allowing applicants to swap with others in their cohort or into vacant places, alongside an improved process for trainees wanting to move regions. Also a guaranteed training location for doctors who need to be in a particular region because of ill health or disability, or because they care for someone who is unwell or disabled.
    - From April 2017, streamline the process for doctors moving between trusts to reduce the duplication of pre-employment checks, mandatory and induction training, starting at a regional level.
    - Introduce, in 2017/18, a new programme making £10 million available for HEE to implement new plans with the Colleges to improve support for doctors returning to training after maternity leave and other approved time out.
    - Improve engagement with senior clinicians. Guardians of safe working hours and directors of medical education will set up a junior doctors' forum in each trust. From June 2017, NHS Improvement will make new information resources available to facilitate engagement, and work with HEE and the GMC to ensure adequate engagement is taking place.
    - We commit to continuing to engage with junior doctors locally and nationally, and to taking forward proposals outlined in HEE's recent progress report.

Action will be taken to address **specific staff shortages**, including:

- *Emergency Medicine*: HEE is running an expanded intake of the run-through ACCSEM course, and will add an extra year of 75 additional training posts.

- *Endoscopists*: HEE will operate an accelerated programme to train non-medical endoscopists, with the first 40 staff completing their training in 2016 and another 160 by the end of 2018.

- *Ultrasonography*: We will train 200 healthcare professionals in sonography by 2019/20 to support maternity services.

- *Radiology*: expanded training to build imaging capacity, growing the number of new CCT holders from the current average annual output of approximately 170 to 230 by 2021/22.

The NHS will continue to develop **new professional roles**, including doubling the number of Nursing Associates to 2000 this year, continuing to grow the Physician Associate workforce, and expanding clinical pharmacists and mental health therapists embedded in primary care as set out in Chapter Three.

Action on **NHS staff health and wellbeing** will be extended.[63] In 2017/18 all trusts will have a plan in place to improve the health and wellbeing of their workforce. By 2018/19, the CQUIN incentive payment will be paid to NHS providers that improve the health and wellbeing of their staff by 5% (on a 2015/16 baseline), as measured by the staff survey. We are introducing the new NHS GP Health Service, to support doctors suffering from mental ill-health and addiction.

The NHS will become a better and **more inclusive employer** by making full use of the talents of its diverse staff and the communities it serves. On workforce race equality, over the next two years trusts are expected to show year-on-year improvements in closing the gap between white and BME staff being appointed from shortlisting, and reduce the level of BME staff being bullied by colleagues. The programme to improve the employment opportunities for people with learning disabilities will be expanded. And in 2018/19 over four-fifths of trusts, CCGs and national NHS leadership bodies will have set their baseline measurement for the new Workforce Disability Equality Standard and set out their first year action plan. The NHS will work actively with Government to safeguard and secure the contribution made by international nurses, doctors and other staff as the Brexit negotiations proceed.

Leading STPs and ACSs (see Chapter Six) will work with their staff and trade unions on ways of **encouraging flexible working and 'de-risking' service change** from the point of view of individual staff. This could take the form of an NHS staff 'passport' to enable, for example, nurses to work in both primary care and in hospital, helping support team-based working. Since only 52% of staff are currently satisfied with the current opportunities for flexible working, it might also mean discussing with staff side representatives and unions new options to encourage individuals who are currently choosing agency or locum work back in to substantive NHS

employment. The practicability of term time contracts, seasonal hours, and annualised hours contracting will also be tested.

The national leadership bodies will take action to implement the next steps of the 'Developing People, Improving Care' framework for improving **leadership and improvement capabilities** across the health and care system, with a particular focus on systems working, building improvement skills for staff at all levels, and compassionate inclusive leadership. The framework set out a number of immediate actions in 2017/18, including making available support for systems leadership development to each STP footprint, developing the role of local leadership academies, launching a system-wide programme to address discrimination against staff with protected characteristics, supporting organisations to improve talent management, and establishing a national support function for senior leaders. We are also developing specific improvement capability programmes for boards and executive teams and for primary care practitioners, and CQC and NHS Improvement are jointly creating a single 'Well-Led' Framework.

Refreshed workforce planning will now confirm these estimates and requirements. **HEE will publish its annual Workforce Plan in April**. Local Workforce Action Boards will support their STPs in revising, updating and delivering their workforce plans.

CHAPTER NINE

PATIENT SAFETY

Like healthcare systems all over the world there are times when things go tragically wrong. We all understand that healthcare is a people business, and that with the very best intentions people will make mistakes. Improving safety is about reducing risk and minimising mistakes. The NHS has embarked on a journey to become one of the safest healthcare systems in the world.

What's been achieved in England in the last three years?

- A complete overhaul of CQC standards, and comprehensive ratings inspections of all trusts, as well as primary care providers. The CQC has completed its first round of acute hospital inspections which has seen 31 hospitals go into 'special measures' turnaround and 20 come out – including 7 moving to a 'good' rating.
- The introduction of the duty of candour and new protections for those who raise concern and blow the whistle mean that the NHS is now more transparent:
    - Introduction of an Independent National Officer (INO) for whistleblowing based in the Care Quality Commission (CQC) to lead and support a network of individuals within NHS trusts appointed as 'local freedom to speak up guardians'.
    - Consultation on new legislation to prohibit discrimination against applicants believed by the prospective employer to have been whistleblowers, published in March 2017.
    - Whistleblowing statutory framework extended to include student nurses and student midwives, meaning those people are now afforded protection under the Public Interest Disclosure Act; our intention is to extend the definition further to include other healthcare students in 2018.
    - NHS Prescribed Persons for the NHS extended to include NHS Protect, Public Health England, Healthwatch England and Health Education England and Local Education and Training Boards.
- Patient Safety Collaboratives, each established and led locally by an Academic Health Science Network, are now delivering a locally-owned improvement programme in order to create safer systems of care, to learn from errors (including medication errors) and reduce avoidable harm. Sign Up To Safety is a 3 year, voluntary national campaign launched in June 2014 as part of a set of initiatives to reduce avoidable harm, save lives and improve patient safety across the NHS in England.
- NHS Litigation Authority - from April 1st 'NHS Resolution' – has introduced a national Safety and Learning Service to work with NHS organisations, with the use of Scorecards, to help them understand

their claims data to better assess where local interventions would have the greatest impact in reducing high volume or high cost claims. NHS Resolution has also supported the national campaign and in 2015/16 provided over £18m of Sign Up To Safety incentive payments to support local safety improvement plans across the country.

- Rigorous inspection, with CQC's completion in January 2017 of comprehensive ratings of all trusts, primary care and adult social care providers, providing a baseline assessment of the quality and safety of these services. These comprehensive inspections have helped trusts to understand the specific areas where improvements are needed and to take targeted action, and have provided increased transparency on performance for people who use services.

Key improvements for 2017/18 and 2018/19

- *Preventing healthcare acquired infections*. The NHS, led by NHS Improvement, will build on its success in reducing the incidence of MRSA bloodstream infections and C. difficile infections to make the same progress on Gram-negative infections such as E. coli, Klebsiella and Pseudomonas bloodstream infections. By 2020/21 the level of such healthcare associated infections will fall by 50%. This will be achieved with a system-wide approach by relevant providers and commissioners:
  - Extending mandatory data collections to more cases and publishing and learning from locally comparable data on key infections published by Public Health England.
  - Following guidance and tools developed by NHS Improvement to support local teams to prevent Gram-negative bloodstream infections.
  - Giving E. coli infections the same level of priority as MRSA and Clostridium difficile through, for example, displaying numbers of infections on ward information boards.

- *Maternity safety*. 44 Local Maternity Systems will be in place from April 2017, leading and delivering transformation of maternity services by implementing *Better Births* for their STP, including:
  - Providing more personalised, safer maternity services with women having access to unbiased evidence-based information. Women will be better able to make choices about their care and have more continuity of care during the ante natal, birth and postnatal periods. Seven 'early adopter' areas delivering new models of maternity care for 125,000 births a year and over 15% of the population by the end of 2018, including offering improved continuity of care to over 20,000 women.
  - Working to achieve the national maternity ambition to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon

after birth by 20 per cent by 2020, demonstrating progress towards the national ambition to reduce rates by 50 per cent by 2030.

- *Learning from deaths*. We want the NHS to become the world's largest learning organisation, with a culture that uses all sources of insight, including from complaints[64], to improve services and quality of care, particularly for the most vulnerable. As part of the implementation of the CQC report Learning, Candour and Accountability, trusts will be expected to have proper arrangements for learning from deaths of patients in their care. From April 2017 trusts will be asked to publish data on all deaths judged as likely to have been caused by problems in care – along with actions taken to learn and prevent such deaths in future. This information will be provided quarterly and summarised in each organisation's annual Quality Accounts. Alongside such learning, the NHS will also:
  - Improve support to and communication with bereaved families and carers.
  - Improve the standards and understanding of data on harm and mortality.
  - Ensure that services for people with learning disabilities and mental health problems are a core part of this learning.

- *Improving inspections.* The CQC will develop a more targeted, responsive and collaborative approach to regulation, including specifically considering how to regulate new care models and complex providers. CQC will work with NHS Improvement to deliver the Use of Resources rating of NHS acute trusts.

- *Improving investigations*. From April 2017 the new Healthcare Safety Investigation Branch will be operational, undertaking up to 30 investigations where learning from patient safety can be maximised, and advising the NHS on how to improve its own investigations. Revised guidance on investigating serious incidents will also be published by NHS Improvement. Together these changes should ensure safety incidents are investigated appropriately, to ensure patient concerns are allayed and learning is spread quickly across the NHS.

- *Reducing medication error*. We will also develop plans to reduce the level of medication error across the NHS, ensuring that patients can always be confident that the medicine they are prescribed is the right one for them.

