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

10am – c.12.30pm WEDNESDAY 29TH NOVEMBER 2017

LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
11-1	To receive apologies for absence	Chair of the Trust Board	Verbal
11-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
11-3	Minutes of the Part 1 meeting of 18th October 2017	Chair of the Trust Board	1
11-4	To note progress with previous actions	Chair of the Trust Board	2
11-5	Safety moment	Chief Nurse	Verbal
11-6	Chairman's report	Chair of the Trust Board	3
11-7	Chief Executive's report	Acting Chief Executive	4
11-8	A patient's experiences of the Trust's services	Chief Nurse[1]	Verbal
11-9	Review of the Board Assurance Framework 2017/18	Trust Secretary	5
11-10	Integrated Performance Report for October 2017 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. mortality) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce)	Acting Chief Executive Chief Operating Officer Chief Nurse Medical Director Chief Nurse Director of Finance Acting Chief Executive	6
	Quality items		
11-11	Update on the Care Quality Commission (CQC) inspection	Chief Nurse	7
11-12	Planned and actual ward staffing for October 2017	Chief Nurse	8
11-13	A Trust-wide approach to improvement	Acting Chief Executive	Presentation
	Planning and strategy		
11-14	"Operational management of winter – expectations and communication" letter from NHSI, and the Trust's response	Chief Operating Officer	9
11-15	Business Case regarding the Trust's hosting of the Kent and Medway STP	Director of Finance	10
	Assurance and policy		
11-16	Ratification of revised Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)	Trust Secretary / Director of Finance	11, 12 & 13 (N.B. The full documents have been issued as supplements to the main reports)
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
11-17	Charitable Funds Committee, 16/10/17 (incl. approval of revised Terms of Reference)	Committee Chair	14
11-18	Workforce Committee, 30/10/17 (incl. approval of revised Terms of Reference; quarterly report from the Guardian of Safe Working Hours; and annual report from the Director of Medical Education on work schedule reviews relating to education and training)	Committee Chair	15
11-19	Audit and Governance Committee, 21/11/17 (incl. approval of revised Terms of Reference)	Committee Chair	16
11-20	Quality Committee, 31/10/17 & 08/11/17	Committee Chair	17
11-21	Trust Management Executive (TME), 22/11/17	Committee Chair	18
11-22	Finance and Performance Committee, 14/11/17 & 27/11/17 (incl. quarterly progress update on Procurement Transformation Plan)	Committee Chair	19, 20, 21 (to follow)
	Other matters		
11-23	Proposal regarding the Freedom to Speak up Guardian	Trust Secretary	22
11-24	Trust Board development framework	Chair of the Trust Board	23
11-25	**To consider any other business**		
11-26	**To receive any questions from members of the public**		
11-27	To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest	Chair of the Trust Board	Verbal
	Date of next meeting: 20th December 2017, 10am, Education Centre, Tunbridge Wells Hospital		

David Highton,
Chair of the Trust Board

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON WEDNESDAY 18TH OCTOBER 2017, 10A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Jim Lusby	Acting Chief Executive	(JL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
In attendance:	Maureen Choong	Associate Non-Executive Director	(MC)
	Kate Holmes	Matron, Acute & Emergency (Maidstone Hospital) (for item 10-8)	(KH)
	Nazeya Hussain	Associate Non-Executive Director	(NH)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sarah Overton	Director of Strategy (for items 10-9 to 10-15)	(SOv)
	Kevin Rowan	Trust Secretary	(KR)
	Nick Sinclair	General Manager, Acute & Emergency Directorate (for item 10-8)	(NS)
	Akbar Soorma	Clinical Director, Acute & Emergency Directorate (for item 10-8)	(AS)
Observing:	Darren Yates	Head of Communications (until item 10-19)	(DY)
	Rebecca Southall	Quality Governance Associate, NHS Improvement	(RS)
	David East	Member of the public	(DE)
	Nick Walker	Liaison VAT Consultancy Ltd	(NW)

10-1 To receive apologies for absence

Apologies were received from Alex King (AK), Non-Executive Director; and Tim Livett (TL), Non-Executive Director. DH then welcomed MC to her first Trust Board meeting.

DH also gave notification that the Care Quality Commission (CQC) was undertaking an unannounced inspection at Tunbridge Wells Hospital (TWH) that day and at Maidstone Hospital (MH) on 19/10/17.

10-2 To declare interests relevant to agenda items

No interests were declared.

10-3 Minutes of the 'Part 1' meeting of 7th September 2017

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

10-4 To note progress with previous actions

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

- **7-11 ("Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions")**. COB reported that Kent and Medway NHS and Social Care Partnership Trust had introduced a similar 'finder fee' scheme, so contact would be made with that Trust to learn from their experience. COB added that further financial analysis was also being undertaken. It was therefore agreed to leave the action open.
- **7-11 ("Consider appointing Non-Executive Director 'champions' for Safeguarding Adults and Children")**. COB confirmed that MC had agreed to take on the role. It was therefore agreed to close the action.
- **9-11 ("Provide an update to the October 2017 Trust Board meeting on the review of the rates of pay for Bank staff")**. JL reported that the issue had been discussed at the Executive

Team meeting on 17/10/17, and it had been agreed that the next step was to undertake further financial analysis. DH asked whether the outcome would be ready to report to the November 2017 meeting of the Trust Board. JL confirmed this would be the case.

10-5 Safety moment

COB reported that the theme for October was "Saying Sorry - our Duty of Candour" and highlighted the following points:

- The statutory duty to discuss with patients when things went wrong would be promoted among staff. The process involved an initial contact with the patient being followed by a formal letter
- Patients were involved in Serious Incident (SI) investigations, and were kept informed of the progress of such investigations
- The information leaflet for patients carers and relatives was being revised, and was hoped to be completed by the end of October

MC noted the potential opportunity to address any deficiencies in relation to notifying families, and asked what steps were in place at present to address such deficiencies. COB replied that an assessment of this was currently underway with the Patient Safety Team.

10-6 Chair's report

DH referred to the report that had been circulated and added the following points:

- Since the last meeting, Glenn Douglas had finally been able to resign from his position as Chief Executive, so the Board's formal thanks to Glenn should be recorded (although there would be other opportunities to thank Glenn in person). JL was therefore made the Trust's Accountable Officer on 19/09/17, although a recruitment process for the appointment of a substantive Chief Executive was underway
- The Non-Executive Chairs and Vice-Chairs of the Board's sub-committees had been confirmed, subject to the Trust Board approving a separate proposal under item 10-25
- The evaluation of the Trust Board would be postponed until later in 2018, on the basis (among other things) of the fact that most Non-Executive Directors were new in post
- DH had attended a meeting with the Chief Executive of NHS England, who had remarked that the level of demand seen by the Trust had not been reflected across the country. The Trust therefore needed to better understand the reasons for the demand it had seen

DH noted that since he had written his report, the Finance Department had been awarded the Healthcare Financial Management Association Kent, Surrey and Sussex "Finance Team of The Year", and Richard Sykes (Head of Financial Management) had been awarded the "Outstanding contribution" award.

10-7 Chief Executive's report

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

- The Trust had seen significant peaks in activity and pressure, which was a forewarning of the harsher reality of the winter period
- JL had confidence in the work being led by COB in preparation for the CQC inspection
- The Listening into Action (LiA) programme was continuing, and JL was likely to submit a report to the November 2017 Trust Board meeting. Staff had however responded well thus far
- The CQC had already held some focus groups with staff, and the CQC had stated that staff had been open and honest, which was pleasing. The feedback given by staff was also reported as being constructive and balanced
- JL had made a conscious effort to visit clinical areas, and also thank staff for their hard work

MC asked whether LiA was being used as an enabler, and also asked whether the programme was sufficiently developed to enable some "you said, we did" messages to be published to staff. JL replied that the LiA programme was definitely regarded as an enabler and not a rigid programme. JL also stated that the Trust was now at the stage where real progress had been made, and the suggested 'you said, we did' messages could be provided. JL added that there was also however a need to debunk certain myths, such as, for example, the availability (or lack) of linen. JL concluded by stating that he intended to use his weekly email update to describe the issues that had been

addressed via LiA. CIB added that some of the LiA 'quick wins' had been included as part of the daily CQC 'huddle' meetings.

Presentation from a Clinical Directorate

10-8 Acute and Emergency

[N.B. Item 10-8 was considered after item 10-4]

DH welcomed AS, NS and KH to the meeting. AS then commenced the presentation by highlighting the following points:

- The Directorate included the Emergency Departments (EDs) at both hospital sites, managing all types of Accident & Emergency patients including a registered Trauma Unit at TWH; Acute Medical Units (AMUs) at both sites providing Ambulatory Care and the management of short stay non-elective medical patients; and Site Practitioner Teams on both sites
- The Directorate's workforce involved Multi-Disciplinary Teams (MDTs) i.e. Consultants, Speciality Doctors, Training Doctors, Nurse Practitioners, Paramedic Practitioners, Paramedics, Nurses, Musculoskeletal Practitioners, Clinical Support Workers, Nursery Nurses, Administrative and Clerical staff, and reception staff
- There was an overall vacancy rate of 19%, but active recruitment plans and skill mix reviews were in progress

NS then continued with the presentation, highlighting the following:

- For the current year to date, SLA income was £27,967,553 and other operating Income was £1,162,878, so total income was £29,129,878
- ED attendance was a major issue, and staff were faced with large attendances on most days. The ED's response to such surges in activity was analogous to a Formula One motor racing team supporting its driver during a pit stop, in that a range of support services were provided for the patient, to ensure they received the care and treated they required
- ED attendances continued to rise, as the ED was a trusted brand, and patients wanted treatment quickly, so the Trust needed to respond to this demand
- The Trust had achieved the required performance against the NHS Improvement (NHSI) trajectory for the A&E 4-hour waiting time target over the last 4 months, with performance over those months being 92.5%, 93.3%, 93.2% and 90% respectively
- For Risks / Challenges / Opportunities, ongoing increasing ED attendances was a key issue, but the Directorate was very good at managing an unpredictable attendance profile. An investment had been made for an IT solution which would enable improved oversight of the whole Trust, so any surges could be managed

AS then pointed out that patient expectations had changed, in that patients were now better informed, via the internet, and the previous deference to medical professionals had eroded. AS added that the demands of patients therefore needed to managed. NS then continued, and highlighted the following further Risks / Challenges / Opportunities:

- The Trust had sufficient beds, but there was a mismatch in the availability of inpatient beds against demand i.e. discharges were not occurring quickly enough
- There was an increased need for assessment beds to support new patient pathways
- The Trust had been unable to consistently recruit and retain staff. The impact of being able to work in London, for higher pay, was a key factor, as was the option of Agency work
- Future improvements included the Integrated Urgent Care Centres. The Trust was also one of only 2 in the country to pilot "NHS Pathways" for NHS England and NHS Digital, which aimed to have consistent triage across all emergency healthcare partners (111/999)
- Further improvements included the ongoing review of traditional staffing models in planning future workforce

AS summarised by stating that the Directorate was dynamic, resilient and caring.

SDu commended the presentation but stated that she believed it undersold the work and effort the Directorate's staff did to manage the demand seen. SDu also asked for details of the things what would make a difference to AS, NS and KH's day to day working lives. AS referred to the

"Transforming urgent and emergency care services in England" review, and stated that having an agreed patient pathway with other specialties would make a difference. AS elaborated that although professional standards of practice were currently in place, pathways would provide clarity on the expected response from other specialties when patients were referred from ED. AS added that the number of 'Medically Fit For Discharge' (MFFD) patients was also a challenge. SDu asked AG and JL whether AS's points had been accepted and were being considered. AG replied that work on pathways with other specialties was progressing, to prevent referrals back to the ED, but noted that further work was required on this, with PM's support. PM explained that a solution was easier said than done, as the circumstances involved were often not straightforward. DH added that he had recently attended the induction training for Higher Specialist Trainee doctors, and Dr Milner had emphasised the need to adhere to the aforementioned professional standards.

NH then asked for further details of the plans for integrated Urgent Care. AS added that the Trust had obtained funding from the Department of Health to develop GP services, and discussion was also underway with West Kent Clinical Commissioning Group (CCG). NS added that the intention was to provide a fully integrated Urgent Care service from September 2018, which would extend the current 11-hour service to a full 24-hour service. NH asked whether there was confidence that West Kent CCG would be able to support the full service. AS replied that there was hope that this would be the case.

SO then referred back to the Formula One analogy used by NS, noted the competitive nature of Formula One, and asked whether it was known how the Trust processes compared against those in place at other Trusts. NS responded that it was difficult to definitively prove the areas where the Trust's EDs were more (or less) efficient compared to others, but improved data would help quantify such performance.

PM congratulated the work on ambulatory care, and noted the need for the Frailty Unit at TWH. NS confirmed this was in progress.

DH then thanked AS, NS and KH for their presentation.

10-9 Integrated Performance Report for September 2017

JL firstly referred to the discussion that had taken place on the Radio 4 "Today" programme earlier that morning regarding NHS performance, but noted that the Trust's performance on the A&E 4-hour waiting time target had been good recently, and gave thanks to AG for this. JL added that the Trust's trend on Cancer waiting times, and on the 62-day Cancer waiting time target in particular, had given JL confidence, despite the continuing issues with tertiary referrals. JL added that he was however concerned with the growing backlog of patients waiting, and cautioned against allowing the backlog to reach a point where it would not be possible to recover.

Effectiveness / Responsiveness (incl. DTOCs)

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

- A&E 4-hour waiting time target performance was very closely linked to the flow of patients across both hospital sites, but AG had confidence in the EDs, which had been reinforced by the presentation given under item 10-8
- Working with partners was important, and Pathways 1 and 2 of the Home First programme were in place, whilst Pathway 3 was very close to being introduced
- Other actions such as daily ward rounds and implementing the SAFER bundle were continuing to be reinforced, as such work was effective and all Trusts were trying to carry out the same actions. The Trust Board 'Away Day' held earlier in 2017 had noted the effect of elderly frail patients
- For the Referral to Treatment (RTT) target, although NHS regulators had not been as focused on this compared to previous years, the Trust was continuing to consider what could be done to increase elective activity (and some of this would be considered during item 10-16)
- Work had been undertaken on the Cancer pathways that had caused most problems with the 62-day Cancer waiting time target. The Lower Gastrointestinal (GI) pathway had previously been problematic, but all of the changes that had been identified had been put in place, and this

was now one of the better performing tumour sites. The MDT was rightly very proud of their performance. Overall performance on the target was not yet at the required 85%, but the number of patients on the waiting list backlog had reduced from the previous year

Safe / Effectiveness / Caring

COB then reported the following points:

- Pressure Ulcers were rated red, following an increase in the rate. The total number of Pressure Ulcers had increased (to 17) in September, which included a Grade 3 and Grade 4 Ulcer. These were SIs and were currently under investigation. Some immediate action had been taken once the increase had been identified, including communicating to all staff to remind them of their responsibilities, and the position in October had shown improvement thus far. The response also included work regarding incontinence pads and the use of female urinals. A small, but effective, Tissue Viability team was focusing on the issues
- There had been 3 falls-related SIs, and these were being closely monitored via the Falls Group
- The number of SIs had increased, with 77 for the year to date, compared to 55 for the same period last year. This figure would however reduce to 72, as 5 cases had been downgraded following liaison with West Kent CCG. An early review of the SIs had showed an increase of SIs in Maternity, so work was underway to confirm whether stillbirths should be deemed to be SIs. A number of SIs were also related to accusations of assault, and a report on these had been considered at the Trust Board in September 2017
- Staff had been encouraged to increase their reporting of incidents and this was felt to be a factor in the increased number of SIs, so COB was not overly concerned with the increase
- The date for Venous Thromboembolism (VTE) assessments was incomplete, and COB had been assured that the final figure for the month would show an improvement from that reported
- The complaints response performance had not yet recovered, as although the corporate Complaints Team was now at full staffing complement, responses were being delayed by Divisions. COB was therefore liaising with the Complaints lead and communication would be issued to Divisions regarding this
- The positive responses given for the Friends and Family Test (FFT) in Maternity had increased

DH referred to complaints responses, and asked whether the staffing establishment of the Central Complaints Team was sufficient to prevent performance being adversely affected by, for example, a staff member taking 2 weeks Annual Leave. COB acknowledged the Team was lean, but confirmed that she believed the staffing establishment was sufficient.

MC asked how the issues reported by COB linked with the work PM was leading on regarding learning from incidents. COB confirmed that the issues were very closely linked, and the Associate Director, Quality Governance was closely involved in all aspects. PM noted that a successful first meeting of the Learning Group had been held on 17/10/17, with MC dialling in to the meeting.

Safe / Effectiveness (incl. Mortality)

PM then reported that the Summary Hospital-level Mortality Indicator (SHMI) figure was the first one that had been published for some time, and was, at 1.07, an improvement on the previous figure of 1.08. PM also referred to the improvement in the Stroke metrics, noting that he had been called to a Quality Committee ‘deep dive’ meeting regarding this before he had been appointed as Medical Director, and stated that it should be acknowledged how well the Trust performed.

SDu then referred to readmissions, noted that these were increasing (although the indicator was still rated green), and asked for a comment. PM cautioned against interpreting a direct relationship between readmissions and increased discharges, but stated that a review of themes and trends for readmissions would be undertaken if the trend continued.

Safe (infection control)

SM then reported the following points:

- There had been 1 case of Clostridium difficile, so performance was now back in accordance with the required trajectory

- There had no cases of MRSA bacteraemia, which was in large part due to excellent performance on MRSA screening
- The work on E. Coli continued, and would be subject of a 'one year on' meeting with the Secretary of State for Health during w/c 23/10/17, to which SM had been invited

Well-Led (finance)

SO then highlighted the following points:

- The month saw a deficit of just over £1m, which was in accordance with plan, and which meant that the financial plan for Quarters 1 and 2 had been met
- Sustainability and Transformation Fund (STF) monies (of £1.5m) had been achieved for Quarter 2. However, the achievement had required a number of significant actions, which had been discussed in detail at the Finance and Performance Committee on 16/10/17 and the first Trust Management Executive (TME) meeting on 11/10/17. The latter meeting had acknowledged the need to establish some extraordinary Finance and Performance Committee meetings to review Divisional Cost Improvement Plan (CIP) performance
- Staffing had affected the financial position, and there was a clear correlation between the position, substantive staffing and temporary staffing

Well-led (workforce)

JL reported that Simon Hart, the new Director of Workforce, had joined the Executive Team Meeting on 17/10/17, which had been very positive. JL continued that Mr Hart's arrival was an opportunity to refresh and review the Trust's approach to staffing, taking into account some of the ideas from Mr Hart's 10 year tenure at Oxleas NHS Foundation Trust, which had a reputation for being innovative.

DH then reinforced SO's point regarding the relationship between finances and staffing, and emphasised the need to consider innovative solutions to the Trust's current, and future, workforce challenges, particular in some areas of Medical staffing. PM noted that that issue had been discussed at length at the last Clinical Directors' Committee meeting, and the need for innovative solutions (rather than just continuing to try and recruit to traditional roles) had been reinforced. PM added that the retention of Consultants was a key issue, noting that there had been some recent resignations, but was hopeful that the LiA process would support efforts to retain such staff.

Quality Items

10-10 Update on the anticipated inspection by the CQC

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

- The Trust's Provider Information Request (PIR) had been submitted in August 2017
- A small CQC project group had been established, and a project plan developed
- A daily 'huddle' was held each morning, facilitated by SO, which had been very helpful
- Weekly communications had been a key focus, using the 'Take 5, Talk 5' approach. Recent communication had emphasised the importance of mutual respect among staff
- Communication sessions had also been held for staff, which had now evolved into smaller 'drop-in' sessions
- The Trust Board handbook was being finalised
- The CQC were on site that day, and would return on 19/10/17. It was possible that the inspectors would also return on other days. However the aforementioned daily huddle, which had been stood down that day, would resume on 19/10/17
- The CQC's Well Led inspection had been scheduled for 12/12/17 and 13/12/17, and BS was observing the Board meeting to provide support with the Trust's Well Led Framework assessment

DH acknowledged the amount of work undertaken in preparation for the inspection and stated that he did not believe the Trust could have prepared any more than it had done. COB pointed out that although a small project team was leading the preparations, a far larger number of staff had been involved. JL noted that in COB's absence, SO had led the CQC inspection item at the Executive Team meeting on 17/10/17.

10-11 Planned and actual ward staffing for August and September 2017

COB referred to the circulated report and highlighted that it showed the ratings for each area, but noted there was now a need to demonstrate continuity by identifying the Wards that were the subject of close monitoring. DH agreed, and added that the key consideration was to indicate the Wards that gave COB and AG the most cause for concern. COB acknowledged the point, and stated that at present, this was Wards 20 and 21. AG added that Ward 22 was also a concern.

COB acknowledged the need to revise the report submitted to future Trust Board meetings.

Action: Revise the "Planned and actual ward staffing" report submitted to the Trust Board to enable clearer identification of the Wards of most concern to the Executive Team (Chief Nurse, November 2017)

10-12 Review of clinical outcomes

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

- Because of the wide range of services provided, there was an absence of very clear outcome measures for many areas, which was in part related to the fact that process measures were easier to obtain
- There were varying views as to the usefulness of Patient Reported Outcome Measures (PROMs), when compared to, for example, Patient Reported Experience Measures (PREMs)
- The report did not contain detailed comparative data for the previous year, as this would have made the report far longer. However, PM intended to develop a rolling programme of Directorate-based clinical outcome reporting, and a proposal was scheduled to be submitted to the 'main' Quality Committee in November 2017
- Work was taking place in relation to fractured neck of femur, and Professor Briggs would soon return to the Trust (in relation to the 'Getting It Right First Time' (GIRFT) programme)
- The 'red' ratings for the Trauma Audit and Research Network (TARN) should be treated with caution, as these only related to 1 patient
- PM had been given assurance that the Myocardial Ischaemia National Audit Project (MINAP) data for "Maidstone" was as expected
- The Trust's Sentinel Stroke National Audit Programme (SSNAP) performance was good, and MH had achieved an 'A' rating

DH noted the intention to discuss the plans to report at Directorate-level at the next 'main' Quality Committee, and queried whether the plans would be brought to the Board's attention in due course. PM confirmed this would be the case.

SDu then pointed out that Attachment 8 had already been discussed at the 'main' Quality Committee, and commended the work involved in producing the report. SDu added that she believed the report was the most comprehensive, and probably the most useful, document that had been submitted to the Quality Committee. PM noted that SDu's commendation should be directed to James Jarvis, the Associate Director of Business Intelligence, who had produced the report.

10-13 Quarterly mortality data (incl. Policy for Undertaking Mortality Case Record Reviews)

PM referred to the circulated report and highlighted that it was required to be submitted to the Trust Board, and although the Board scrutinised mortality frequently, it was hoped that the report provided an increasing level of assurance. PM also emphasised that although the mortality rate had reduced, he believed this was related to having better control on the process, rather than the Trust's Nurses and Doctors improving the quality of care they gave. PM therefore cautioned against interpreting any future increase in Hospital Standardised Mortality Ratio (HSMR) as a sign that the quality of care given by Nurses and Doctors had worsened. The point was acknowledged.

SO then referred to the monthly HSMR, and noted that the data for October, November and December 2016 may lead to an increase in the 12-month rolling average HSMR once these months were taken into account. The point was also acknowledged.

DH noted that only 2 staff had received training on the Structured Judgement Review (SJR) process, and asked if this was sufficient. PM replied that there were officially enough SJR-trained staff at the Trust, but he would like more staff to be trained.

Planning and strategy

10-14 Update on the Kent & Medway Sustainability and Transformation Partnership (STP)

JL reported that action was likely to take place over the next month, and elaborated that discussions regarding the future of Stroke services across Kent and Medway were continuing, and the Trust was actively engaged in those discussions. JL added that the Trust had expressed willingness, and a desire, to operate a Hyper Acute Stroke Unit (HASU) at either of its hospital sites, and this had been made clear.

DH asked whether the situation in East Kent would affect the timescales in regarding the future of Stroke services. JL responded that he believed the process should continue, regardless of what happened in East Kent.

10-15 To approve the Trust's strategy

JL introduced the item by reporting the following points:

- It was important to understand that the Strategy was the product of circa 2 years of work, as this point may not been apparent from the Strategy discussion held at the first TME meeting on 11/10/17
- Although it had been agreed to circulate a revised version of the Strategy very soon after the TME meeting, this had not occurred, as JL wished to discuss the Strategy with the Accountable Officer of West Kent CCG. The CCG's Executive Team had then discussed the Strategy and confirmed they had no major issues with its content, although they commented that they wished to see the Aligned Incentives Contract (AIC) referenced more
- With the aforementioned impending major strategic discussions, it was important that as a Trust, a clear view was presented regarding the Strategy over the next 5 years

SOv then gave a presentation which highlighted the following points:

- The Strategy work had commenced with a series of workshops, and the clinical strategy that had been developed had been subject to annual reviews. The Strategy had also been refreshed using the LiA process, and in particular the LiA 'pulse' survey
- The "Caring, Sustainable and Improvement driven" concept had been 'road tested', including via the Patient Experience Committee
- It was important for the Board to approve the more accessible version of the Strategy that had been submitted, as staff were keen to understand the Strategy in more detail. The Strategy also helped substantiate the key messages from LiA
- The Strategy would be a dynamic document, and would therefore be reviewed at least annually, although aspects of the Strategy may need to be refreshed before then
- If the Strategy was approved, a 6-week communications programme would be implemented

DH asked how the CQC's Well Led inspection linked to the communications regarding the Strategy, noting that the end point of a 6-week programme would be close to the date of the inspection. COB noted that she and the Communications Team would liaise with SOv to ensure appropriate links were in place.

DH emphasised the need for the Strategy to also connect to other initiatives. JL agreed, and noted that the Strategy had been consistent over the last few years, so the links to, for example, LiA, would be natural.

DH then commented that the Trust had not tracked the delivery of Strategic objectives, so the Strategy would now enable relevant metrics to be developed and monitored, perhaps as part of the performance dashboard. JL acknowledged the point.

NH also noted the need to promote the messages within the Strategy, and link these with the development of, for example, the Trust's appraisal process. DH agreed, and emphasised that the Strategy needed to support the achievement of strategic goals by staff.

SDu then noted that the Non-Executive Directors had seen the Strategy document for the first time at the aforementioned TME meeting on 11/10/17, and acknowledged the work that had taken place on the document in response to the comments made at that meeting, but stated that she was still uncertain as to whether the document sufficiently captured the need to broadcast the Trust's achievements to its staff. SDu also remarked that she did not feel the Strategy reflected patients' desire to be treated with kindness, and therefore proposed that the word "kind" be included within the Strategy.

DH acknowledged SDu's latter point, and proposed that given the late finalisation of Attachment 10, the Trust Board should approve the Strategy in principle, subject to final drafting, and then delegate its authority to a smaller group of Trust Board Members, to finalise any final editorial changes. This was agreed. DH then suggested that SDu be involved in that group. SDu agreed. NH and MC also volunteered to join the group.

The Trust Board therefore approved the Strategy in principle, subject to the comments made at the meeting, and subject to final editorial changes being agreed by MC, SDu, and NH.

Action: Arrange for the Director of Strategy to liaise with the Non-Executive Directors who expressed a desire to be involved in a working group, to agree the final editorial changes required to the Trust Strategy, to enable the document to be finalised and published (Acting Chief Executive, October 2017)

10-16 Update on the 2017/18 Winter & Operational Resilience Plan

AG referred to the circulated report and made the following additional points:

- A number of aspects were certain such as the Christmas period, but a number of uncertainties were also involved, so planning assumptions had therefore been made
- The key issue was ensuring that patients were safe
- The SAFER patient flow bundle was a key aspect underpinning the plan
- Delayed Transfers of Care (DTOCs) had been a recurring theme at the Trust, which had had a very detrimental impact on bed occupancy. There had been a reduction in DTOCs, but the level was not yet at the recommended 3.5%
- Each Division had reviewed their own bed needs, and there were described on page 7 onwards
- The items listed in italics in Attachment 11 had not yet been implemented, as some further work was required
- A Gastroenterology Consultant (Dr Blaker) wanted to develop the work on outlier patients
- The plan included the "going green for winter" scheme, the use of "red and green days" and the concept of "stranded" patients

DH asked for more details of the "red and green days" scheme. AG explained that the concept was based on the principle that every day a patient was in a bed should add value to their care and treatment, so a "red day" was a day that involved delays, as the actions that should have occurred did not take place. AG then continued, and highlighted the following points:

- A revised Escalation Policy was being finalised, although there was a policy currently in place
- For this winter, it had been agreed to appoint an additional Surgical Matron at TWH to work with the Site Team on the management of the pathway for non-elective surgery
- A 7-day Pharmacy service was included in the plan, but this service had been reduced to 5-6 days because of staffing. However 7-day service would resume from the beginning of December
- Therapy staffing was a risk to the ability to manage surges of activity
- There were also financial risks, as all of the winter funding had been allocated even though further items of expenditure were needed. Liaison was therefore taking place with Finance colleagues
- The Trust also needed to be mindful of the impact of potential inclement weather and an influenza pandemic

DH asked whether the arrangements for responding to Norovirus and infection control were well practised. SM confirmed that Wards knew exactly what was being done, and the issues were not escalated unless, for example, there had been Ward to Ward transmission. DH asked whether the required controls were easier to implement at TWH because of the single-room environment. SM confirmed that the processes worked well at both hospitals.