- *Patient Safety Incident Management system (PSIMS)*. NHS Improvement will develop and deliver a new Patient Safety Incident Management System. This will be designed for all healthcare settings and will make it easy and rewarding to record patient safety

incidents, provide feedback, and enhance learning from what has gone wrong.

- *Global leadership for patient safety*. The NHS approach to patient safety is widely recognised as world-leading. We continue to work with national and international partners to ensure we can best benefit the safety of patients in England, for example through contributing to and leading WHO patient safety initiatives and the pan-European Patient Safety Expert Group.

CHAPTER TEN

HARNESSING TECHNOLOGY AND INNOVATION

The major work programmes mapped out in this Plan are underpinned by an agreed, costed and phased NHS technology plan, building on the recommendations of the Wachter review. It will simplify patient access to care, in the most appropriate location, while supporting people in managing their own health. Specifically, during the coming two years we will implement solutions that:

- Make it easier for patients to access urgent care on line.
- Enable 111 to resolve more problems for patients without telling them to go to A&E or their GP.
- Simplify and improve the online appointment booking process for hospitals.
- Make patients' medical information available to the right clinicians wherever they are.
- Increase the use of apps to help people manage their own health.

Helping people manage their own health

The way that people use services has changed over the past ten years, often expecting to have the option of accessing services online or by telephone. Over the next two years the NHS will make very significant steps towards increasing how its services can be accessed online, whilst remembering that healthcare is about people and that many patients want and need the reassurance of a real person to talk to face to face.

The NHS has led the world for ten years with its health and care website "NHS Choices" www.nhs.uk which provides comprehensive and trusted advice on conditions and services. In 2016 there were more than 1.5 million visits per day of NHS Choices; over 550 million through the year. Progress has also been made in enabling patients to access their GP record online: 95% of GPs offer online appointment booking, repeat prescriptions and access to their summary care record. 10.4 million people are now registered for online services with 1.9 million repeat prescriptions ordered online in February 2017, 1.1 million appointments managed online and 1 million views of patient records in the same period.

- *NHS apps.* In Spring 2017 we will launch the NHS Digital Apps Library with the initial offer including at least 20 apps with categories for Mental Health and Diabetes. This will comprise three tiers of application – 'NHS approved' apps which have a published evidence base, assessed by a process developed with NICE, demonstrating that

they can help a person manage and improve their health; 'NHS connected' apps which means that they have been tested and approved for connection to NHS systems, allowing you to download information from NHS systems into the app; and 'Health apps' which will be directory of other health applications which you may choose to use. From April 2017, developers will have the ability to self-assess themselves against NHS criteria, such as where they store your data and whether they sell or use your data for other purposes. The 'NHS connected' category will become vibrant during 2017 and 2018 as we make it easier for app developers to connect to NHS data sources.

- *Support for children's health.* From April 2017 parents in London will have access to their children's health record through the online "red book".

- *Personal online access*. By September 2017 we will have upgraded NHS Choices to become NHS.UK, which will offer a more personalised and tailored experience. It will then be possible for patients to book appointments and access their personal health record through NHS.UK.

- *Free wifi in GP surgeries.* Building on the success of the NHS wifi early adopter stage, which commenced in January 2017 and saw us roll out free wifi for patients and professionals across approximately 1,000 surgeries, the wider rollout to the remainder of GP surgeries over the next year, subject to HM Treasury approval, will help encourage the uptake of online health services.

Digitising hospitals

While the NHS leads the world in the use of IT in primary care, the adoption of information technology in the acute, community and mental health sectors lags behind. In 2015, NHS England conducted a survey of information technology adoption, known as the Digital Maturity Assessment. From this we are able to see the best, the worst and the large number in the middle. In September 2016 we announced the first 12 Global Digital Exemplar acute trusts and since then we have announced four more.

Global Digital Exemplars. These organisations are the most advanced IT hospitals in the NHS and have committed to work to become world class exemplars for the rest of the NHS to learn from. Their task is not only to become great, but to work with other acute trusts to develop a blueprint that can be deployed to other hospitals, reducing the time and cost for further adoption. Our intention is that, in the future, hospitals won't merely choose an IT vendor, they will choose a hospital that they want to partner with and implement the same system, keeping the IT 80% the same and making only the 20% of changes that are absolutely necessary to meet local needs. Subject to HM Treasury capital approvals, the first **Acute GDEs** are:

- Alder Hey Children's NHS Foundation Trust

- Cambridge University Hospitals NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Imperial College Healthcare NHS Trust with Chelsea and Westminster NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Salford Royal NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- West Suffolk Hospitals NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

In order to spread the learning and ensure that the blueprints really are suitable for other hospitals, the GDEs will be partnered with "fast followers" who will work with the GDEs during their implementation and begin deploying the blueprints elsewhere in parallel. The GDEs are currently identifying their "fast follower" sites, and these will be confirmed over the coming quarter.

Over the past few months we have also conducted a search for **Mental Health digital exemplars**. Subject to HM Treasury capital approvals, successful organisations will be:

- Berkshire Healthcare NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Worcestershire Health and Care NHS Trust

- *NHS Digital Academy*. By September 2017 we will launch a new academy to train a new generation of Chief Information Officers and Chief Clinical Information Officers. By increasing the skills to align information technology with business and clinical needs we will increase the chances of successful adoption of new information technology and its use to drive quality and efficiency.

Technology to support the NHS priorities

Urgent and Emergency Care

- NHS 111 Online. Throughout 2017 we will be working to design online triage services that enable patients to enter their symptoms and receive tailored advice or a call back from a healthcare professional, according

to their needs. We will be testing apps, web tools and interactive avatars in local areas and using detailed evaluation to define the best approach. By December 2017 all areas will have an NHS 111 online digital service available that will connect patients to their Integrated Urgent Care via NHS 111.

- NHS 111 Telephone: Clinical decision support systems are well used throughout the health system. They have supported our ambulance services and urgent care services for many decades. The developments in technology mean these systems are improving exponentially - becoming more personalised and intelligent and able to process more data in real time. From summer 2017 we will be developing and testing new specialist modules of clinical triage for Paediatrics, Mental Health and Frailty and demonstrating the impact of risk stratification. By March 2019 an enhanced triage will be available across integrated Urgent Care, with the potential to also support Urgent Treatment Centres, Care homes and Ambulance services.

- To ensure that patients get the right care in the most appropriate location, it is also important that clinicians can access a patient's clinical record. By December 2017 every A&E, Urgent Treatment Centre and ePrescribing pharmacy will have access to extended patient data either through the Summary Care record or local care record sharing services. We will also have access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and UTCs.

- By December 2018 there will be a clear system in place across all STPs for booking appointments at particular GP practices and accessing records from NHS 111, A&Es and UTCs supported by improved technology APIs and clear standards.

- During 2017 we will begin the work with vendors to seamlessly route electronic prescriptions from NHS 111 and GP Out of Hours to pharmacies via the Electronic Prescription Service (EPS). This will speed up the supply of medicines, and significantly reduce the time and cost involved.

Elective access and unwarranted variation

Analysis of activity across the NHS shows very large variations in the number of patients being referred to hospital outpatients, being followed up repeatedly in outpatients and receiving elective operations. These variations cannot be explained by differences in health need and are often present between different GPs in the same area and different doctors in the same hospital. Patient and clinician time is wasted on repeating tasks because the information collected by another clinician is not available, and straightforward tasks that could be undertaken by many patients online are still done by clinical staff.

- By summer of 2017 GPs will be able electronically to seek advice and guidance from a hospital specialist without the patient needing an outpatient appointment.

- In the summer 2017 an updated online patient appointment system will be launched, providing patients with the ability to book their first outpatient appointment with access to waiting time information on a smartphone, tablet or computer. Alerts will advise patients which hospitals have longer waits so that that they can avoid these hospitals if they wish.

- The NHS e-Referral Service is currently used by patients to arrange just over half of all referrals into consultant-led first outpatient appointments. By October 2018 all referrals will be made via this route, improving patients' experience and offering real financial and efficiency benefits.

Digital contribution to research

The ability to collect, aggregate and analyse the data generated by the NHS is not only critical to delivering the triple aims of healthcare, but also underpins the NHS and wider life sciences research strategies. Interoperability will be key to successfully making use of NHS data to support the life sciences research strategy.

Innovation for future care improvement

The UK has a world-leading life sciences industry which is both a magnet for investment and an engine for economic growth - enhancing productivity, driving healthcare innovation and employing over 220,000 people across the regions of the UK. Many important healthcare technologies - from vaccines to MRI scanners - have been nurtured by our strong science base and universities, innovative culture and leading healthcare system.

Over the past year alone:

- NHS England agreed to commission nationally 33 ground-breaking new treatments, including auditory brainstem implants for people with profound hearing loss; microprocessor controlled prosthetic knees for people with lower limb loss; and Ivacaftor for young children with cystic fibrosis.
- A new Innovation and Technology Tariff (ITT) aims from April 2017 to expedite uptake and spread of innovation across the NHS. The first six innovations will mean 160,000 patients eligible to benefit. These products include those that reduce obstetric anal sphincter injuries as a result of episiotomies; reduce incidence of ventilated associated pneumonia which causes between 3,000 and 6,000 deaths every year; and provide effective treatment for clostridium difficile without the use of antibiotics.

- We have also established a national Clinical Entrepreneurs Programme, and the NHS Innovation Accelerator which has supported adoption of innovations that at least 390 organisations are now using.
- 13 new NHS Genomic Medicine Centres have been established across the country to collect samples, engage patients and family members in the programme to establish the infrastructure needed to make genomic medicine a routine part of NHS care. These centres have collected over 25,000 cancer and rare disease samples. Over 20,000 whole human genomes have been sequenced. By sequencing the genomes in these samples not only can we better understand these diseases, we can also target specific treatments on the patients who will benefit most from them.
- PHE has supported ground-breaking research which has led to a new technique for sequencing the genome of the bacteria that causes tuberculosis. This technique will enable faster and more targeted treatment of people with TB. Speedy diagnosis will also help scientists detect and respond to potential outbreaks as they happen. This matters since the UK still has one of the highest rates of infection in Europe.
- The NHS has invested in the Small Business Research Initiative Programme to support 80 small and medium enterprises.

For 2017/18 and 2018/19 the NHS will take further steps to enhance our global position:

- Begin the roll out of new treatments funded by NHS England's specialised commissioning, including mechanical thrombectomy treatment for stroke.
- NHS England will publish an Implementation Plan setting out its delivery contribution to the UK Strategy for Rare Diseases in 2017/18
- Expand the NHS's genomics capability, collecting 50,000 samples in 2017/18 rising to 90,000 in 2018/19. By the end of the 2018 calendar year, 100,000 whole human genomes will have been sequenced. By the end of 2018/19, we will also have developed a genomic medicine service for England, underpinned by a new consolidated genomic laboratory infrastructure and facilitated by informatics, data and analytical platforms to enable the sequencing data we generate to improve clinical practice.
- Create a more fertile environment for clinical trials by enhancing the Health Research Authority, harmonising approval and recruitment processes, and streamlining bureaucracy including through the use of digital tools.
- One of the unique features of the NHS is the central role of general practice and this creates valuable opportunities to study 'longitudinal' data. NHS England and MHRA increased the number of GP practices registered on the Clinical Research Practice Data Link system (CPRD) by 25% in 2016/17 and in 2017/18 we will recruit an additional 1800-2000 practices to CPRD.
- In 2017/18, the NHS Innovation Accelerator will select another round of innovations that address the population challenges prioritised by STPs.

- Academic Health Science Networks and 'test beds' will take collective responsibility for driving national adoption of proven innovations, in line with the Accelerated Access Review.
- The NHS's international reputation has already led to major agreements with China, the Middle East and Latin America over the last few years, helping put money back into the NHS and UK economy and strengthening our investment in R&D. Healthcare UK (the export organisation for the UK's health and care sector) has helped health sector organisations win over £5 billion worth of contracts over the last three years. Healthcare UK aim to grow our exports by around 15% per annum to 2020.

More generally, under the banner of the government's Industrial Strategy, the life sciences sector deal will bring government and the NHS together with industry and charities to create new jobs and economic growth across the UK as well as aiming to improve care for NHS patients. The NHS is a key contributor and a committed partner to providing an environment where technologies can be developed and tested, and used to transform services to improve outcomes and reduce cost. This opportunity sits alongside further strengthening of the science base and clinical trials capability and the creation of an environment which enables small biotech and medtech companies to thrive and grow, and enhancement of our medicines manufacturing capabilities.

As medicine transforms over the next 20 years, the cutting-edge technology in our Universities combined with the NHS presents unique conditions to create new industries, companies and jobs based in the UK and transform the way innovation is delivered to patients, offering an attractive place to research and test new treatments in partnership with innovators. Potential areas include artificial intelligence, the application of genomics to medicine, the development of a range of new diagnostic tools, and therapies for conditions that will enable more healthy aging.

CHAPTER ELEVEN

CONCLUSION

The NHS Five Year Forward View reminded us that the Health Service was born at a time of national austerity and international strife:

> "It was founded in 1948, in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.
>
> Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.
>
> Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making.
>
> Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in our analysis suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government."

That remains our considered view.

So while this Plan doesn't seek to be the final word on the future of the NHS, it does chart practical and realistic next steps for the next few years.

Get these right, and patients, staff and the taxpaying public will all notice the difference.

And the NHS will earn the right to make its case for their continuing support, now and for future generations.

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- Q1 performance payment will be made if on the A&E 4 hour target a trust achieves the higher of either 90% or an improvement on its own January-March 2017 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off by the relevent Regional Director and the National UEC Director.
- Q2 performance payment will only be made if a trust meets the achieves the higher of either 90% or an improvement on its own Q2 2016/17 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off from the relevant Regional Director and the National UEC Director.
- Q3 performance payment will only be made if a trust achieves the highr of either 90% or an improvement on its own Q3 2016/17 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off from the relevant Regional Director and the National UEC Director.
- Q4 performance payment will only be made if a trust meets 95% in March 2018.

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Trust Board Meeting – April 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

4-14 Summary report from Quality C'ttee, 10/04/17 Committee Chair (Non-Exec. Director)

The Quality Committee has met once since the last Board meeting, on 10th April (a 'deep dive'). Regrettably, the meeting was not quorate as only 1 Non-Executive Director was able to be present, but the meeting proceeded as scheduled.

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

- A review of progress with **actions agreed from previous meetings**, which included an update on the current issues with the Urology service and Medway NHS Foundation Trust
- The Clinical Director for Trauma and Orthopaedics (& former Trauma Director) attended to give a presentation on the **outcome and follow-up from the South East London, Kent and Medway (SELKaM) Network Review visit in Sept. 2016**. The Committee heard that the hospitals at Tunbridge Wells, Medway (Maritime) & Ashford (William Harvey) became Trauma Units (linked with Kings' College Hospital as the Major Trauma Centre) in 2010; and SELKaM had been the best performing Network in the country for patient outcomes for 2014 & 2015. It was noted that an NHS England Peer Review visit was held on 13/01/15, followed by a SELKaM re-visit on 07/09/16, & the visits assessed: Reception & Resuscitation, Definitive Care, & Rehabilitation. No immediate risks were identified, but 1 'serious concern' & some other 'concerns' were raised. The Committee was given assurance of the response to each, which included confirmation that the 'serious concern' (which related to the lack of a full-time Programmed Activity (PA) session for the Trauma Director) had been addressed, as Dr Milner had now taken over the role and been allocated 1 PA. It was also noted that the Trust would hear the formal feedback from the SELKaM Network later in April 2017
- The Clinical Director, Diagnostics & Pharmacy / Clinical Lead for Length of Stay then accompanied the Chief Operating Officer for a **review of actions to reduce Length of Stay** (LOS). The progress made so far was discussed in detail, as were the risks and challenges that remained, which included the need to change 'hearts and minds' to ensure staff accepted that reducing LOS would create capacity. Despite the risks, the opportunity for transformational change management was acknowledged, although this required continued persistence and determination. Given the importance of the issue, it was agreed to schedule a further review at the Quality Committee 'deep dive' meeting in October 2017. It was also agreed to schedule a review of the Trust's plans for developing Acute Frailty Units at the Quality Committee 'deep dive' meeting in August 2017
- It was noted that the **June 2017 'deep dive' meeting** would involve the re-scheduled "Detailed update on the working relationships within Obstetrics and Gynaecology" (this was scheduled for April, but the Clinical Director for Women's & Sexual Health had to withdraw because of clinical commitments); a "Follow-up review of End of Life Care"; and an "Update on the actions being taken in response to the Trust's higher than expected mortality rates"

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

- The Trust Secretary should provide the Medical Director with the report outlining the Trust's response to the "Acute Kidney Injury: Adding Insult to Injury" report from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) which had previously been submitted to the Quality Committee
- The Medical Director should review the recently-issued reports from the NCEPOD, and determine whether any of the subjects would be suitable for review at a 'deep dive' meeting

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – April 2017

Maidstone and Tunbridge Wells NHS Trust

4-15	Summary of the Trust Management Executive (TME) meeting, 19/04	Deputy Chief Executive

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

- In the **safety moment**, the Chief Nurse highlighted the work taking place to mark the safety theme for the month, which was patient and staff safety (with a focus on incident reporting)
- The draft **Annual Governance Statement for 2016/17** was reviewed and endorsed (this will now be submitted to the External Auditors, and Audit and Governance Committee (in May))
- The proposed Plan for the **"Hospital at Night" initiative** was reviewed, and it was agreed to ensure that the Director of Medical Education (DME) was involved in its development. Clinical Directors were also asked to nominate prospective clinical candidates to be involved in the initiative and/or chair the "Hospital at Night" Programme Board
- Proposed **Boarding guidelines** were reviewed, for when patients needed to reside on a Ward without an allocated bed space (which occurred during recent periods of inpatient pressure)
- A revised **Sustainable Development Management Plan (SDMP)** was reviewed and endorsed (subject to some agreed amendments). The Plan is required to be approved by the Trust Board, and is therefore enclosed in Appendix 1, for approval.
- Updates were given on the **national 7 day service programme** and the **Financial Recovery Plan (FRP)/Financial Special Measures (FSM),** which included the year-end financial position
- The **Performance for month 12**, 2016/17 was discussed. The issues raised included the continuing efforts being made to understand the increased Hospital Standardised Mortality Ratio (HSMR), the improved performance on the A&E 4-hour waiting time target, the continued lack of elective activity and impact on the 18-week Referral to Treatment (RTT) target, and performance on the Cancer 62-day waiting time target.
- Representatives from the Business Intelligence department attended to discuss a report on **trends in A&E attendances**, which clearly demonstrated the sustained increase over previous years, and the sizeable challenge posed by the increasing age of the population
- The year-end **infection prevention and control** position was reported, which confirmed there had been 28 cases of Clostridium difficile, against the limit of 27. The economy-wide targets relating to E. Coli bacteraemia were 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 large number of Nursing vacancies (for which it was noted that a report would be considered by the Executive team w/c 24/04) and patient flow. For Planned Care, the key issues were continued low levels of elective activity; the Business Case for the future use of Theatre 6 at Tunbridge Wells: the 62-day Cancer wait target: the increasing RTT backlog (which was now at its highest ever level, although $^{1}/_{3}$ of this related to Outpatients); and the increasing backlog for Histopathology reporting (where it was agreed that the next Informatics Steering Group meeting should discuss request to purchase further licences for voice recognition software, to assist in the timely reporting of histopathology specimens). For Women's, Children's & Sexual Health, the key issues were the number of births during 2016/17 (which was the highest ever level), and the shortage of Middle Grade Doctors in Paediatrics
- The key issues discussed at the latest **Clinical Directors' Committee** and **Executive Team meetings** were noted, which were similar to the issues discussed at the TME
- The latest position on the **national 7 day service programme** was given, and the proposals for the **implementation of the 'Listening into Action' programme** were presented
- The **case for change for the Kent and Medway STP** was received, as was NHS England's report**,** "**Next steps on the NHS five year forward view**"
- The **year-end review of the Board Assurance Framework** was considered, and the latest position regarding the **2016/17 Internal Audit plan** was noted
- The Chief Nurse reported on the **national changes to the Midwifery Supervision statute, and Trust response**
- The **impact of the recent bed reconfiguration at Tunbridge Wells Hospital** was reported
- The summary report from the **Trust Clinical Governance Committee** was received, as was