DH then asked about the timescales for implementing Pathway 3 of the Home First initiative. JL replied that he had recently discussed this with the Accountable Officer from West Kent CCG, and they had confirmed JL's understanding of the situation, so SO would now liaise with his counterpart at the CCG regarding the funding. SO added that he was expecting a meeting to take place within the next 2 weeks. PM emphasised the importance of Pathway 3 to the winter plans. JL agreed, but reminded Trust Board Members that Pathway 3 had been a central tenet of the Trust's winter plan for the previous year, but this had not been implemented on the grounds of affordability, and it was therefore essential that this was not repeated. DH asked SO whether it was intended that all parties would make a contribution to the funding of Pathway 3. SO confirmed this was the intention.

DH commended the comprehensive nature of the report and thanked AG and her colleagues.

Assurance and policy

10-17 Self-assessment against the Well Led Framework

DH referred to the circulated report and commended the comprehensive nature of the assessment. COB noted the involvement of KR in this, and then highlighted the following points:

- The assessment included many of the issues and actions that had already been discussed at the meeting
- The Trust had rated itself as "Requires Improvement" for the Well Led domain, but "Good" overall, as part of the preparation for the CQC's inspection, and the content of Attachment 12 reflected this
- The assessment would evolve and develop over the coming months
- A table-top review exercise would be undertaken by NHSI, to identify the support they could provide, but this would include observation at Quality Committee meetings, and may also involve discussions with Trust Board Members ahead of the CQC's Well Led inspection

DH pointed out that some of the issues would be addressed, to close the actions, by the time the CQC's Well Led inspection took place, but not all of the actions would be completed by that date. The point was acknowledged.

DH asked whether the CQC would receive a similar self-assessment. COB replied that the CQC had not requested such a self-assessment, but the content of Attachment 12 reflected the content of the PIR that the Trust had submitted to the CQC.

10-18 Ratification of revised Policy and Procedure for the production, approval and ratification of Trust-wide Policies and Procedures ("Policy for Policies")

KR referred to the report that had been circulated and made the following points:

- The Trust's current policy process had been in place since July 2014, following the Board's approval of proposals to strengthen the process at that time. The main focus of those proposals was the establishment of the Policy Ratification Committee (PRC), which is a sub-committee of TME
- The associated policy had not had not been updated at that time, but had been informed by the 3 years of the PRC's operation, and now been updated. The key changes were described on page 3 of Attachment 13
- The revised policy was approved by TME on 20/09/17, and then reviewed at the PRC on 13/10/17, which recommended the document for ratification by the Trust Board. Given the impact of the policy on the Trust's entire policy approach, it was considered appropriate for the policy to be ratified by the Board, in the same way that, for example, the Risk Management Policy and procedure had recently been submitted to ratification at the Board (and which was duly given)

COB highlighted the importance of the clarification that a policy's "review date" was not an expiry date. PM asked whether this principle would be applied retrospectively. KR confirmed that this was the case, and in fact had always been the case, although the point had not been made as clear as it was now.

The revised Policy and Procedure for the production, approval and ratification of Trust-wide Policies and Procedures ("Policy for Policies") was ratified as circulated.

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

10-19 Quality Committee, 11/09/17 & 13/09/17

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

- The Quality Committee 'deep dive' meeting had undertaken a review of progress with implementing 7-day services, and the Committee had agreed that monitoring should remain under the remit of the TME, unless the Board wished to receive direct reports on the subject
- The 'deep dive' meeting had also reviewed compliance with the Mental Capacity Act 2005
- Attachment 14 also contained details of the issues discussed at the 'main' Quality Committee held on 13/09/17

The Trust Board agreed that the implementation of the 7 day services programme should continue to be monitored via other forums (including the TME).

10-20 Audit and Governance Committee, 27/09/17 (incl. the Annual Audit Letter for 2016/17)

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

- The Annual Audit Letter for 26/17 was appended to Attachment 15. The key message was once again that a well-constructed audit exercise had been undertaken, and the Auditors had been very complementary about the Finance staff who had provided the required information
- The Audit and Governance Committee was concerned regarding the delivery of objective 4 within the Board Assurance Framework (BAF) (which was to deliver the control total for 2017/18)

SO referred to the latter point, and noted that at the time of the Audit and Governance Committee meeting, he had rated his confidence in the achievement of objective 4 as 'amber', but acknowledged that the rating was now more accurately rated as 'red'. DH stated that this would need to be discussed at the next Board meeting. KR noted that the BAF was scheduled to be reviewed again at the November meeting of the Trust Board.

10-21 Patient Experience Committee, 05/10/17

KR referred to the report that had been circulated and noted that he had chaired the meeting as AK had had to give his apologies at short notice. Questions were invited. None were received. The fact that the meeting was non-quorate was acknowledged.

10-22 Trust Management Executive (TME), 20/09/17 & 11/10/17

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

- A formal record of Executive Team meetings was now being taken, and KR now attended, which strengthened that aspect of the Trust's corporate governance arrangements. The notes from the meetings would be submitted to the TME
- Consultant appointments would also likely be notified to the Trust Board in future
- The TME meeting had noted the implementation of the new PAS, and although there were some frustrations, there had been no major significant problems. Everyone involved should therefore be thanked, noting that many staff had worked at weekends and through the night

10-23 Finance and Performance Committee, 25/09/17 &16/10/17

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

- Agency expenditure had been discussed and acknowledged as a key issue

- There was a pressing need to review Divisional CIP plans, and therefore Divisions would be invited to attend some extraordinary meetings of the Finance and Performance Committee

10-24 Charitable Funds Committee, 16/10/17

SDu reported that the Terms of Reference had been reviewed and a change was agreed to allow Associate Non-Executive Directors the same rights as other members of the Committee. SDu added that the Terms of Reference would be submitted to the Trust Board, for approval, in November 2017.

SDu also reported that the Fundraiser role had been discussed and it was noted that the post had not been approved at the Agenda for Change banding that had been proposed, but it was agreed to proceed with recruitment and then review this further, based on the response received. SO added that the post had been approved by the Vacancy Recruitment Panel that had been held on the afternoon of the Charitable Funds Committee meeting.

Other matters

10-25 Proposed amendment to the Terms of Reference of Trust Board sub-committees

KR referred to the report that had been circulated and invited questions. None were received.

The proposed amendments to the Terms of Reference of Trust Board sub-committees were approved as circulated.

10-26 Board members' hospital visits

The report was noted. SDu asked whether it would be possible for Non-Executive Directors to be notified of any pre-arranged visits to clinical areas by members of the Executive Team, to enable the former to take part in the visit, if this was convenient. KR agreed to arrange this.

Action: Arrange for the Non-Executive Directors to be notified of any pre-arranged visits to clinical areas by members of the Executive Team, to enable Non-Executive Directors to take part in the visit, if convenient (Trust Secretary, October 2017 onwards)

10-27 To consider any other business

The Trust Board delegated the authority to the 'Part 2' Board meeting being held later that day to make a decision regarding the arrangements for the hosting of the Sustainability and Transformation Partnership, and next steps.

10-28 To receive any questions from members of the public

No questions were posed.

10-29 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, which enabled the 'Part 2' Trust Board meeting to be convened.

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11-4 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]
7-11 (July 17)	Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions	Chief Nurse	July 2017 onwards	The issue has been discussed at the Recruitment & Retention group and an outline paper has been prepared for Executive Team discussion and consideration. The Executive Team agreed to the principle, but asked that further work be undertaken on the specific details (which is not yet complete).
10-26 (Oct 17)	Arrange for the Non-Executive Directors to be notified of any pre-arranged visits to clinical areas by members of the Executive Team, to enable Non-Executive Directors to take part in the visit, if convenient	Trust Secretary	October 2017 onwards	Non-Executive Directors will aim to be notified of any scheduled visits. However, the process regarding Safety Walkarounds will be reviewed at the Trust Board away day on 07/12/17.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-11 (Sep 17)	Provide an update to the October 2017 Trust Board meeting on the review of the rates of pay for Bank staff	Deputy Chief Executive	November 2017	The Executive Team Meeting discussed the matter and agreed that trained Nursing staff on the Bank would be paid to either their substantive band increment, or the current bank rate (i.e. mid-point band 5), whichever was higher
10-11 (Oct 17)	Revise the "Planned and actual ward staffing" report submitted to the Trust Board to enable clearer identification of the Wards of most concern to the Executive Team	Chief Nurse	November 2017	The "Planned and actual ward staffing" report submitted to the November 2017 Trust Board has been revised as requested
10-15 (Oct 17)	Arrange for the Director of Strategy to liaise with the Non-Executive Directors who	Acting Chief Executive	October 2017	A meeting was held between the 3 relevant Non-Executive Directors and the Director of

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	expressed a desire to be involved in a working group, to agree the final editorial changes required to the Trust Strategy, to enable the document to be finalised and published			Strategy after the Trust Board meetings on 18/10/17, and proposed amendments were provided. The Strategy document was then revised and has since been published.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
7-14 (July 17)	Arrange for details of the length of the Trust's backlog maintenance programme to be included in future Estates and Facilities Annual Reports	Chief Operating Officer	July 2018	The Director of Estates and Facilities has been notified of the request, and been asked to ensure the information is included in the 2017/18 Annual Report, which is scheduled to be considered by the Trust Board in July 2018

Trust Board meeting - November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-6 Chair's report **Chair of the Trust Board**

Chief Executive Post

An executive search and open advertisements in NHS Jobs and Times Online for the substantive Chief Executive post at the Trust have been underway over the last 6 weeks or so. I am pleased to confirm that we have a short list of 3 candidates who will participate in the selection process on the 4th and 5th of December 2017. Sarah Dunnett, our Vice Chair, has agreed to chair a panel of internal and external stakeholders on the afternoon of December 4th, and a formal interview panel, including a senior director from NHS Improvement, will take place on the morning of December 5th. I am confident that we will have a confirmed appointment in place prior to the announced inspection by the Care Quality Commission of the governance and management of the Trust against the Well-Led framework. This is scheduled to take place on December 12th and 13th.

Non-Executive and Executive Director Posts

I am very pleased to confirm that since the last meeting of the Board, Maureen Choong, previously one of our Associate Non-Executive Directors, has been appointed as a Non-Executive Director for a four year term commencing on November 16th 2017. Maureen will Chair our Patient Experience Committee, be a member of the Quality Committee and be the Non-Executive Lead for both Safeguarding and Resuscitation. Her background in senior Nursing positions in the NHS will bring a fresh perspective to the Board.

Steve Phoenix, our Non-Executive Director appointed in July 2017, will be able to take up post with effect from 1st December 2017 for a two year term. He will chair the Workforce Committee and be Vice Chair of the Quality Committee and the Audit & Governance Committee. He will also hold the portfolio for Emergency Preparedness, Resilience and Response, which I have been covering on an interim basis pending his arrival.

Our new Director of Workforce, Simon Hart, will also take up his post on 1st December, having completed his notice period at his previous employer. Simon has an impressive track record, particularly in the area of effective staff engagement and we look forward to his contribution.

These appointments mean that the Trust Board will be complete for the first time for some months and we look forward to taking the Trust forward into 2018.

Consultant Appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and 2 other Committee members. I intend for the details of the delegated appointments made by the AAC to be a regular section within my report to the Board, but for this month's report, the details of new substantive Consultant arrivals and departures in September and October have been provided in Appendix 1.

Care Quality Commission (CQC)

As mentioned above, the Trust will have an announced CQC review of the Well-Led framework in December. However, in line with their new method of inspection, CQC inspectors have now made a series of unannounced inspections to review our clinical services. I have been very pleased to hear that the verbal feedback from the inspectors has consistently been that our staff have been very welcoming and helpful. It will be some time before we will know the outcome of the overall inspection. I would like to thank Claire O'Brien and her team who have worked so hard to provide the CQC with all the required information and to prepare our staff to be as ready as possible.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Appendix 1: Details of new substantive Consultant[2] appointments and departures

New substantive Consultant appointments				
Start date	**Title**	**First name**	**Surname**	**Department**
11/10/2017	Dr	Jasmine	Ishorari	Rheumatology
02/10/2017	Dr	Nitin	Raichura	Radiology
04/10/2017	Dr	Thomas Joseph	Smith	Urology
26/09/2017	Dr	Chhaya	Kuravinakop	Paediatrics
04/09/2017	Dr	Tuck-Kay	Loke	Respiratory

Substantive Consultant departures				
Leaving date	**Title**	**First name**	**Surname**	**Department**
08/10/2017	Dr	Kashif	Hafeez	Consultant MAU

[2] The lists therefore exclude Specialty Doctor, Clinical Fellow, and Locum Consultant posts

Trust Board meeting - November 2017

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Maidstone and Tunbridge Wells NHS Trust

11-7 Chief Executive's report — Acting Chief Executive

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

1. Maidstone and Tunbridge Wells NHS Trust (MTW) continues to place a high level of focus on its winter preparedness and the provision of safe, high quality care for thousands of patients who we expect to see over the coming months.

   The last couple of years have seen significant pressures at Tunbridge Wells Hospital (TWH) during winter with a direct impact on our ability to maintain effective non-elective flow. The impact on our elective capacity has also been particularly severe. With this in mind, and as part of our preparation for the winter ahead, the Planned Care Division is finalising plans for some significant changes to secure as much elective capacity within our Trust as possible and improve emergency theatre capacity during the winter months. It is very important that we take whatever action we can to minimise the risks posed by another winter of increased pressure. The implementation of these plans will leave us in much better shape to deal with the challenges that undoubtedly lie ahead.

   Work has started in the Emergency Department at TWH to make improvements to the department and to incorporate a space for GPs to see patients. This project is part of the Developing Primary Care initiative (GP streaming) and associated schemes and follows a successful bid for funding from NHS England.

   The changes will also include increased Clinical Decision Unit space and additional toilets in the Surgical Assessment Unit, revision of the reception area and expansion of the waiting area. It is anticipated that the developments and introduction of the designated GP-led service will help improve patient flow and reduce the demand on the Emergency Department. Work will start in the Maidstone Emergency department after Christmas.

   We are also focusing on the wellbeing of our staff. With the operational pressures that we have, It's even more important for us to look after ourselves. Actions include protecting our staff, their loved ones, and our patients from flu by providing colleagues with as many opportunities as possible to have the flu jab.

2. Inspectors from the Care Quality Commission have carried out a series of unannounced visits to Maidstone and Tunbridge Wells hospitals as part of their new-look annual assessment process for all healthcare providers.

   I have thanked our staff for the professional and friendly way in which they welcomed the CQC inspectors to our Trust. Inevitably the CQC have found examples of very good practice as well as areas in which we need to improve. Where specific issues have been highlighted we have taken immediate action. We welcome the CQC back to our Trust in early December as part of their planned review of MTW's progress against the well-led aspect of the care regulator's key domains. It is important that we learn from our overall assessment and turn it into an opportunity for our patients and staff. If we use the experience in the right way we can build on the momentum we are creating to begin to turn MTW into a truly improvement-driven

organisation. We are already using Listening into Action (LiA) as a means of tapping into the knowledge and expertise of staff to solve problems and improve the way we do things. This is delivering tangible staff-led improvements in our patient experience as a result.

3. There has been an enormous amount of hard work throughout MTW to change our Patient Administration System from Patient Centre to Allscripts. It has been a mammoth task and I've been very conscious about the strain this has placed upon staff. Having implemented the new system we are taking the opportunity to reassess our IT strategy and how we can best build on this new platform.

4. Rates of third and fourth degree perineal tears have reduced significantly at MTW. Thanks to the collective efforts of our midwives and doctors to improve our patient experience, we have moved from being a national outlier in 2015/16 to now being substantially below the national average.

5. Hundreds of cancer patients will benefit from the appointment of our new Mesothelioma Clinical Nurse Specialist. Louise Gilham will support patients from across Kent who have this form of deadly cancer caused by exposure to asbestos. This new post has been made possible through funding from Mesothelioma UK.

6. We have marked the outstanding achievements of our staff at our Annual Staff Stars Awards ceremony. Given the inevitable pace at which we provide care on a daily basis, this was a wonderful opportunity to celebrate their achievements and recognise the high standing in which so many are held by colleagues and patients alike.

   Earlier this month, a patient whose life was saved by the quick actions of staff at TWH came in to the Emergency Department to say a heartfelt thank you to some of those who helped her. Lorna Arduino met with Dr Angela Feazey, Dr Richard Griffiths, Dr Megan Purcell-Jones and Dr Antony Gough-Palmer who all played a major role when she was brought into TWH in November last year with an aortic dissection. Without their quick intervention and care, and Lorna's speedy transfer to Kings Hospital in London, she almost certainly wouldn't have survived. Lorna told us: "I was told by my surgeon at King's that the reason I am alive is down to the fact that the staff who cared for me at Tunbridge Wells Hospital acted so quickly. I can't explain how grateful I am."

   Dr Feazey described Lorna's visit as follows: "It was wonderful for us all to see Lorna. We were absolutely amazed at how well she looks. When she came in to us last year, she had gone from being fine to being catastrophically unwell in a matter of hours and we weren't at all sure that she would survive. So often, we treat people but don't find out what happened to them after they leave our care so to be able to give her a hug and hear from her first-hand meant the world to all of us."

7.

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 – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-9 Board Assurance Framework (BAF) 2017/18 and Risk Register — Trust Secretary

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

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

Additional aspects relating to the Risk Register

A summary of the status of the Risk Register is enclosed in Appendix 1. Having reviewed the current list of red risks (Appendix 1), it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Board is obviously free to challenge this.

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

The key objectives in the 2017/18 BAF were approved at the Board on 26/04/17 (objectives 1-5) and 19/07/17 (objective 6). The latest rating of the 6 objectives in terms of the Responsible Director's confidence that it will be achieved by the year-end (which was based on performance at month 6) is as follows:

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

For this report, based on comments made at the previous meetings of the Board and Audit and Governance Committee, an alternative method of RAG rating has been used, which shows the RAG rating on a continuous, rather than discrete, scale (and therefore gives further information regarding the level of confidence within a rating of 'red', 'amber' or 'green').

Review by the Trust Board

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

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

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

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

Strategic objectives

It was noted at the October 2017 Trust Board meeting that the Trust had not tracked the delivery of Strategic objectives, but that the Strategy that the Board approved at that meeting would now

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

enable relevant metrics to be developed and monitored. It is proposed that this monitoring occur via the BAF. If the Board agrees, the Trust Secretary will liaise with the Director of Strategy and Acting Chief Executive to propose some objectives (to either the December 2017 or January 2018 Board meeting) for inclusion in the BAF when it is next submitted to the Board (in February 2018).

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 21/11/17
- Trust Management Executive (TME), 22/11/17
- Finance and Performance Committee (objective 4 only), 27/11/17

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

Review and discussion

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

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

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

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

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

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

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

a. The issue has a high profile at the Trust Board and Quality Committee, and the response has been led by the Medical Director. One of the new Deputy Medical Directors will also be asked to take the lead on this (although responsibility will remain with the Medical Director) (1)
b. The Assistant Director of Business Intelligence is directly involved in the analysis to understand the situation, & there is close liaison with Dr Foster (2)
c. The Trust is following the investigation pathway recommended by Dr Foster (i.e. checking coding, casemix, structure, process, individuals & teams) (3)
d. The Clinical Coding department restructure is underway, which is expected to result in improvements via closer working between clinical staff and Clinical Coders (3)
e. The Trust is adapting its process of detailed Mortality Reviews to comply with the latest guidance/recommendations from the National Quality Board (as is expected by NHS Improvement) (3)
f. 'Deep dive' reviews were undertaken into some of the 'red flag' alerts identified by Dr Foster, but the Trust's approach to such alerts has developed, and these are now first considered within the Mortality Surveillance Group before considering whether a more detailed review is required

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

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

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

If "No", what other data is needed?

1. N/A

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

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

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

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

- At month 6, the 12-month rolling average HSMR was 104.6 (the baseline/expected rate is 100), which is rated as 'green', and the 1-month HSMR for 2017 is 1.0717 (which is within "Band 2", "As expected")

[3] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to improve key aspects of clinical care and safety"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

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

2 To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target[6]

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

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

1. The capacity required to deliver the 'new norm' for non-elective activity being insufficient
2. A&E attendances continuing to remain higher than plan
3. Bed occupancy remaining above 92%
4. The level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard
5. The Trust failed to adopt and/or implement the latest best practice in relation to patient streaming and other aspects
6. The identified Social Care changes that create capacity failing to materialise

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

a. Demand and capacity planning for 2017/18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning (1)

b. The Directorate management team and the Information Department have agreed a set of monthly targets to facilitate how the required performed is monitored (the Trust must achieve 90% or above for Q1, Q2 & Q3, and then 95% in March 2018). Monthly targets are also in place (2)

c. The Trust's bid for £645k national funding has been agreed, to provide dedicated co-located areas for GP-led care (which will enable up to 20% of A&E patients to be seen more appropriately by GPs), and the refurbishment works have commenced (5)

d. The Chaucer Acute Frailty Unit (CAFU) opened at Maidstone Hospital in June 2017 (5)

e. There has been intensive focus by the Urgent Care management team on resolving capacity and flow issues affecting the non-elective patient pathways (4, 5)

f. The funding for the introduction of 'Home First' Pathway 3 has now been agreed

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

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

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[7]

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

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

- The latest performance for the year to date (at month 6), is 90.5%. The month 6 performance was 89.99%. There remain a number of unpredictable factors that may affect performance

[5] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust is unable to manage (either clinically or financially) during the winter period"

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

May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total	Q1	Q2	Q3	Q4
90.9%	91.9%	89.6%	90.7%	89.8%	91.1%	91.1%	87.8%	85%	90%	95%	90.05%	90.07%	90.03%	90.01%	90.11%

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[8] *Key objective*

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

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

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

1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of clarity over the performance required by each Directorate, and the monitoring of such performance
4. If there was inefficiency of recruitment processes
5. If there was a lack of urgency/commitment by recruiting managers
6. If there was uncertainty over the status of vacancies
7. Absence of Director-level ownership of the objective (given the gap between the previous Director of Workforce leaving and the new Director starting in post)

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

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Increased recruitment staffing resource (4)
d. Divisional New Ways of Working Task and Finish Groups (4, 5)
e. Establishments and workforce requirements have been reviewed as part of the Business Planning process for 2017/18 and 2018/19
f. Establishment levels are likely to be reviewed as part of the Business Planning for 2018/19 and 2019/20 (6, 7)
g. The new Director of Workforce start on 01/12/17, but they have been in contact, and developed relationships with, the Senior Human Resources Management Team since they were appointed (7)

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

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The 6-monthly review of Ward and non-Ward areas submitted to the Trust Board in July 2017
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[9]

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

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

- The vacancy rate for the year to date (at month 6, 2017/18) is 10.8%. The actions already in place will continue, but no additional actions are considered to be required at this stage

[8] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust does not have the correct level of substantive workforce for effective delivery"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[10] *Key objective*

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

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

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

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

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

a. The Executive has continued to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. The Trust has signed up to its control total, and submitted a plan to achieve this (1, 7)
c. Control targets have been set for each Directorate to reduce their cost run rate (2)
d. A number of 'Grip and Control' measures have been implemented to ensure delivery (2, 3)
e. The Performance Management Framework is now embedded (3)
f. The Plans were informed by the Phase 1 Financial Improvement Programme report from KPMG LLP and by guidance and advice from NHSI (including that from the Finance Improvement Director) (6, 7)
g. Action has been taken to engage with external stakeholders, including agreeing an aligned incentives contract with West Kent CCG for 2017/18 (8)
h. A series of fortnightly CIP progress meetings with each Division have been established (which will continue throughout 2017/18) (2, 4, 5)
i. The Director of Finance met with the Directorates with an overspend during October 2017
j. An extraordinary Finance and Performance Committee has been scheduled for 14/11/17 to review the Divisional CIP performance
k. Each Division has been asked to produce further actions to improve their run-rate

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

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

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[11]

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

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

- The year to deficit (at month 6) was £1.1m, which is in accordance with the submitted plan. Year to date CIP delivery (at month 6) was £9.2m, which £4.1m adverse to the submitted plan. The adverse CIP position is the primary driver behind the pressure on the Trust's financial performance, although good budgetary control has mitigated some of the slippage on delivery.

[10] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to demonstrate an ability to achieve future financial viability"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[12] *Key objective*

5 To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target[13]

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

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

1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. Pathways not being optimal in relation to achieving the required performance
3. Insufficient communication of the performance needed beyond Cancer & Haem. (only $^1/_3$ of delivery is within that Directorate's control – the remainder is within Diagnostics, Surgery & Medicine)

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

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

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

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

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

If "No", what other data is needed?

1. N/A

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

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[14]

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

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

- At month 5, 2017/18, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 73.7%, but for MTW-only patients was 81.8%.

[12] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to maintain and improve its reputation as a Cancer provider"

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

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

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[15] *Key objective*

6 To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway"[16] [17]

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

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

1. An insufficient level of elective and outpatient activity being undertaken
2. Non-elective activity continuing at current levels (incl. A&E attendances)

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

a. Close monitoring continues for the highest-risk non-complaint specialties (T&O, Gynaecology, and Cardiology) against action plans put in place to reduce their longest waiters
b. These specialities are trying to continue to reduce their backlogs by maximising available capacity across both hospital sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays
c. Operational teams are focused on their recovery plans to increase elective activity and 2 RTT summits are being held with the specialties in September
d. The Trust has engaged a productivity company, Four Eyes Insight Ltd, to optimise theatre productivity and efficiency, to maximise the level of elective activity undertaken

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

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

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

If "No", what other data is needed?

1. N/A

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

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

July 2017[19]	September 2017	November 2017	February 2018
☐	☒		

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

- At month 6, 2017/18, performance was 84.6%

[15] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to maintain and improve its reputation as a Cancer provider"

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

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

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
89.85%	90.03%	90.46%	90.89%	90.73%	91.35%	91.79%	92%	92.07%	91.88%	91.71%	92%

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

[19] A rating for July 2017 was not applicable as this objective was not approved by the Trust Board until 19/07/17.

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

At 21/11/17, there are:
- 24 'red' rated risks
- 46 'amber' rated risks
- 17 'green' rated risks
- 0 'blue' rated risks

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

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

The issues covered by the current 24 'red' rated risks will be familiar to the Trust Board and its sub-committees, as these have been previously discussed (some very regularly) at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. However, the issues highlighted with a * have been newly added to the Risk Register since the last summary report to the Board. The issues covered are as follows (noting that some of the 24 risks are similar and therefore described by an overall theme):
- High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- Ability to manage patient flow due to capacity and demand issues
- Achieving the Cancer waiting time targets
- The gaps in relation to Medical devices training and a trainer/coordinator
- The delivery of the annual financial plan
- The cost pressures associated with the use of temporary staff
- The lack of appropriate Medical cover on night shifts for the Paediatric unit
- The shortage of Paediatric Specialty and Associate Specialist (SAS) ('middle grade') doctors on day shifts for paediatrics
- The delivery of the Cost Improvement Programme (CIP) for the Urgent Care Division
- Nursing staffing levels in Orthopaedics
- The governance arrangements for Point of Care testing
- Delays in reporting of diagnostic tests at East Kent Hospitals University NHS Foundation Trust
- Lack of Consultant Oncologists specialising in Head & Neck, Lymphoma and Skin Cancers
- Staffing levels in the Occupational Therapy and Physiotherapy teams affecting service delivery*
- Procurement of medical devices using Integra without following due process Effect of failing to maintain a quality management system in Blood Sciences and Microbiology*
- Provision of tamper evident resuscitation trolleys*
- Unreliable data collection tool increasing number of missed referrals from A&E to Virtual Fracture Clinic*
- Issues with image storage on ultrasound machines leading to delays and potential errors in diagnosis*

It should also be noted that the last 2 bullet points relate to 3 red-rated risks that have been added to the Risk Register within the past 10 days. There was minimal consultation with the Risk and Compliance prior to these risks being added, so further information/clarification is actively being sought. It is therefore possible that either the RAG rating and/or the risk score of these 3 risks will be amended.

As was noted on the cover page of this report, having reviewed the 'red' rated risks listed above, it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum.

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

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

Guidance on likelihood / probability

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

Risk grading matrix

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

Trust Board meeting – November 2017

Maidstone and Tunbridge Wells NHS Trust

11-10 Integrated Performance Report, October 2017	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

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

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

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

Review and discussion

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

The 'story of the month' for October 2017

1. 4 hour emergency standard

Performance for the Trust for October delivered below the expected trajectory despite the continuing focus on patient flow and capacity across the non-elective pathway. The 89.3% achievement was an improvement of 2% compared to the same month last year.