the 3 **recently-approved Business Cases** (which included the "Bloodhound Phase 2" system)
- An update on the **implementation of the replacement PAS+** noted the intention to aim for a 'go live' date in autumn 2017 (though this had not been confirmed)
- Formal updates were received on the recent activity of the TME's main **sub-committees** (the Clinical Operations & Delivery Committee, Health & Safety Committee and Policy Ratification Committee)

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. Information and assurance
2. To approve the Sustainable Development Management Plan (SDMP) (Appendix 1)

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

Maidstone and Tunbridge Wells NHS Trust

Sustainable Development Management Plan

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1. Vision, Strategy and Scope

1.1. Sustainability Vision

The Sustainability Vision of the Trust is “The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust”

1.2. Sustainability Strategy

The Trust recognises that in delivering healthcare services its sites and operations may have adverse impacts on the environment and it is essential that these are minimised and maintained as such through continuous monitoring, mediation and changing culture around the environment and sustainability. The trust is committed to providing healthcare and services to the populations of today without compromising the opportunities of the populations of tomorrow.

The Trust recognises that, to deliver sustainable healthcare, it must achieve positive social impacts, must mitigate its impacts on the environment and must achieve a level of financial efficiency and effectiveness.

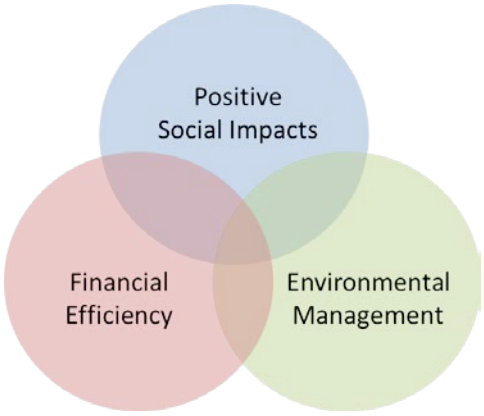


Figure 1: Components of Sustainability

The Trust has developed a Sustainability Strategy that will be implemented through a Sustainable Development Management Plan (SDMP) that comprises of 6 key areas of focus:

- Corporate Vision and Governance
- Leadership, Engagement and Development
- Healthy, Sustainable and Resilient Communities
- Sustainable Clinical Care Models
- Commissioning and Procurement
- Operational Management and Decarbonisation

Figure 2 shows the relationship between the Vision, the Policy, the SDMP, the SDMP Action Framework and the EMS to form the sustainability strategy.

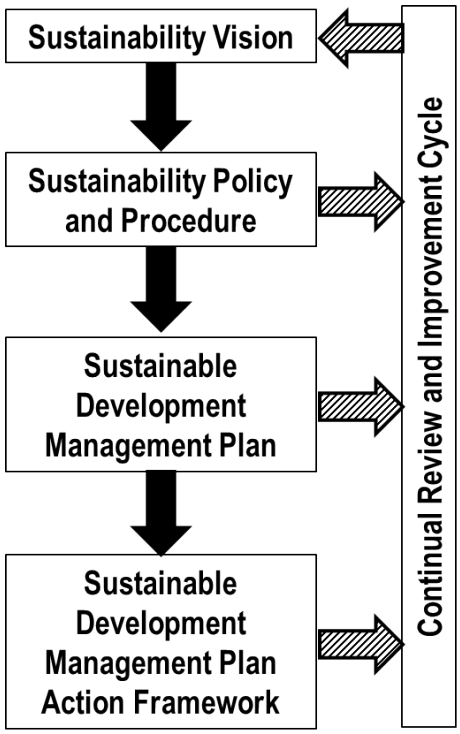


Figure 2: Relationship of the components of the Sustainability Strategy

1.3. Scope

This Plan is applicable across the entire geographical extent of the Trust where the Trust has direct operational responsibility

2. Drivers for Change

The need for an SDMP is driven by different factors, both internal and external to the NHS and the Trust.

The Kent and Medway Sustainability and Transformation Plan (STP), driven by central Government, is reviewing the services that are being provided by each Trust and the ways that they support and interact with each other to ensure they are as sustainable and efficient as possible and to remove duplication and inefficiency.

The Trusts themselves are also required to review *how* they are delivering the services to ensure that they are operating in the most efficient and sustainable manner possible

2.1. Financial

- **Operational Budget Constraints**

The challenge to the health and care system is clear. Kent, like the rest of England, has an ageing population that will put increasing demands on the system, and will require long-term complex care. This, along with unhealthy lifestyle behaviours and the rising cost of technology means that nationally the NHS faces a £30bn funding gap by 2021.

- **Energy Costs**
  The costs of energy are set to remain volatile in the short term and are predicted to rise in the medium to long term. The wholesale energy price is dependent upon many natural and geopolitical variables, none of which are within the immediate control of the Trust.
  In 2013/14 the Trust spent a total of £4,039,990 on the procurement of Gas, Electricity, Biomass and CRC Compliance

- **Water Costs**
  The deregulation of the commercial water industry in April 2017 means an element of uncertainty in the water industry. Whilst the industry will undoubtedly become more transparent and competitive the predictions are that, ultimately, prices for water supply and disposal will increase year on year.
  In 2013/14 the Trust spent a total of £684,307 on Water Supply, Sewerage and Effluent Treatment.

- **Material and Services Costs**
  The increase in the cost of materials and services, whilst being limited through effective procurement strategies, will continue to increase in line with inflation. External factors, such as Brexit, have potential to adjust the trajectory of increase to an unknown extent.

2.2. Legislation and Performance Targets

- **Climate Change Act 2008**
  The Climate Change Act (2008) was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. The 80% target is set against a 1990 baseline.
  The act enables the UK to become a low carbon economy. It sets in place a legally binding framework allowing the government to introduce measures which will achieve carbon reduction and mitigate and adapt to climate change.

- **NHS Carbon Reduction Target**
  As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law. Contributing to the Climate Change Act target with a 34% reduction in carbon emissions by 2020 is a key measure of our ambition across the country. Reduced environmental impact will be measured against the target of 34% reduction in CO2e emissions by 2020 and be well placed to meet the 50% target by 2025.

- **Public Services (Social Value) Act 2012**
  The Public Services (Social Value Act) was passed at the end of February 2012 and came into force in January 2013. Under the Act, for the first time, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

- **Modern Slavery Act 2015**
  The Modern Slavery Act 2015 is designed to tackle slavery in the UK. The Transparency in Supply Chain Provisions require commercial organisations to publish an annual statement regarding slavery within their supply chain if they have an annual turnover above a threshold (£36 million). However, the Department of Health has confirmed that publicly-funded NHS activities were not intended to be within the scope of the Act, and therefore the £36 million threshold only applies to profit-making activities.

2.3. Demands upon Services

Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge & Malling and Tunbridge Wells, the following changes are predicted over the next 20 years:

- The overall population of the four districts is expected to increase, with the highest increases in Maidstone for 65 years or over (11% increase) and Tonbridge & Malling for people aged over 85 years (26%).

- The under-five population will remain fairly constant with an increase of less than 4% over 20 years.

- The population aged 5-19 will increase by just over 12.5% across that period. The under 15 population will increase by 12% over his period. The number of people aged between 16 and 64 years will increase by 11% across that period.
- The population of 65+ is set to increase by 58.93% from 2015 to 2035 increasing from 101,000 to 152,600 people and during the same period, within this the population of 85+ group is predicted to increase by 127.3% during the same period, from 12,100 to 27,500 people.

  This population increase has serious implications for health and care delivery from both a financial and activity perspective.

- Older people have the greatest risk of their health being affected by cold temperatures. The majority of excess winter deaths are in people 75 years old

- The prevalence of multi-morbidity increases substantially with age

- The prevalence of dementia increases with age and these patients need additional elements in their care

3. Aims and Objectives

The Trust believes that the Sustainability vision is achievable through the successful implementation of the aims and objectives detailed below:

3.1 The Trust has a clear vision of its Sustainability Goals

3.2 Responsibility and accountability for sustainable development is clear in the Trust

3.3 Leaders at all levels have engaged widely and developed a narrative for sustainable development that aligns visions, priorities and delivery

3.4 The Trusts approach to environmental and social responsibility is supported and owned by local people.

3.5 The Trust has consolidated partnerships and makes use of its leverage within local frameworks.

3.6 All staff are aware of the benefits of acting sustainably, have the competencies and skills to implement sustainability initiatives and are empowered to challenge unsustainable behaviour

3.7 The Trust actively supports programmes and schemes to improve the health and fitness of its stakeholders and staff

3.8 The Trust has a network of engaged and enthusiastic volunteers form the local community who capitalise on positive experiences and support the operations of the Hospital

3.9 The entire environment in which the Trust delivers care will promote wellness, will minimise emissions and will be resilient to changes in climate

3.10 The trust understands and minimises the current and future risks to the organisation from climate change

3.11 Adaptation plans are in place that link to business continuity and emergency planning processes

3.12 Transformation of the Trust services deliver improved health outcomes coupled with social and environmental benefits.

3.13 The Trust assesses and minimises the Environmental, Financial and Social Impacts of its procured goods and services

3.14 The Trust operates an environment where non essential energy use is eliminated

3.15 The Trust delivers efficient low carbon transport services

3.16 The Trust is operates an environment where non essential water use is eliminated

3.17 The trust applies the Waste Hierarchy in all aspects of its operation, diverts 100% of waste from Landfill and maximises recycling

3.18 The Trust operates in a manner that assesses the environmental aspects of its activities and mitigates any impacts associated with them

4. Targets

The targets of the SDMP are as follows:

4.1 Reduce scope 1 and 2 carbon emissions by 28% by 2020/21 against a 2013/14 baseline in line with the NHS Carbon Reduction Target of 80% by 2050

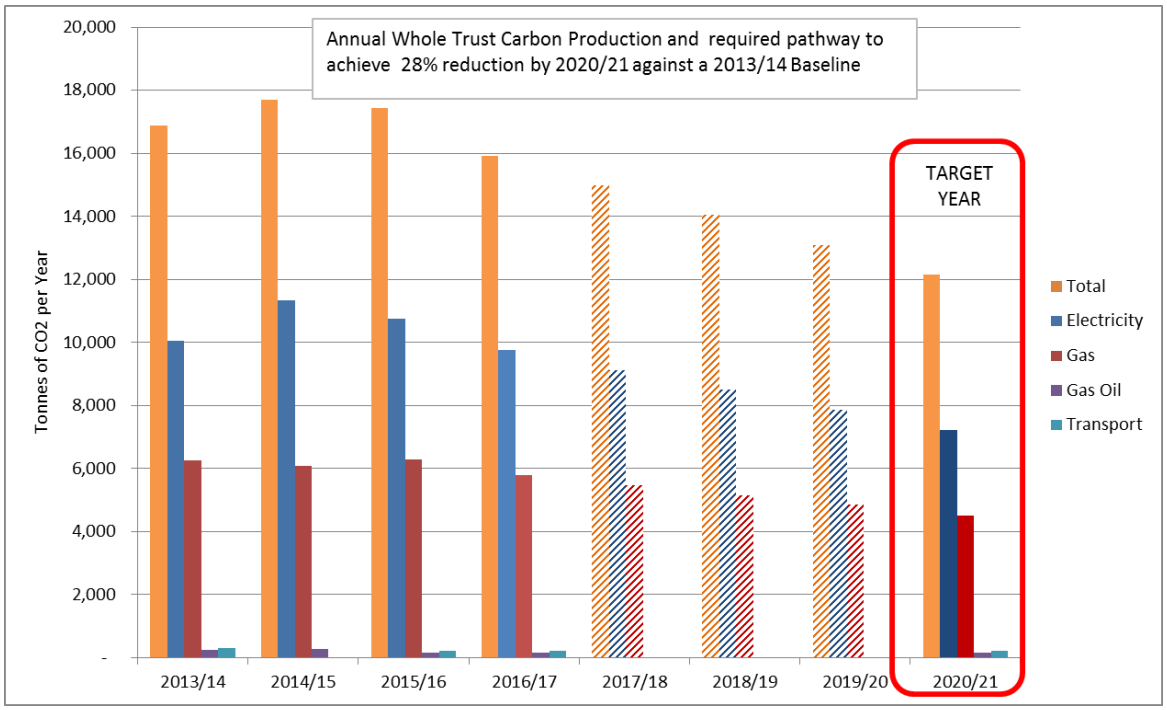
The table and graph below shows the baseline years scope 1 and 2 emissions in Tonnes of Carbon Dioxide, the performance of subsequent years and the required emissions to achieve the target of 28% reduction.

2014/15 and 2015/16 were disappointing and showed an increase against the baseline year but this trajectory has been significantly reduced by a highly successful 2016/17 period.

Target Reduction against a 2013/14 Baseline	28%

Scope 1 and 2 Carbon (tCO2) Total and Target

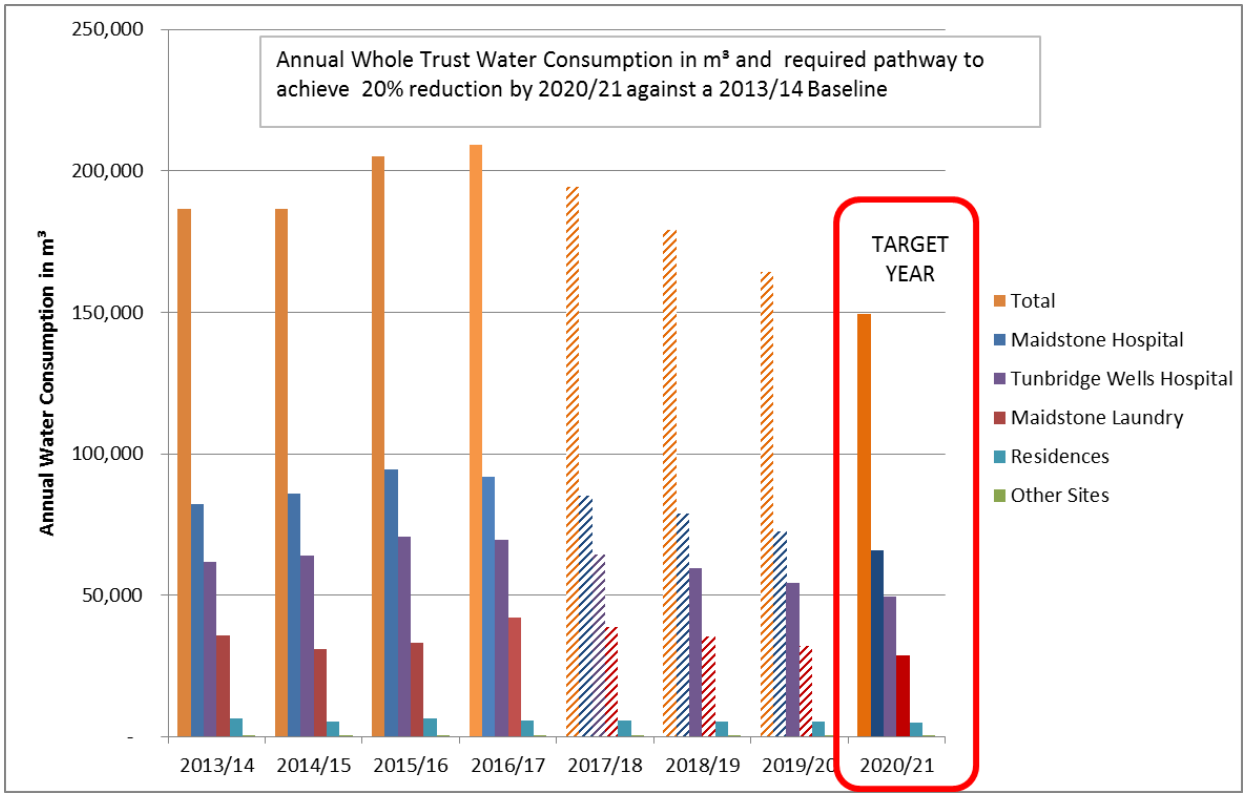
Year	Electricity	Gas	Gas Oil	Transport	Total	% Reduction Achieved against Baseline	Year on Year Reduction Achieved / Required	Annual Reduction Required (tCO2)
2013/14	10,043	6,269	242	321	16,875			
2014/15	11,348	6,073	282		17,703	4.9%	4.9%	
2015/16	10,755	6,284	161	228	17,428	3.3%	-1.5%	
2016/17	9,748	5,793	147	222	15,911	-5.7%	-8.7%	Elec
2017/18	9,119	5,474			*14,971*	*-11.3%*	*-5.9%*	629
2018/19	8,490	5,154			*14,030*	*-16.9%*	*-6.3%*	Gas
2019/20	7,860	4,834			*13,090*	*-22.4%*	*-6.7%*	320
2020/21	*7,231*	*4,514*	*174*	*231*	*12,150*	*-28.0%*	*-7.2%*	Total
2013/14 is Baseline Year		RED text is required emissions to remain on target trajectory						940



4.2 Reduce absolute water consumption by 20% by 2020/21 against a 2013/14 baseline

The table and graph below shows the baseline years consumption in cubic metres, the performance of subsequent years and the required consumption to achieve the target of 20% reduction.

WATER (m³) Total and Target						
Year	Maidstone Hospital	Maidstone Laundry	Tunbridge Wells Hospital	Residences	Other Sites	Total
2013/14	82,345	35,719	61,833	6,370	303	186,570
2014/15	85,788	30,978	64,012	5,184	479	186,441
2015/16	94,521	33,006	70,861	6,272	586	205,246
2016/17	91,821	41,988	69,403	5,665	328	209,205
2017/18	*85,335*	*38,635*	*64,419*	*5,523*	*307*	*194,218*
2018/19	*78,849*	*35,282*	*59,435*	*5,381*	*285*	*179,231*
2019/20	*72,362*	*31,928*	*54,451*	*5,238*	*264*	*164,243*
2020/21	*65,876*	*28,575*	*49,466*	*5,096*	*242*	*149,256*
Annual Reduction Required	6,486	3,353	4,984	142	21	14,987



5. Specific Areas of Focus

5.1. Corporate Vison and Governance

The Trust will make carbon reduction and sustainable development corporate responsibilities and will ensure that they are integrated into the governance and reporting mechanism.