- A&E Attendances remain higher than last year but the activity is returning to the previous expected levels rather than the continuous growth that we have seen over the last 18 months.
- Non-Elective Activity (excluding Maternity) however remains considerably above plan 20.9% higher than plan for Oct at 3,867 discharges, but almost exactly the same as October last year
- There were 1201 bed-days lost (5.3% of occupied bed-days) due to delayed transfers of care which is an improving position
- Non-elective LOS was 8.09 days for October discharges after spiking at 8.68 in Jan. Although more detailed analysis is being undertaken the initial findings are that the increase in October relates more to emergency surgery and orthopaedic activity rather than in Medicine. The average occupied bed days remained at 710 in October

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been:

- Increasing the level of senior doctor cover in the ED at specific times of the day.
- Twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone
- Focus on SAFER to achieve an improved length of stay.
- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis & RCA reviews as appropriate
- Winter "Capacity Huddle"s commenced chaired by the COO
- Implementation of Live Data dashboards to give an understanding of the current position
- Daily system-wide DTOC huddles chaired by the CEO.

2. Delayed Transfers of Care

Following the downward trend in the percentage of delayed transfers of care, this remained the same in October at 5.3% but remains an improved position. The number of bed days lost increased from 1,125 in July to 1201 in October but the total bed-days also increased. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1 & 2 of the Home First initiative in full and there are positive plans in place to implement pathway 3 during December. The Frail Elderly unit at Maidstone is operating effectively with plans for the TWH Frailty Unit in advanced development but with limiting factors of staffing and capacity being a key risk.

Row Labels	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
A : Awaiting Assessment	5	12	20	22	32	14	14	13	11	7	2	2	7
B : Awaiting Public Funding	5	3	6		4	3	1	3	3	3	2		2
C : Awaiting Further Non-Acute NHS Care	14	6	23	8	13	16	17	21	27	11	8	21	15
Di : Awaiting Residential Home	34	19	21	30	24	35	21	8	16	16	23	32	21
Dii : Awaiting Nursing Home	69	63	112	78	77	76	57	70	94	53	63	42	46
E : Awaiting Care Package	58	51	89	49	30	38	35	39	43	27	27	32	24
F : Awaiting Community Adaptations	8	5	7	9	10	13	6	8	7	15	8	5	10
G : Patient or Family Choice	20	16	14	9	19	28	6	10	8	10	13	14	28
H : Disputes		1			1	1	1	1	2		1		
I : Housing	2	4	8	3	5	4	3	3	5	6	8	2	2
Grand Total	**215**	**180**	**300**	**208**	**215**	**228**	**161**	**176**	**216**	**148**	**155**	**150**	**155**
Trust delayed transfers of care	**7.9%**	**6.3%**	**8.1%**	**6.7%**	**7.1%**	**6.2%**	**5.6%**	**6.0%**	**6.1%**	**5.4%**	**4.5%**	**5.3%**	**5.3%**

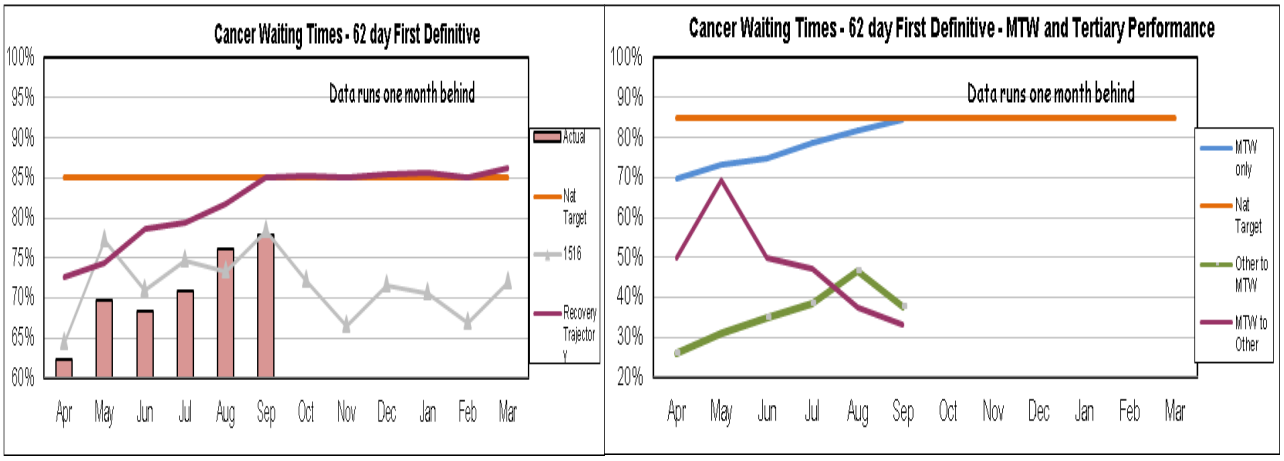
3. Cancer 62 Day First Definitive Treatment

The 62 day performance has improved further in October which has shown an improving trend over the last three months. The delivery plan remains focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help

reduce the backlog. The total number of breached patients was lower than in August but treatments were also lower in September than in August. 90.5 treatments were completed in September.

The key improvement initiative for the cancer services is the **daily huddle** where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same day.

In addition, straight to test triage clinics are now well established for colorectal and lung referrals. This is reducing the overall length of pathways for these patients and has significantly improved the performance of lower GI.



62 Day Performance - All			
Tumour	Total	Brch	%
Breast	22.5	6.5	71.1
Lung	5	1.0	80.0
Haemat.	2.5	0.5	80.0
Upper GI	8.5	0.5	94.1
Lower GI	12.5	0.5	96.0
Skin	1.5	0.5	66.7
Gynae	9.5	2.5	73.7
Urology	22.5	6.5	71.1
Head & Nk	5.5	1.0	81.8
Sarcoma	0	0.0	0.0
Other	2.5	1.0	50
Total	90.5	20.0	77.9

62 Day Performance - MTW			
Tumour	Total	Brch	%
Breast	22	6	72.7
Lung	4	0	100
Haemat.	2	0	100
Upper GI	7	0	100
Lower GI	12	0	100
Skin	1	0	100
Gynae	8	2	75.0
Urology	19	4	78.9
Head & Nk	3	0	100
Sarcoma	0	0	0.0
Other	1	0	100
Total	78	12	84.6

In October, Urology and breast have contributed the largest number of breaches overall.

MTW only patient performance in percentage terms continues to improve month on month.

Breaches for lower GI in absolute numbers have reduced compared to the previous month

4. Referral To Treatment – 18 weeks

October performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 85% which has declined since last month due to the planned decrease in outpatient activity as part of the new PAS go live at the beginning of the month. Our trajectory requires us to achieve 92% by the end of November 2017.

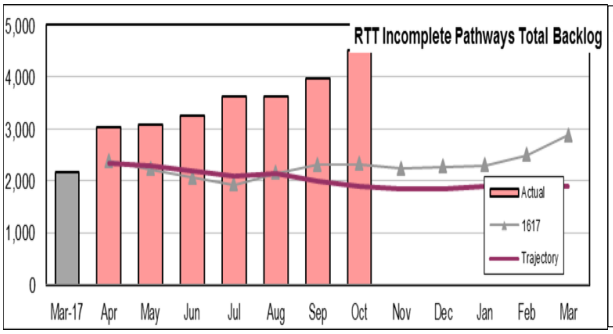
The Trust continues to be non-compliant at a speciality level for T&O, Gynae, ENT, General Surgery, Cardiology, Neurology, Endocrinology and Diabetes. The majority of the backlog is concentrated in T&O, Gynae, ENT, Cardiology and Neurology-all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs despite cancellations by maximising available capacity across both sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays.

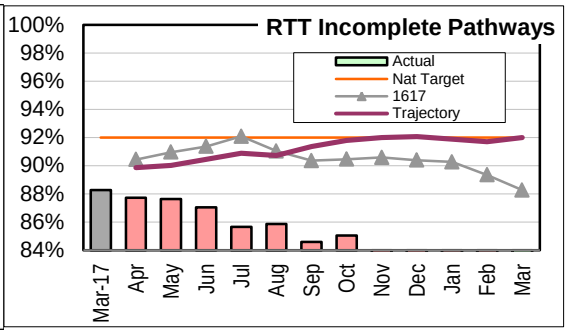
	Oct-17	Oct-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	4519	1900	2619
RTT Waiting List	30157	23139	7018
RTT Incomplete performance %	85%	91.79%	-6.8%

Operational teams have focused their recovery plans to increase elective activity and arrange extra clinics to ensure the backlog does not grow further. The key actions are:

- Improve overall theatre utilisation to increase levels of elective activity. The Trust has commissioned a productivity company – FourEyes to support us with this work.
- Implement remedial actions to specialties furthest from trajectory - T&O, Gynaecology, and Cardiology, including
    - the transfer of some elective cases from TWH to Maidstone (ENT & Gynae)
    - Full utilisation of the Maidstone Orthopaedic Unit
    - The transfer of some T&O & Gynaecology cases to DVH
- Continue weekly PTL/RTT performance monitoring to monitor overall performance
- Continuous validation of the waiting lists.

There were 176 operations cancelled on the day of which 49 were reportable.





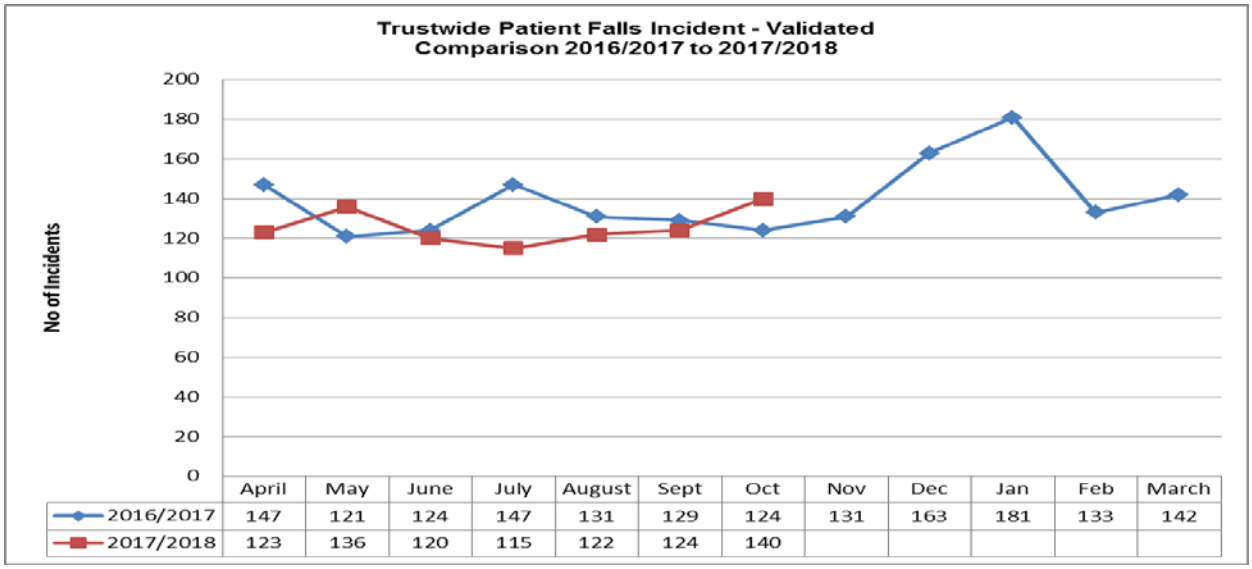
Quality and Safety November

Patient Falls incidents

There were 140 patient falls reported for the Trust for October which is an increase compared to September when the total number was 124. Graph 1 reports on the total numbers of falls for this year compared to last year. The total rate of falls per thousand bed days is 6.22 – year to date the rate is 5.77 against a limit of 6.0 per 1000 bed days. (Our own internal target) This is the highest number of falls to date this year. A breakdown of patient falls by site is shown in graph 2 as below; the total number of falls on the TWH site is consistently higher compared to the Maidstone site.

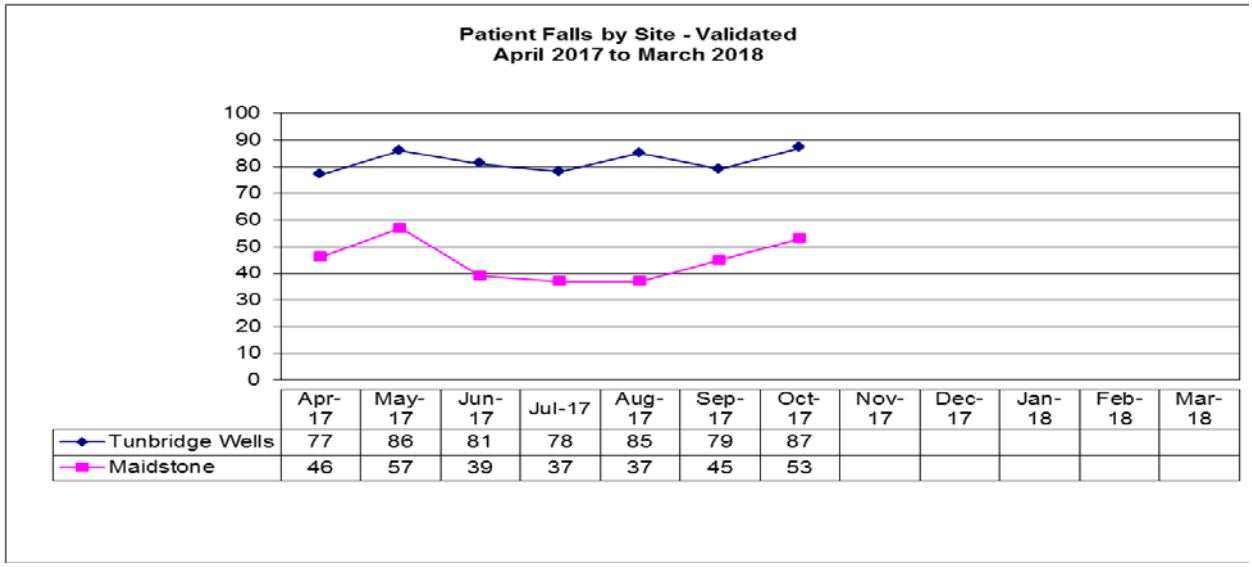
2 falls were declared as Serious Incidents (SI) in October compared to 3 for the same period this time last year. This makes a total of 21 SIs year to date compared to 17 this time last year.

Graph 1: Trust wide patient falls.



	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2016/2017	147	121	124	147	131	129	124	131	163	181	133	142
2017/2018	123	136	120	115	122	124	140					

Graph 2: patient falls by site for April 2017-March 2018



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Tunbridge Wells	77	86	81	78	85	79	87					
Maidstone	46	57	39	37	37	45	53					

Learning identified through recent investigation of serious incidents relating to falls includes the following actions:

- Falls prevention care plan to be reviewed when patients condition changes (improve, deteriorate or on transfer).
- Patient assessment to clearly identify the level of enhanced care requirements for individual patients.
- To avoid multiple transfers of patient with cognitive impairment and or delirium.
- Post fall protocol to be followed; assessment for injuries undertaken and appropriate moving and handling method used.
- Assessment and documentation of assessments for risk of falls and intervention to be reviewed when patients are transferred from one clinical area to another.
- Patient to be assessed for risk of falls, obtain collateral history for patient having been transferred from another healthcare provider.