The Trust will have a clear vison of its Sustainability Goals and will ensure that responsibility and accountability for sustainable development is clear within its organisational structures. The targets and

The Trust will produce evidence of its progress towards targets to satisfy the requirements of its regulators and commissioners. In addition the Trust will publish performance information to provide assurance to its stakeholders that the Trust is managing its corporate responsibility commitments.

5.2. Leadership, Engagement, Partnership and Development

The Trust aspires will be a demonstrable leader within the provision of sustainable healthcare and is committed to engaging and partnering at all levels, both locally, regionally and nationally to deliver this ambition. The Trust will ensure that the SDMP is adopted by Heads of Department and Senior Management Team members and is cascaded through the lines of control

The Trust will engage with local stakeholders to ensure that its approach is dovetailed to local initiatives and activities as well as to seek endorsement of and support for its sustainability strategy and actions. The trust is committed to ensuring that local feedback and opinion is recognised within its decision making and that

local community assets and initiatives are embedded within its care provision. The trust is committed to communicating its vision, goals and strategy to local stakeholders and will put in place a communications plan to ensure the openness and transparency of its programmes. The approach is one of supporting and enhancing local activities where they exist and working in partnership with local groups to achieve a common aim.

The Trust is committed to engaging in local, regional and national forums and platforms, both internal and external to the NHS to ensure that it maximises on all potential leverage that is available and benefits from and demonstrates best practice to the wider stakeholder community.

The trust recognises its own staff members are essential and intrinsic to the delivery of sustainable healthcare and is committed to supporting and developing its staff to have the competencies and skills to deliver sustainable healthcare within their specific areas of operation and to challenge and rectify practices that are not complementary to this aim. This will be achieved through the mainstreaming of sustainability into the recruitment process, into job descriptions and daily activities and operations through a comprehensive review of operational procedures and policies.

5.3. Healthy, Sustainable and Resilient Communities

The Trust recognises the inherent value of a healthy community and will actively support programmes and schemes to improve the health and fitness of its local community, stakeholders and staff through direct activities, the use of volunteers and the partnership with local organisations.

The Trust recognises that investing in volunteers is investing directly in its stakeholders and seeks to capitalise on positive experiences and feedback to expand the scale and role of volunteers within the operation of the sites.

The Trust is committed to improving the health and welfare of its staff, both in and outside of the workplace, through the promotion of healthy living options, support services and the partnership with organisations that provide specialist services.

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. The Trust will improve access to its green spaces and natural environments for stakeholders and will maintain and enhance the biodiversity capacity of its managed estate. The Trust will develop and publish a Biodiversity Management Strategy for its entire estate and will engage with local ecological partners and volunteers in its preparation.

The Trust recognises that its buildings and facilities have a significant impact on the environment, both due to the embedded carbon and resource depletion involved in their construction and in the energy consumed and carbon produced in their operation. The Trust will ensure that any refurbishment, redevelopment or new development seeks to minimise the environmental impact and associated carbon footprint of the construction process, the materials used and the subsequent operation of the facility through the use of appropriate technologies and strategies.

The Trust will ensure that any redevelopment or new development of its facilities appraises the potential changes to the climate, the potential effects of those changes on the facility and seeks to mitigate them at the design stage.

The effects of climate change to the Trust have the potential to be severe, and the organisational risk register will be updated to include the appraisal of the legal, financial, infrastructure and service related risks and action plans will be developed to manage the risks that have been identified. The Trust will use standard risk assessment tools and externally available guidance and support to assist with the risk assessment process.

The Trust recognises that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds.

The Trust will prepare plans for the risks identified and will integrate the process of planning with the existing processes for Emergency Planning and Business Continuity.

5.4. Sustainable Clinical Care Models

The Trust is committed to the transformation of its service to deliver improved health outcomes coupled with social and environmental benefits.

The Trust recognises that the way that healthcare services are delivered will need to change to accommodate the changes associated with rising costs, changing population intensities, demographics and locations. Financial and budgetary pressures will continue to challenge the service provision as well as the ever changing and evolving structure of NHS services within the local and regional setting.

The Trust will ensure that environmental and social sustainability assessments are included as a standard within the templates for business case and service redesign templates and will review the models of care and patient pathways to take into account the overhead use of resources and carbon footprint.

The Trust will consider the most appropriate locations of services and facilities to minimise internal travel and will seek to maximise the opportunities presented by technology to facilitate remote and distance meetings.

The Trust will work in partnership with NHS stakeholders to ensure the realisation of the Health and Social Care Sustainability and Transformation Plan (STP) and the integration and redesign of services across Kent and Medway to deliver better standards of care, better health and wellbeing and better use of staff and funds.

5.5. Commissioning and Procurement

The Trust aims to fully assess the environmental, social and financial impacts of its procured goods and services whilst remaining compliant with the systems and procedures established.

The Trust will minimise procurement of new items and will seek to reuse existing equipment where this is operationally viable. The sharing and internal recycling of resources will be promoted and encouraged to all staff and departments

Where procurement is required the Trust will develop tools to assess the lifetime financial and environmental impact of the required item, to include the manufacture, delivery, operational usage, consumable requirement, maintenance, decommissioning and disposal and will seek to use the assessment to influence the outcome of tender review decisions.

The Trust is committed where possible to sourcing all products from certified sustainable and renewable sources and will specify this as a requirement of its supply chain.

The Trust is fully committed to working within the NHS Procurement and Commercial standards and using the standards as a vehicle for improving the efficiency of the systems it operates and the sustainability of the services it provides.

The Trust is committed to fully complying with all relevant aspects of the Public Services (Social Value) Act 2012 and the Modern Slavery (2015) Act and will publish clear statements and guidance for its partners and supply chain.

The Trust is committed to maximising the local economic benefit of its activities through the use of local suppliers and local labour where the skills and experience are available to undertake the required tasks and where the local selection is permissible under procurement guidelines.

5.6. Operational Management and Decarbonisation

The Trust is committed to operating in a manner that eliminates unnecessary energy and water use, utilises equipment and materials effectively, reduces waste production, maximises waste recycling, accurately assesses and mitigates impacts to the environment and causes no environmental damage through accidental discharges or spills.

The Trust will monitor and report upon its energy and water usage and its Scope 1 and Scope 2 emissions on an annual basis and will set internal targets with the aim of reducing the carbon emissions associated with its activities by 28% by 2020 against a 2013 baseline in line with the NHS Carbon Reduction Target of 80% by 2050.

The Trust will create a tangible culture that is intolerant of energy and water wastage, will optimise equipment and systems for efficient operation and will monitor, record and report on the energy and water performance of different geographical areas and departmental zones.

The Trust will identify opportunities for capital replacement and upgrade of equipment and infrastructure that will have an energy and water saving benefit and will prepare relevant business cases and justification.

The Trust is committed to reducing the emissions associated with transport and providing efficient low carbon transport services across its operational environment and will document this through the publication of a green travel plan.

The Trust is committed to applying the waste hierarchy in all aspects of its operation, including those of subcontractors, to ensure that none of its waste is send to landfill and to maximising the recycling of waste that is produced.

The Trust will regularly assess the environmental aspects and impacts of its operation and will have in place suitable procedures and processes to prevent any unplanned or uncontrolled discharge to the environment. The Trust will maintain and practice emergency response procedures to intercept any spillage or environmental incidents that may occur to ensure that any potential impacts are mitigated.

6. Sustainable Development Management Plan Action Framework

Specific actions arising from and related to this SDMP will be tracked through the SDMP Action Framework.
All actions within the framework will have a member of the committee assigned as lead for the action and will have timeframes for implementation and review timeframes established and recorded.
Progress against actions contained within the framework will be reviewed by the Sustainable Development and Environmental Committee on a quarterly basis.

7. Review

This plan will be reviewed and ratified on an annual basis by the Sustainable Development and Environmental Committee

8. Conclusion

It is essential that the Trust reviews and improves its financial, social and environmental efficiency in order to respond to the significant changes that are occurring within the local, regional, national and global operating environments.

In order for the Trust to achieve its vision it is imperative that the environmental impacts are mitigated, the financial burdens are reduced and the social impacts are transformed across all aspects of the Trusts operations.

Sustainable Development Management Plan Action Framework

Theme	Sub Theme	Aims and Objectives	Ref	Actions Required	Measure of Success	Targets and Objectives	Reference Documents	Lead	Time frame	Status (RAG)	Comments
Corporate Vision and Governance	1.1 Corporate Vision	The Trust has a clear vision of its Sustainability Goals	1.1.1	Sustainability Vision is Documented	Sustainability Vision is ratified and published			SM	30.04.2017		Visoin agreed by SDEC Dec 2016 and included in Policy
			1.1.2	Sustainability Policy is Documented	Sustainability Policy is ratified and published			SM	30.04.2017		Policy ready to be ratified, antiicpated to be ratified April 2017
	1.2 Governance	Responsibility and accountability for sustainable development is clear in the Trust	1.2.1	Sustainable Development and Environment Committee is established	Sustainable Development and Environment Committee meeting minutes			SM	Complete		
			1.2.2	Terms of Reference in place for Sustainable Development and Environment Committee	Terms of Reference ratified and published			SM	Complete		
			1.2.3	Sustainability KPI's are set and monitored throught the Sustainable Development and Environment Committee	Quarterly Sustainability KPI monitoring reports			SM	30.03.2017		KPI's need to be set
			1.2.4	Trust reports sustainability performance via the annual report	Annual Report includes Sustainability data			SM	30.03.2017		Data being Gathered
Leadership, Engagement, Partnership and Development	2.1 Leadership	Leaders at all levels have engaged widely and developed a narrative for sustainable development that aligns visions, priorities and delivery	2.1.1	Agree a board level executive for sustainability.	Board level executive in place				Complete		Steve Orpin is the appointed person
			2.1.2	Chief Executive signed endorsement of Sustainability Vision, Policy and SDMP	Document signed by Chief Exec			SM	30.04.2017		Awaiting Ratification
			2.1.3	Senior Management Team / Heads of Department engagement endorsement of Sustainability Vision, Policy and SDMP	Document signed by Heads of Department / Senior Management Team			SM	30.06.2017		Awaiting Ratification
	2.2 Engagement	The Trusts approach to environmental and social responsibility is supported and owned by local people.	2.2.1	Ensure local viewpoints and opinions have an avenue to be represented to the Senior Management Team	Local feedback and opinion is recognised within trust decision making						
			2.2.2	Understand and harness the assets that exist in local communities to enable a more sustainable delivery of health and care in the future.	local community assets are embedded within care provision that fosters a feeling of mutual ownership						
			2.2.3	Outline a communications plan for reporting on sustainability to staff and public.	Communications plan in place						
	2.3 Partnerships and Networks	The Trust has consolidated partnerships and makes use of its leverage within local frameworks.	2.3.1	Engage with local non NHS groups to enhance awareness of the Trusts commitments and approaches	MTW Membership / attendance at local groups						
			2.3.2	Engage with other healthcare partners to further develop cooperative approaches and mutual support	MTW Membership at forums and groups						
			2.3.3	Engage with Kent NHS Sustainability Forums	MTW Membership at forums						
			2.3.4	Engage with National NHS Sustainability Forums	MTW Membership at forums						
	2.4 Staff Development	All staff are aware of the benefits of acting sustainably, have the competencies and skills to implement sustainability initiatives and are empowered to challenge unsustainable behaviour	2.4.1	Generic text on sustainability to be developed for inclusion in all job descriptions	Job Descriptions include section on Sustainability						
			2.4.2	Sustainability is included as a component of the staff induction process	New starters have an awareness of Sustainability issues at MTW						
			2.4.3	Develop staff sustainability awareness program	Increased awareness of Sustainability isues amongst existing MTW staff						
			2.4.4	Review workforce policies to ensure they promote sustainable behaviour	Sustainability is engrained in all policies and procedures						
			2.4.5	Hold annual sustainability awards to recognise the most environmentally and socially sustainable team/department.	Staff engagement and awareness of sustainability issues						
Healthy, Sustainable and Resilient Communities	3.1 Healthy Staff	The Trust actively supports programmes and schemes to improve the health and fitness of its stakeholders and staff	3.1.1	Physical Activity: Promote local running clubs and teams, couch to 5k, Park Run.	Promotional emails and messages. Posters	The target is to get the programs started and available to staff. Success of tehse programs will be measured by a reduction in sickness and absence and an increase in health and wellbeing		CL			
			3.1.2	Physical Activity: Identify and deliver exercise classes such as yoga and pilates	Delivery of on-site classes. Working with KMPT on classes in Maidstone. Circuit training sessions for staff being set up and delivery to start in January from both Maidstone and Tunbridge Wells locations close to the hospitals.			CL			
			3.1.3	Physical Activity: Local gym membership, negotiate NHS discount where possible. Local teams and sports. Lunch time table tennis.	Promotion / advertising to staff local sports facilities, those offering NHS discount.			CL			
			3.1.4	Physical Activity: Promoting use of stairs not lift. Centralise printers, encourage employees to get up and move to printer / fax / photocopies etc.	Arrows, signposting, notices and communication about using stairs against lifts. Create awareness of sedentary work. Promote walks at lunch time / breaks, even just up and down stairs on a route around hospital if bad weather outside			CL			
			3.1.5	Physical Activity: Cycle to work scheme. Healthy travel, car share scheme - incentive? Parking further from destination to add a walk, Physical Activity: even if simply at the back of the hospital carparks.	Promotion / advertising to staff of cycle to work scheme, parking a little further from place of work.			CL	Complete		
			3.1.6	Mental Health: Identification of appropriate applications for phones and tablets.	Promotion of apps.			CL	Complete		
			3.1.7	Mental Health: Being present in the moment; provision of in-house training on mindfulness and other forms of mindfulness training / learning	Face to face in-house and promotion of on-line courses.			CL	Complete		
			3.1.8	Mental Health: Training on resilience, ability to deal and cope with change and stressful situations.	In-house training. Publicity of on-line training			CL	Complete		
			3.1.9	Mental Health: Provision of 24x7x365 counselling telephone help line and on-going counselling. Face to face counselling.	Delivery and publicity of 24x7x365 service.			CL	Complete		
			3.1.10	Mental Health: Access to information and self-help guides on mental health issues and organisations where support and help can be accessed.	Delivery through occupational health as well as publicity of staff website with information.			CL	Complete		
			3.1.11	Mental Health: In-house training, on-line training, telephonic / electronic support for managers facing difficult situations including supporting staff with mental health problems. spotting signs of poor / deteriorating health, identifying own behaviours and impact on others	Delivery and publicity of managers telephone support line, on-line support and training sessions.			CL			
			3.1.12	Mental Health: Strategic and coordinated approach to promoting employees mental wellbeing. Assessing opportunities for promoting employees mental wellbeing and managing risks. Flexible working. Role of line managers.	Mental wellbeing promoted through all that organisation does from job design, recruitment and training, to the way in which it manages its staff through inclusive and equitable ways, open communication. Confidentiality with staff information. Supportive and learning environment and culture			CL	Complete		
			3.1.13	Wellbeing: Delivery and promotion of smoking cessation services, information, advice and support.	Promotion and publication of services, both internet based and physical.			CL	Complete		
			3.1.14	Wellbeing: Advice and support on healthy lifestyle choices, nurse led weight management clinics	Delivery and offering of clinics.			CL	Complete		
			3.1.15	Wellbeing: Sign up to the workplace charter under the "commitment" stage. Deliver partial completion of the "achievement" stage. Where practical within the timescale, deliver partial achievement of the "excellence" stage.	work through the stages and sections, signing off where applicable with workplace charter support from the Council.			CL			
			3.1.16	Wellbeing: Sign up to the NHS health checks, deliver these through either in-house nurse clinics, or in conjunction with organisation commissioned to deliver them through on-site clinics.	delivery of NHS health checks clinics.			CL			
			3.1.17	Wellbeing: Self help information and signposting for support through external agencies provided by the Trusts health and wellbeing web portal.	Delivery of web portal for staff to access.			CL	Complete		
			3.1.18	Wellbeing: Board Director and Senior Clinician as health and wellbeing champions for mental and physical health.	Individuals identified and promoted to Trust staff.			CL			
	3.2 Engaging Communities	The Trust has a network of engaged and enthusiastic volunteers form the local community who capitalise on positive experiences and support the operations of the Hospital	3.2.1	Streamlining of recruitment process to enable easier access for volunteers	Positive feedback on a smooth recruitment process			Anne-Marie Stevens			
			3.2.2	Expand role and nature of volunteers within the hospital	Increase in number of Volunteers			Anne-Marie Stevens			
			3.2.3	Ensure that volunteers are motivated and enthusiastic and have a desire to stay within the hospital environment	Increased retention of volunteers			Anne-Marie Stevens			
	3.3 Sustainable Communities - Designing the Built Environment	The entire environment in which the Trust delivers care will promote wellness, will minimise emissions and will be resilient to changes in climate	3.3.1	Produce options for improved access and increased green space in the grounds.	Greater green space utilisation and access			Stu Meades			
			3.3.2	Recognise and Enhance the biodiversity capacity of the estate	Trust wide Biodiversity Management Strategy in place			Stu Meades			
			3.3.3	Ensure that any refurbishment, redevlopment or new development seeks to minimise the carbon footprint of the works and the subsequent operation of the building	Low carbon specification included within any tender to works			Stu Meades			
			3.3.4	Ensure that any refurbishment, redevlopment or new development appraises the potential changes to the climate and environment and mitigates those impacts at the design stage	Climate change resilience appraisal to be included within any design			Stu Meades			
	ommunities - essment	The trust understands and minimises the current and future	3.4.1	Create a section in the organisation risk register that addresses the challenges of building resilience to climate change and covers the legal, financial, infrastructure and service risks.	Organisational Risk Register reflects climate change risks			Rob Parsons			
			3.4.2	Identify risks and opportunities to health and well being in the local area, assess levels of preparedness and develop plans to improve resilience.	Action Plans			Rob Parsons			