Friends and Family test

The response rates to the Friends and Family test have fluctuated for the month in some areas. In Maternity services the response rate dropped to 13.6% for October compared to 21.5% for

September which is below the target of 25% response rate, however positive responses received in maternity increased to 97.6% which is the highest positive response rate this year for the service.

There has been an increase in the ED responses for the month with a total response rate of 18.1% compared to 5.2% for last month which was due to some practical issues around the order and supply of the FT cards which is now resolved.

The response rate for inpatients was 22.1% with a positive response of 95.1%
The FFT group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. There is a continued focus to embed the process of collecting feedback into daily routines and sharing good practice. This has been demonstrated through the development of an AE Case study.
The group are supporting a couple of options as part of embedding the FFT into practice as follows:

- Reviewing the option of having a 'IWGC' app on iPads within children's inpatient services may help increase overall response rates.
- Use of 'word clouds' and other visual displays being rolled out across all areas over the next three months. To assist with raising awareness of feedback and importance of facilitating this.

Pressure Ulcers:

The incidence of hospital acquire pressure injury has reduced slightly in October with 14 incidents reported compared to 17 in September, this equates to a rate (per 1000 admissions) of 2.31 against a threshold of 3.00.

There have been two SIs declared in October (1 category 3 and 1 category 4) which are under investigation. The two SIs that were reported in September have been reviewed at the pressure ulcer review group. One was deemed unavoidable and one was inconclusive.

Mixed sex breaches.

There were 8 mixed sex accommodation breaches for October. There were on the acute medical unit on the TWHG site. The situation was quickly resolved. The main cause of the breach was related to breakdown in communication with the team at the time. This has been addressed and this is not expected to be an issue again.

Complaints

There were 45 new complaints reported for October, which equates to a rate of 2.0 new complaints per 1,000 occupied bed days.

61.0% of the complaints have been responded within target for October compared to a target of 75%. This is a significant improvement in performance compared to last month which was 44%.

The Central Complaints Team (CCT) is now fully staffed (as of 18th September) so are now better placed to support the directorates. In order to maintain focus on performance the following measures are in place:

- Regular meetings continue with directorate links to monitor progress
- Daily complaints huddle introduced to review immediate deadlines and ensure all cases are allocated within capacity
- Weekly CCT review of all responses approaching deadlines continues with early escalation to the Chief Nurse
- Monthly performance review meeting introduced with the Chief Nurse to identify any problem areas.

Infection Prevention and Control

MRSA – There have been no cases of MRSA bacteraemia attributable to the Trust since November 2016.
The MRSA screening programme is integral to preventing MRSA bacteraemia. The screening rate for October was 98.5% for elective screening. Due to data issues following the Allscripts implementation it has not been possible to audit non-elective screening for the month.

C. difficile - There was one case of post-72 hour C. difficile infection in October against a monthly limit of two cases. The current rate of C. difficile infection is 4.4 per 100 000 occupied bed days for the month and 10.6 per 100 000 obd for the year to date, both rates are lower than for the same period last year. The trust is currently one case under trajectory for the year with 16 cases seen. All cases are reviewed by the C. difficile panel. Learning from cases is shared at clinical governance meetings. A trend analysis is produced every six months and reported to the IPCC. The highest risk associated with causing C. difficile infection is the use of broad spectrum antibiotics.

Methicillin sensitive *Staphylococcus aureus* bacteraemia – 12 cases of hospital attributable MSSA bacteraemia have been seen year to date, 6 cases below the same period last year. More intensive monitoring of these bacteraemias is currently undertaken following increases in numbers in previous years, with all cases reviewed at the *C. difficile* panel and learning shared at clinical governance meetings.

Gram negative bacteraemia - Following the Secretary of State's announcement of a 50% reduction target in avoidable gram negative blood stream infection by 2020/21, data collection has been commenced to establish the baseline.
From the beginning of April epidemiological data has been collected on all cases of *Pseudomonas sp* and *Klebsiella sp* blood stream infection, in addition to the E. coli data collected for some years, and submitted to the national Data Collection System.
Full RCA is initiated on these cases if data collection suggests that there may have been a significant issue with the management of the patient.
An action plan has been developed across Kent and Medway to achieve the initial target of a 10% reduction in cases in the current year. Nationally some plateauing in the numbers of infections is being seen with MTW data suggesting a reduced rate of increase in infections.

Infection Prevention Team - The infection prevention team works to an annual work plan in conjunction with the annual HCAI action plan.
Key areas of work for the current year include:

- Ensuring high levels of compliance with infection prevention policies – bi-monthly audits are carried out by the IPT to triangulate with the ward audits against the Saving Lives and Hand Hygiene bundles. Outcomes are reported to the IPCC within the directorate reports and fed back to directorates at clinical governance meetings. Additional support and training is given to clinical areas as required
- An audit programme to ensure compliance with Infection Prevention policies.
- Surgical site surveillance – Orthopaedic surgical site surveillance is audited throughout the year.
- Mandatory surveillance of C. difficile and blood stream infections – as discussed above..
- Achievement of national objectives (*C. difficile, E. coli*) as discussed above
- Training of staff and maintenance of the link nurse and AHP networks.
- There are no Infection Prevention policies requiring review. Two policies have been approved by the IPCC and are awaiting Policy Ratification Committee.

Financial commentary

- The Trust's deficit including STF was £2.8m in October which was £3.9m adverse to plan, due to, £1.1m STF underperformance in month due to non-delivery of the financial control target and A&E trajectory, £1.5m slippage against the original plan CIP phasing and adverse variances against budget.

- The Trust's net deficit (including technical adjustments) in October is £2.8m against a planned surplus of £1.1m, therefore £3.9m adverse to plan. The Trusts year to date net deficit (including technical adjustments) is £3.9m, £3.9m adverse to plan.
- The Trust's YTD deficit excluding STF is £7.8m which is £2.7m adverse to the plan.
- In October the Trust operated with an EBITDA deficit of £0.6 m, £4.3m adverse to plan.
- The Trust's normalised pre STF run rate in October was a deficit of £2.5m which was £0.3m higher than September mainly due to a reduction in clinical income (£0.2m) associated with Adult Critical care Activity.
- The Trusts deficit in October was £0.5m higher than the forecast, the key adverse movements to forecast were: Clinical Income (£0.6m adverse), mainly due to Adult Critical Care Income (£0.2m) and PP and Injury recovery income (£0.1m) less than forecasted. Pay was £0.1m favourable to forecast and non-pay was £0.2m adverse to forecast mainly due to an increase in bad debts.
- The key variances in the month are as follows:
  - Total income was £1m adverse in the month; Clinical Income excluding HCDs was £0.1m adverse in October. The key adverse variances in October were Elective & Day Cases (£0.4m) and Out Patient Activity (£0.7m) offset by favourable variances within non elective (£1.7m).The position included an adverse adjustment of £0.9m relating to the aligned incentive contract (£1.3m positive YTD). STF was £1.1 adverse in October due to non-delivery of the financial target, other operating income was £0.1m favourable due to £0.6m STP income offsetting additional costs partly offset by adverse variance relating to Private Patient income (£0.3m)
  - Pay was £1.2m adverse in the month, total pay spend (excluding reserves) was £106k less than September and in line with last month's forecast. Medical Staffing costs remain consistent with last month. Nursing costs reduced by £140k between months mainly due to a reduction in bank payroll weeks between months however agency hours increased to the highest level for 12 months. Compared to October 16 there has been a 9% increase in total agency hours used. The Trust nursing workforce in October was 16% temporary staffing which equated to 20% of total pay, the highest areas using temporary staffing are T&O (27%), Surgery (25%) and Specialist Medicine (23%). Specialist Medicine in October ran with the highest agency usage (10%) which equated to 51% of the Trust agency hours. Scientific and Technical staff spend increased by £90k between months mainly within Pharmacy (£50k) due to catch-up in invoices, increase in agency usage to cover vacant posts and higher grade agency staff being used to cover core vacancies. Support staff costs within Estates and Facilities reduced by £70k with spend returning to normalised levels.
  - Non Pay was overspent by £2.1m in October, £0.6m adverse relating to pass through costs for STP, Clinical Supplies £1m adverse (mainly due to unidentified CIP) , £.0.4m due to recoding adjustment between other non-pay and depreciation partly offset by £0.2m favourable variance relating to reduction of outsourcing costs
- The CIP performance in October delivered efficiencies of £2m which was £1.5m adverse to the phasing of the original plan, £5.7m adverse year to date. The adverse CIP position is the primary driver behind the pressure on the Trust's financial performance. The Trust has a risk adjusted CIP forecast of £23.4m, £8.4m adverse to plan.
- The Trust held £4.1m of cash at the end of September which is marginally off the plan (£4.8m. Following the year end agreement of balances exercise the Trust is in contact with NHS organisations trying to collect all agreed values and escalating any items disputed for resolution. It has also been agreed to switch to invoicing the STP budget in advance, rather than retrospectively. The STP budget was approved at the recent STP programme Board and it is anticipated that the outstanding invoices will be settled shortly.

- The Trust is forecasting to deliver the pre STF deficit of £4.5m, however the Trust needs to deliver the full value of its CIP programme and take additional action of £8.7m to deliver the control total. Please see the Financial Forecast 2017/18 paper which provides further analysis.

Workforce commentary

As at the end of October 2017, the Trust employed 5038.22 whole time equivalent substantive staff, a 45.42 WTE increase from the previous month. Temporary staffing remains higher than planned, but with a larger shift from agency to bank than expected.

Sickness absence in the month (September) decreased by 0.21% to 3.20%, below target for the Trust as a whole. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting long term sickness in outlying areas.
Statutory and mandatory training compliance has reduced marginally to 88.33% from the previous month, but remains above the target percentage.

Turnover has remained broadly consistent with last month at 11.80%, higher than target, despite a slight reduction from a peak of 12.16% in August. HR Business Partners continue to work closely with divisional operational management teams in order to address areas which have a high turnover.

Appraisal compliance for October, following the end of the Trust's designated appraisal window in June, stands at 87.65%, a 1.18% increase from the previous month.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 October 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)	4.59	4.4	13.0	10.6	-2.4	- 0.7	11.5	9.9	
1-02	Number of cases C.Difficile (Hospital)	1	1	20	16	-4	- 1	27	26	
1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
1-04	Elective MRSA Screening	99.0%	98.5%	99.0%	98.5%	-0.5%	0.5%	98.0%	98.5%	
1-05	% Non-Elective MRSA Screening	97.0%	No data	97.0%	No data	-97.0%	-95.0%	95.0%	No data	
1-06	**Rate of Hospital Pressure Ulcers	2.51	2.31	2.76	2.06	- 0.70	- 0.95	*3.01*	2.29	3.00
1-07	***Rate of Total Patient Falls	5.51	6.22	5.75	5.77	0.03	- 0.23	*6.00*	5.66	
1-08	***Rate of Total Patient Falls Maidstone	4.57	6.52	5.09	5.25	0.16			4.97	
1-09	***Rate of Total Patient Falls TWells	6.21	5.59	6.23	6.04	- 0.20			6.10	
1-10	Falls - SIs in month	3	2	17	21	4				
1-11	Number of Never Events	0	1	1	1	0	1	*0*	1	
1-12	Total No of SIs Open with MTW	26	63			37				
1-13	Number of New SIs in month	8	20	63	97	34	27			
1-14	***Serious Incidents rate	0.37	0.89	0.41	0.64	0.23	0.59	*0.0584 - 0.6978*	0.64	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.77	1.26	0.64	1.21	0.57	- 0.02	*0 - 1.23*	1.21	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.3%	95.2%	95.3%	96.3%	1.0%	1.3%	95.0%	96.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	95.9%	97.8%	96.4%	97.3%	0.9%	2.3%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.98%	2.03%	3.42%	2.62%	-0.80%	-0.4%	*3.00%*	2.62%	
1-20	C-Section Rate (non-elective)	12.9%	15.1%	10.0%	14.3%	4.33%	-0.7%	*15.0%*	14.3%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0260	1.0878	0.1	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		109.0	103.9	- 5.1	3.9	Lower confidence limit		100.0
2-03	Crude Mortality	1.3%	1.1%	1.2%	1.1%	-0.1%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.9%	11.2%	11.7%	12.2%	0.5%	-1.4%	*13.6%*	12.2%	14.1%
2-05	****Readmissions <30 days: All	11.2%	10.6%	10.9%	11.6%	0.7%	-3.1%	*14.7%*	11.6%	14.7%
2-06	Average LOS Elective	3.43	3.11	3.24	3.42	0.18	0.21	*3.20*	3.20	
2-07	Average LOS Non-Elective	7.71	7.63	7.58	7.31	- 0.26	0.51	*6.80*	7.31	
2-08	******FollowUp : New Ratio	1.79	1.43	1.81	1.70	- 0.10	0.19	*1.52*	1.70	
2-09	Day Case Rates	85.0%	82.8%	85.0%	85.7%	0.7%	5.7%	80.0%	85.7%	82.2%
2-10	Primary Referrals	9,677	9,078	69,419	62,776	-9.6%	-6.9%	119,266	107,063	
2-11	Cons to Cons Referrals	5,493	3,634	36,266	30,310	-16.4%	-12.0%	58,644	51,693	
2-12	First OP Activity (uplifted in Oct - uncashed)	16,869	15,914	116,884	110,437	-5.5%	-5.5%	201,705	188,348	
2-13	Subsequent OP Activity (uplifted in Oct)	30,795	23,104	218,403	198,095	-9.3%	-8.4%	383,906	337,847	
2-14	Elective IP Activity	690	652	4,795	4,091	-14.7%	-22.3%	8,303	6,977	
2-15	Elective DC Activity	3,851	3,280	26,623	24,489	-8.0%	-7.3%	43,602	41,765	
2-16	**Non-Elective Activity (uplifted in Oct)	4,511	4,982	30,162	33,336	10.5%	21.4%	46,435	56,858	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	13,968	14,340	99,044	100,451	1.4%	1.3%	168,161	169,242	
2-18	Oncology Fractions	5,861	5,390	41,829	34,380	-17.8%	-22.7%	75,273	58,937	
2-19	No of Births (Mothers Delivered)	520	531	3,570	3,559	-0.3%	2.1%	5,977	6,101	
2-20	% Mothers initiating breastfeeding	80.8%	82.6%	79.9%	81.6%	1.7%	3.6%	78.0%	81.6%	
2-21	% Stillbirths Rate	0.4%	0.56%	0.56%	0.39%	*-0.2%*	*-0.1%*	*0.47%*	0.39%	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	8	0	13	13	13	0	13	
3-02	*****Rate of New Complaints	1.06	2.00	1.69	1.87	0.2	0.55	*1.318-3.92*	1.83	
3-03	% complaints responded to within target	53.8%	61.0%	74.3%	60.3%	-14.0%	-14.7%	75.0%	60.3%	
3-04	****Staff Friends & Family (FFT) % rec care	0.0%	66.7%	0.0%	66.7%	66.7%	-12.3%	79.0%	66.7%	
3-05	*****IP Friends & Family (FFT) % Positive	95.1%	95.1%	95.3%	95.6%	0.3%	0.6%	95.0%	95.6%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	90.9%	88.9%	90.7%	91.2%	0.5%	4.2%	87.0%	91.2%	85.5%
3-07	Maternity Combined FFT % Positive	91.6%	97.6%	93.6%	93.8%	0.2%	-1.2%	95.0%	93.8%	95.6%
3-08	OP Friends & Family (FFT) % Positive	82.6%	84.9%	82.6%	84.4%	1.8%			84.4%	