Theme	Sub Theme	Aims and Objectives	Ref	Actions Required	Measure of Success	Targets and Objectives	Reference Documents	Lead	Time frame	Status (RAG)	Comments
	3.4 Resilient C Risk Ass	risks to the organisation from climate change	3.4.3	Use the Climate Ready BACLIAT tool to complement the process of assessing risks and opportunities associated with climate change locally.	BACLIAT tool has been used to support the risk assessment process			Rob Parsons			
			3.4.4	Draw on existing risk assessments, adaptation tools such as the UKCP09 projections and other local information to assess the risks to continuity and assets (buildings, emergency services, vehicles and the supply chain for fuel, food and key products).	Adaption plans in place			Rob Parsons			
	3.5 Resilient Communities - Adaption Planning	Adaptation plans are in place that link to business continuity and emergency planning processes	3.5.1	Involve business continuity and emergency planning colleagues in developing an Adaptation Plan as a core component of the SDMP. The adaptation plan should link to heat wave and cold weather plans, flooding, emergency preparedness and business continuity plans.	Adaption plans in place						
			3.5.2	Gain ISO 223001 certification	Certification gained						
	Sustainable Clinical Care Models	Transformation of the trusts services delivers improved health outcomes coupled with social and environmental benefits.	4.1	Include environmental and social sustainability assessments on business case and service redesign templates.	Environmental and Sustainability assessments are included						
			4.2	Review models of care and patient pathways in every speciality taking into account the overhead use of resources and carbon footprint to identify where resources are used and can be reduced.	Resource efficient operations models of care and patient pathways are being provided						
			4.3	Consider most appropriate service location to minimise travel and facilitate access, including use of mobile technology or telephone clinics.	Services are delivered and available in the right locations with the minimum of unrequired travel						
Commissioning and Procurement - Triple Bottom Line	Over Threshold Procurement	Procurement is undertaken in a compliant manner that takes into account the social, environmental and financial impacts of the service	5.1.1	Develop sustainability score card that appraises the lifetime environmental impact of all procured equipment and services, including manufacture, delivery, usage, consumables, maintenance, decomissioning and disposal	Score Card in Use	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.2	Include sustainability appraisal within procurement tender appraisal	Sustainability Appraisal included	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.3	Develop clear procedures on how the organisation complies with the Public Services (Social Value) Act 2012 and the Modern Slavery Act 2015	Policy guidance statements are issued	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.4	Engage and collaborate with other Trusts in the procurement of Goods and Services	Collaborative procurement underway	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.5	Use local suppliers where at all possible to maximise local economic benefits	Postcode analysis of supply chain	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.6	Ensure that local labour services are utilised on project works where possible	Postcode analysis of labour services	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
			5.1.7	Ongoing contract management of awarded supply agreements required suppliers to demonstrate continual improvement and ongoing efficiencies	Continual efficiencies being delivered through existing contractual agreements	Achieved Level 2 of Standards of Procurement	NHS Standards of Procurement	Emily C-Brown	Oct-18		
	Procurement Systems	The systems and processes for procurement are streamlined and consistent to ensure Trust Wide best value and efficiency	5.3.1	Increase transaction volume covered by an electronic purchase order	Electronic Purchase Orders in widescale usage	90% transaction volume covered by electronic purchase orders	NHS Standards of Procurement	Richard Taylor	Sep-17		
			5.3.2	Increase transaction volume through an electronic catalogue to better capture and influence purchases	Electronic Catalogue in widescale usage	through an electronic catalogue	NHS Standards of Procurement	Richard Taylor	Sep-17		
	Stock Control	Materials are controlled, issued, reused and replaced in an efficient manner that minimises loss and the generation of waste	5.4.1	Promote reuse of unwanted or uneeded items within Trust	Reuse system fully in place			Nicola Waters			
			5.4.2	Stock Management system revieweed to ensure expiry breaches are prevented	No occurences of out of date stock disposal			Nicola Waters			
			5.4.3	Full implementation of Omnicell Inventory Management System across Trust	Omnicell in place			Nicola Waters			
			5.4.4	Steamlining of Deliveries to maximise efficiencies available				Nicola Waters			
Operational Management and Decarbonisation	6.1 Energy	The Trust is operates an environment where non essential energy use is eliminated	6.1.1	Reduce operational energy demand by switching off equipment when not operationally required	Tangiable culture of switching off when not required leading to lower energy consumption	Reduce absolute carbon emissions by 28% by 2020 against a 2013 baseline in line with the NHS Carbon Reduction Target of 80% by 2050		SM	Ongoing		Sustainability Day woill launch an awareness campaign
			6.1.2	Optimise HVAC Equipment - Operating hours, set points, dead bands	Reduced electrical and gas consumption			SM	30.04.2017		1. Survey underyaken by Cynergin. 2.Engaged with BMS engineers to implement changes identified in Survey. 3. renegotiating contracts with BMS maintenance to ensure optimisation is included within scope of work
			6.1.3	Optimise Boilers and Steam Provision	Reduced electrical and gas consumption			SM	30.06.2017		1. Survey undertaken by Spirax to identify improvements in system. 2. Quotes received for replacement parts. 3. budget identified to allow works to commence 2017/18
			6.1.4	Install / utilise existing a network of sub meters to monitor energy performance in geographical areas and the performance of significant energy using equipment and plant	Energy mapping reports are issues to compare distribuiton of energy consumption			SM	30.06.2017		Full quotation received for MTW wide network of meters. Works packages need to be budgeted within existing provisions that have been made for 2017/18
			6.1.5	Ensure relevant feedback loops are in place to report on poor energy performance and increase ownership amongst end users	Departmental consumption reports issued to departments / equipment users			SM			Dependent upon data received from sub metering infrastructure installed in 6.1.4. Need ot engage with Interserve FM for analysis of data at TWH
			6.1.6	Prioritise the usage of low carbon fuel sources where available (Biomass Boiler)	Biomass boiler is operating to the maximum effectiveness and is meeting planning requirements			SM	30.04.2017		RHI application is underway and modifications to pipework and installation of RHI compatible meters is commissioned. A reappraisal of the utilisation methodology of the Bviomass Boiler will be undertaken in partnership with Interserve FM following the completion of works
			6.1.7	Upgrade Internal Lighting to LED across estate, install additional controls and dimmers as operationally appropriate	LEDs installed, reduced electrical consumption			SM	30.09.2017		Specification issued ofr MSH, suppliers being reviewed to idenftify partner, intention to include within EPC in 2017
			6.1.8	Upgrade External Lighting to LED across Estate	LEDs installed, reduced electrical consumption			SM	30.04.2017		Contract awarded for upgrade of 2/3 of external lamps at MSH. Remnainder to be included within EPC
			6.1.9	Upgrade / Install Insulation of Buildings and Infrastructure: Roofspaces, Walls, Pipework, Valves, Ducts, Glazing, Door Openings	Reduced heating and cooling demand, greater user comfort			SM	30.06.2017		Survey being comissione dot model the impact of various insulation options to the fabric of MSH building
			6.1.10	Install CHP Technology at appropriate sites	CHP installed, reduced grid electrical consumption, reduced carbon footprint			SM	30.09.2017		CCHP's for TWH and MSH are components of EPC that is being pursued
	6.2 Transport	The Trust delivers efficient low carbon transport services	6.2.1	Develop a Green Travel Plan that promotes the use of public transport, cycling and walking	Green travel plan in place	Reduce absolute carbon emissions by 28% by 2020 against a 2013 baseline in line with the NHS Carbon Reduction Target of 80% by 2050	Department of Health and Department for Transport publication: Transport and Health				
			6.2.2	Review recurring business mileage expenditure to identify meetings that could be conducted by teleconferencing.	Increased usage of teleconferencing and reduced business mileage						
			6.2.3	Review the operation and performance of the trust owned fleet and ensure that all replacements are low emission or electric vehicles	Trust fleet is being used efficiently and plan in place for low carbon replacements						
			6.2.4	Implement Green Driving training across the fleet staff	Increased fuel efficiency of fleet operations						
			6.2.5	Review car lease scheme arrangements to encourage the use of low emitting vehicles.	Only low emisison vehicles are available through lease scheme						
	6.3 Water	The Trust operates an environment where non essential water use is eliminated	6.3.1	Activley monitor water consumption and investigate out of profile usage	Loggers installed, water consumption reports issued to users	Reduce absolute water consumption by 20% by 2020		SM	30.06.17		Contract signed with Aquafund that offers bureau service that includes data analysis and monitoring
			6.3.2	Set stretching targets around operational response time for repairing leaks	Leak response times have decreased			SM	30.06.17		To be decided by SD&Ecttee
			6.3.4	Install water efficient technology	Equipment installed			SM	30.09.2017		Feature of Aquafund contract. Survey to be undertaken
	6.4 Waste	The trust is applies the Waste Hierarchy in all aspects of its operation, diverts 100% of waste from Landfill and maximises recycling	6.4.1	Engage with supply chain to reduce the amount of packaging being delivered to site	Supply chain reduces product packaging and removes waste from site	100% diversion from Landfill; tangiable decrease in waste production and increase in recycling					
			6.4.2	Maximise the reuse of materials within the individual sites, the wider trust and the regional NHS community to prevent the need for disposal	Re-use / equipment internal recycling system is in place and working						WARP-IT to make presentation to Procurement department
			6.4.3	Allow adequate facilities for segregation and recycling in all collection points	All waste points have the opportunity for recycling			SM			Review of Waste infrastructure an dpractoices has been undertaken. Deficiencies identified. Anticipated to fund from 2017/18 waste budget
			6.4.5	Ensure that all waste within the estate is diverted from Landfill	100% diversion from landfill from waste reports and validated by audit			SM	31.12.2017		This is an issue for Offensive Waste as there are legal restrictions. SRCL are activley engaged in finding solutions to this
			6.4.6	Ensure that all waste arising from 3rd party projects is diverted from landfill by making it a condition of tender	Project specification includes waste requirements			SM	30.06.2017		To be included within project policy
	6.5 Environmental Mangement	The Trust operates in a manner that assesses the environmental aspects of its activities and mitigates any impacts associated with them	6.5.1	Aspect and Impacts register is completed and significant Aspects are identified	Aspects and Impacts Register			SM	30.06.2017		A&I Reguister is completed for MTW and reviewed on an annual basis, needs to be reviewed for TWH and Laundry
			6.5.2	Environmental impacts and risks are incorporated to standard risk assessment template and process	Template adjusted			SM	30.06.2017		
			6.5.3	Pollution Incident Response Plan developed	PIRP in place			SM	30.06.2017		Review of spillage equipment undertaken. Budgeted for 2017/18. PIRP to be developed