	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	89.0%	89.28%	89.5%	90.4%	0.9%	0.2%	90.1%	90.1%	85.4%
4-02	Emergency A&E >12hr to Admission	0	-	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	682	New	3,178					
4-04	Ambulance Handover Delays >60mins	New	87	New	311					
4-05	RTT Incomplete Admitted Backlog	964	2300	964	2300	1,336	1,035	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	484	2219	484	2219	1,735	1,584	631	631	
4-07	RTT Incomplete Pathway	90.5%	85.0%	90.5%	85.0%	-5.4%	-5.7%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	0	4	4	4	*0*	4	
4-09	RTT Incomplete Total Backlog	2,320	4519	2,320	4519	2,199	2,619	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.70%	99.3%	99.7%	99.3%	-0.4%	0.3%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	4	4	3	- 1	- 6	9	9	
4-12	*Cancer two week wait	94.2%	90.5%	91.9%	91.9%	0.0%	-1.1%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.8%	85.0%	86.7%	84.9%	-1.8%	-8.1%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.3%	97.0%	96.5%	96.5%	0.0%	0.5%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	78.4%	77.9%	72.8%	74.9%	2.1%	-3.7%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	81.8%	84.6%	81.8%	84.6%	2.8%		85.0%		
4-17	*Cancer 104 Day wait Accountable	6.5	4.0	53.0	43.0	-10.0	43.0	*0*	43.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	74	49	74	49	-25				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	51	39	51	39	-12				
4-20	Delayed Transfers of Care	8.0%	5.1%	6.5%	5.5%	-1.0%	2.0%	3.5%	5.5%	
4-21	% TIA with high risk treated <24hrs	85.7%	85.0%	78.6%	70.3%	-8.2%	10.3%	60%	70.3%	
4-22	*******% spending 90% time on Stroke Ward	82.7%	93.8%	85.4%	92.1%	6.7%	12.1%	80%	92.1%	
4-23	*******Stroke:% to Stroke Unit <4hrs	58.0%	59.7%	50.9%	59.5%	8.6%	-0.5%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	62.0%	67.7%	54.7%	65.1%	10.4%	17.1%	48.0%	65.1%	
4-25	*******Stroke:% assessed by Cons <24hrs	60.0%	77.4%	61.9%	77.7%	15.8%	-2.3%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	3	0	6	15	9	15	*0*	15	

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	36,222	35,049	247,993	256,592	3.5%	1.6%	436,682	436,682	
5-02	EBITDA	2,248	(602)	7,225	13,580	88.0%	-25.1%	38,055	38,055	
5-03	Surplus (Deficit) against B/E Duty	(542)	(2,789)	(11,945)	(3,865)			6,673	6,673	
5-04	CIP Savings	1,832	2,031	10,912	11,185	2.5%	-33.7%	31,721	31,721	
5-05	Cash Balance	3,974	4,142	3,974	4,142	4.2%	-13%	1,000	1,000	
5-06	Capital Expenditure	251	843	1,740	1,355	-22.1%	-88.0%	*16,948*	12,443	
5-07	Establishment WTE	5,688.3	5,597.5	5,688.3	5,597.5	-1.6%	0.0%	5,597.5	5,597.5	
5-08	Contracted WTE	5,165.0	5,038.2	5,165.0	5,038.2	-2.5%	-1.4%	5,110.9	5,110.9	
5-09	Vacancies WTE	523.4	559.3	523.4	559.3	6.9%	14.9%	486.5	486.5	
5-11	Vacancy Rate (%)	9.2%	10.0%	9.2%	10.0%	0.8%	1.3%	8.7%	8.7%	
5-12	Substantive Staff Used	5,031.1	4,902.2	5,031.1	4,902.2	-2.6%	-4.1%	5,110.9	5,110.9	
5-13	Bank Staff Used	318.2	457.3	318.2	457.3	43.7%	37.2%	333	333.3	
5-14	Agency Staff Used	253.3	142.1	253.3	142.1	-43.9%	-7.2%	153.2	153.2	
5-15	Overtime Used	44.3	48.0	44.3	48.0	8.3%				
5-16	Worked WTE	5,646.9	5,549.6	5,646.9	5,549.6		-0.9%	5,597.5	5,597.5	
5-17	Nurse Agency Spend	(686)	(751)	(5,257)	(4,178)	-20.5%				
5-18	Medical Locum & Agency Spend	(1,183)	(1,313)	(9,105)	(8,520)	-6.4%				
5-19	Temp costs & overtime as % of total pay bill	15.5%	16.5%	16.1%	15.2%	-0.8%				
5-20	Staff Turnover Rate	10.3%	11.8%		11.7%	1.5%	1.2%	*10.5%*	11.7%	11.05%
5-21	Sickness Absence	4.0%	3.2%		3.3%	-0.8%	0.0%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	89.3%	88.3%		87.8%	-1.0%	2.8%	85.0%	87.8%	
5-23	Appraisal Completeness	81.8%	87.7%		87.7%	5.8%	-2.3%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	96.9%	98.1%	99.2%	98.4%	-0.9%		93.5%	98.4%	
5-25	****Staff FFT % recommended work	62.3%	61%	62.3%	61%	-1.7%	-1.4%	62.0%	61%	
5-26	***Staff Friends & Family -Number Responses	422	33	422	33	-389				
5-27	*****IP Resp Rate Recmd to Friends & Family	17.1%	24.7%	22.6%	24.1%	1.5%	-0.9%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.8%	18.1%	15.3%	16.1%	0.9%	1.1%	15.0%	16.1%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	34.6%	13.6%	24.1%	27.5%	3.4%	2.5%	25.0%	27.5%	24.0%

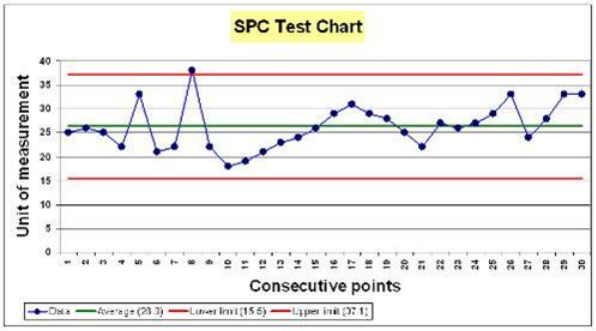
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

****** New :FU Ratio is now both consultant and non-consultant led for all specialties -plan still being agreed so currently last year plan

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

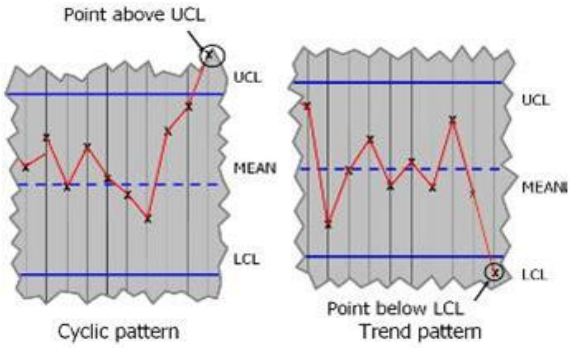
Explanation of Statistical Process Control (SPC) Charts

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:

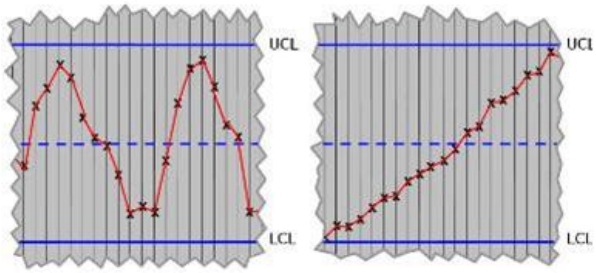


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

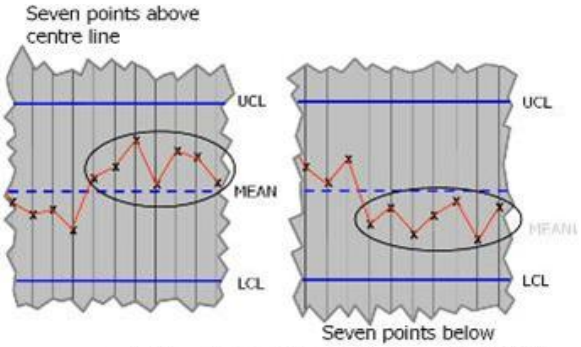


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

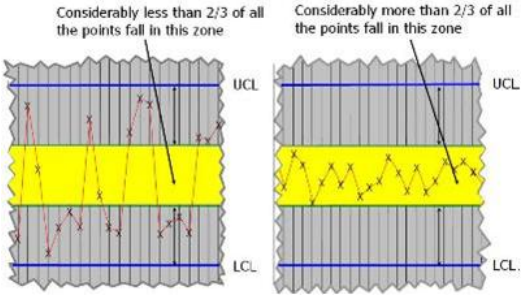


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

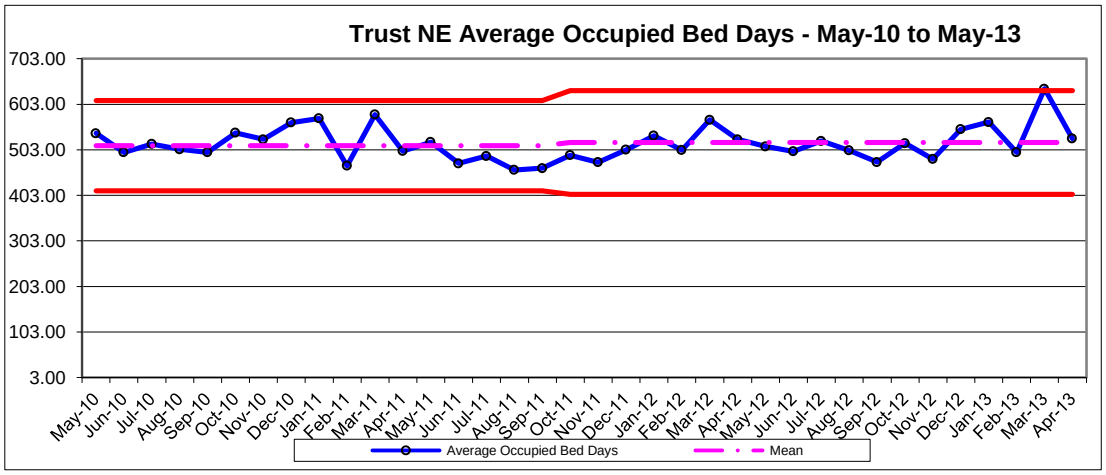


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

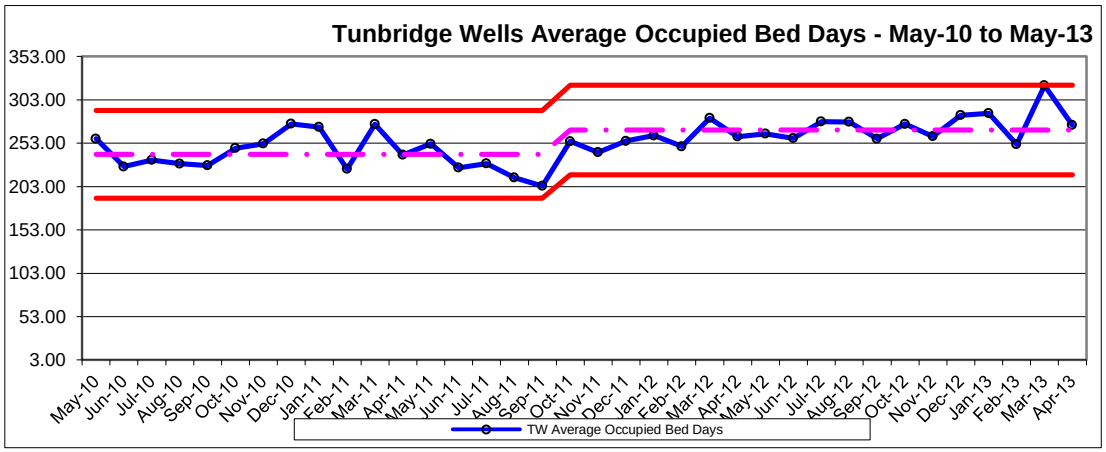


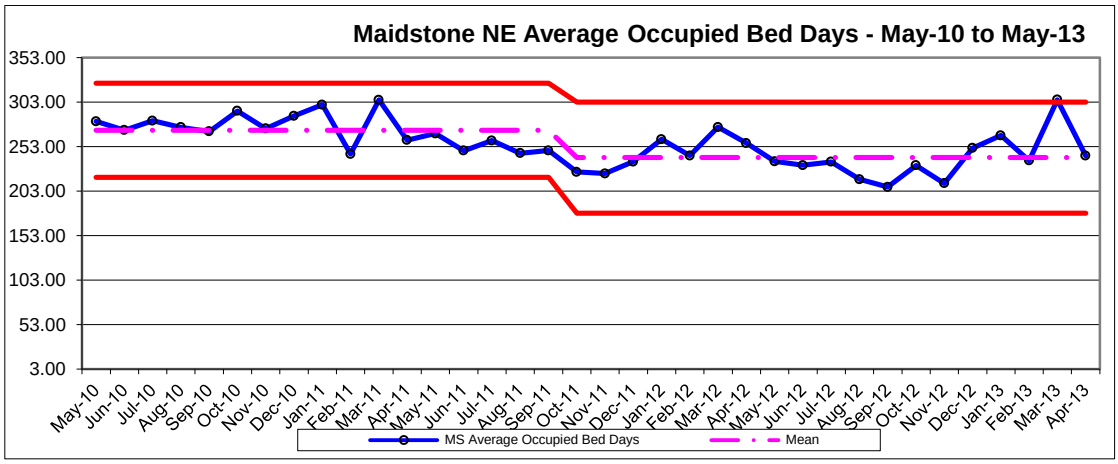
Changes to Control Lines

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:

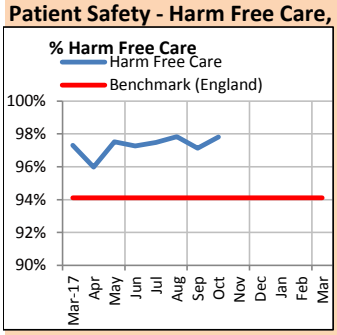


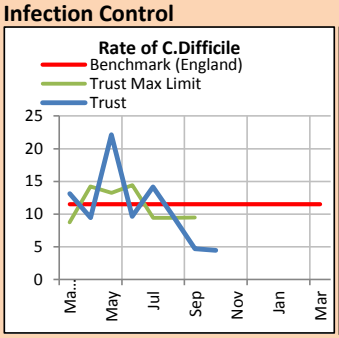


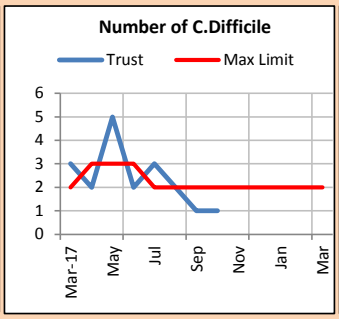
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

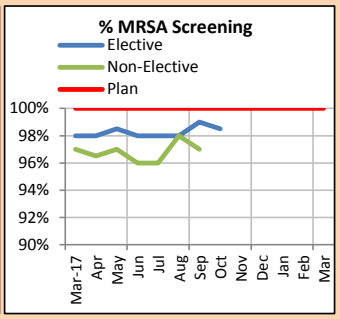
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

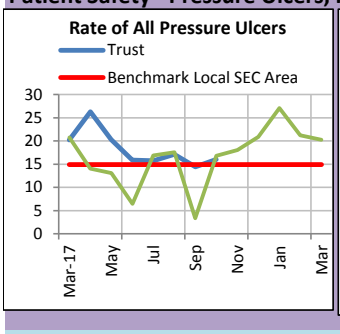


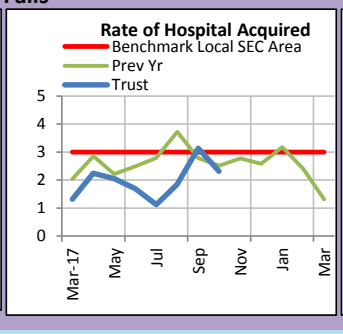


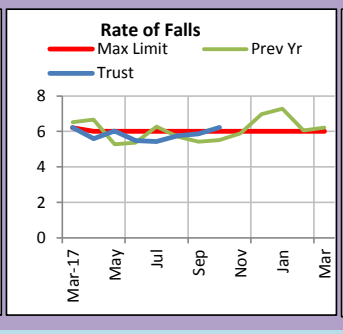


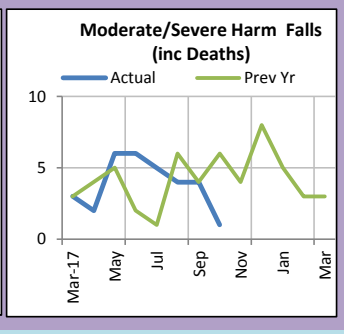


Patient Safety - Pressure Ulcers, Falls

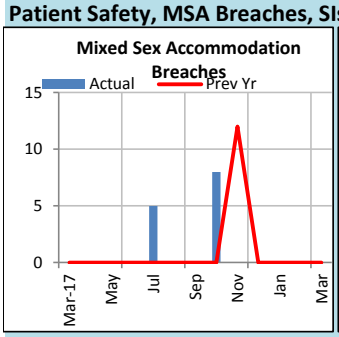


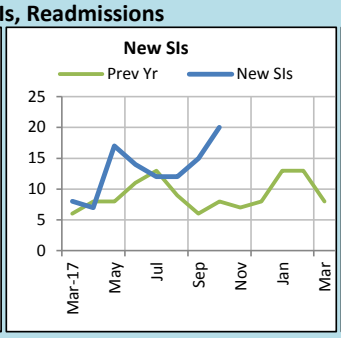


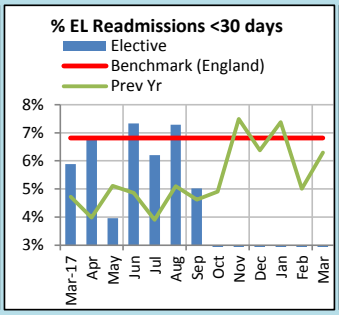


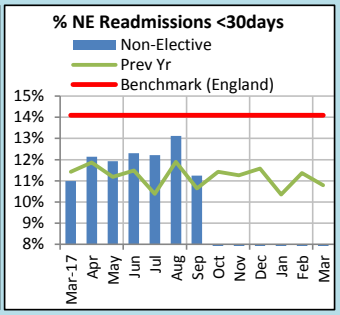


Patient Safety, MSA Breaches, SIs, Readmissions

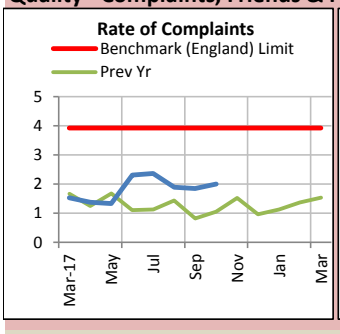


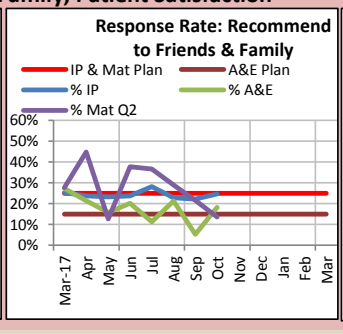


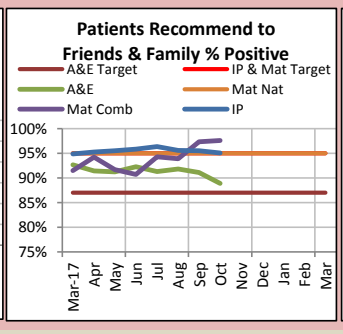


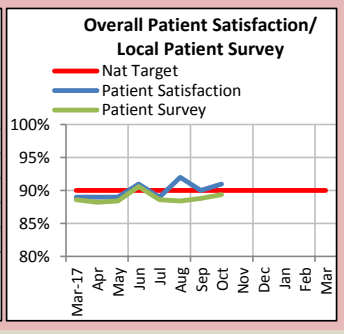


Quality - Complaints, Friends & Family, Patient Satisfaction

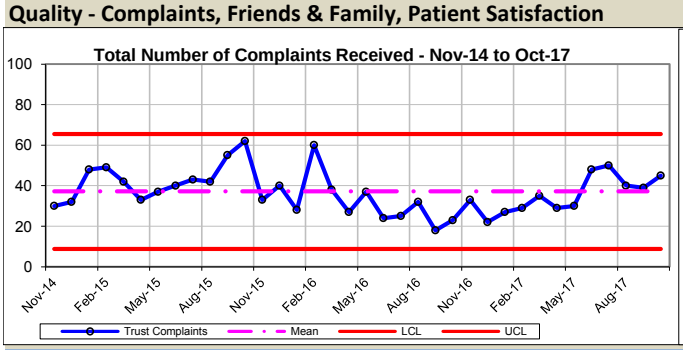


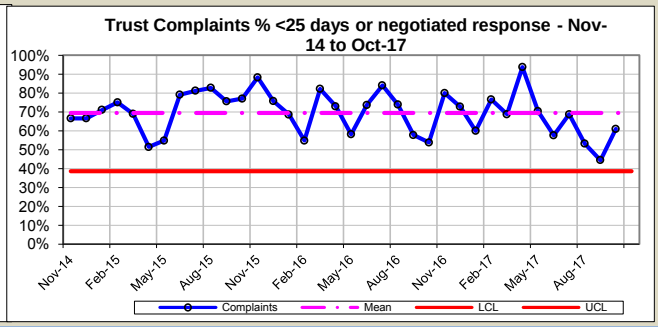




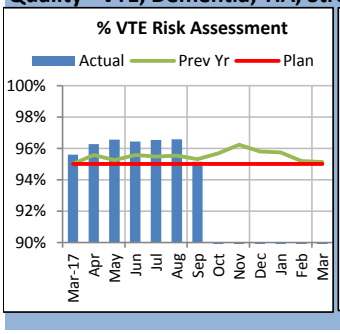


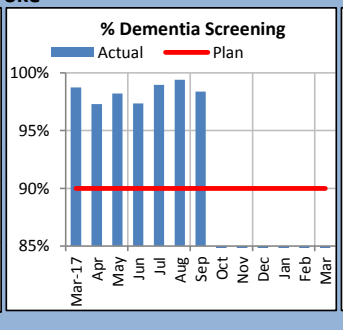
Quality - Complaints, Friends & Family, Patient Satisfaction

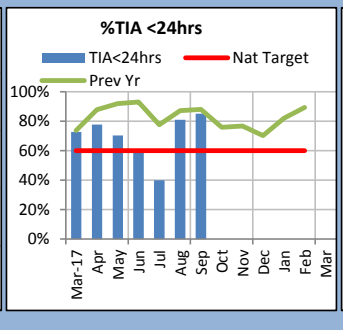


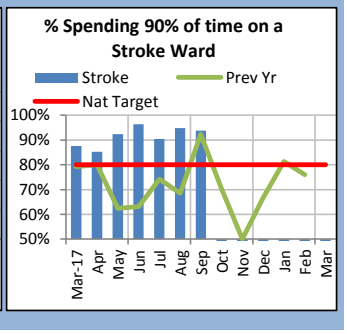


Quality - VTE, Dementia, TIA, Stroke



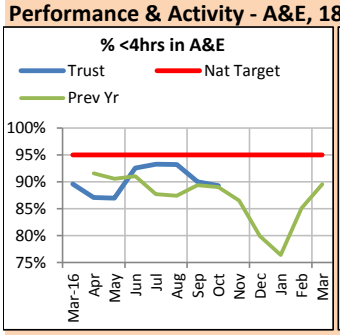


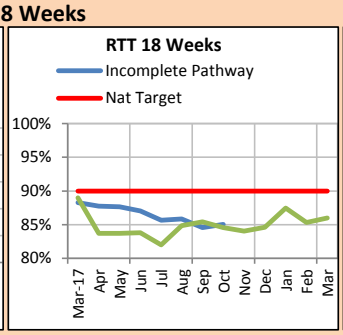


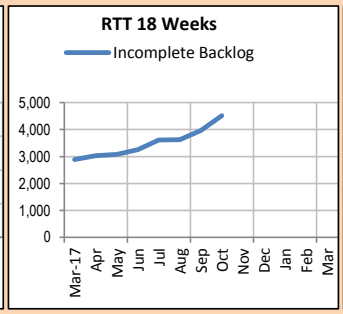


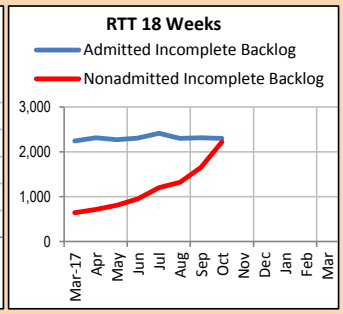
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

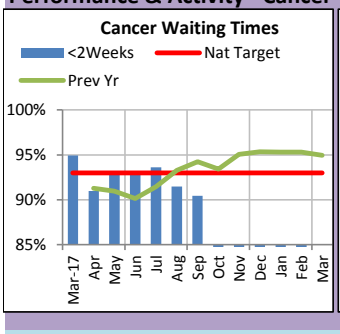


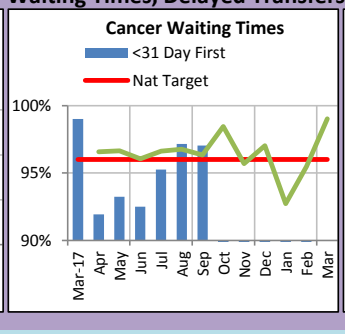


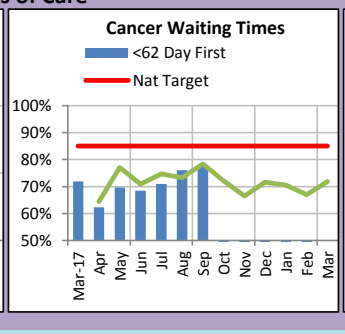


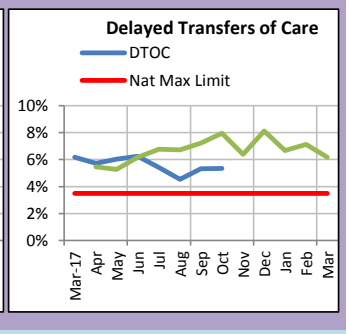


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

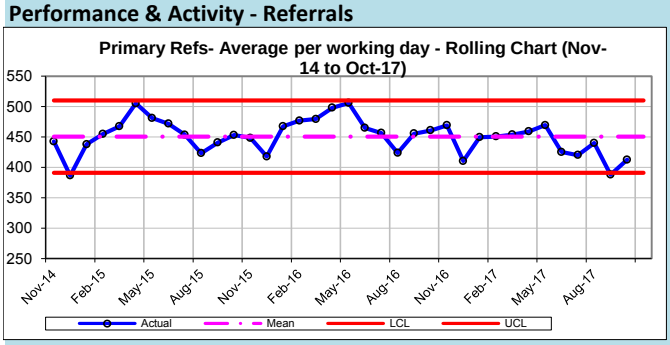


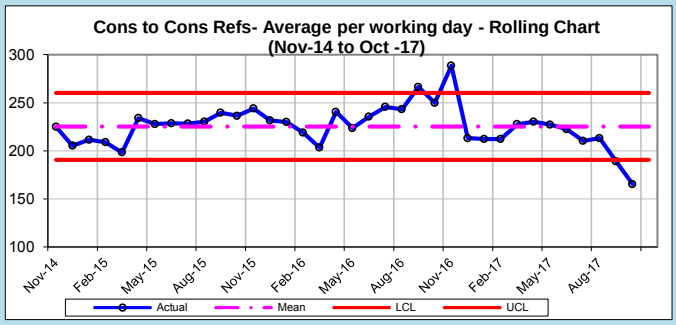




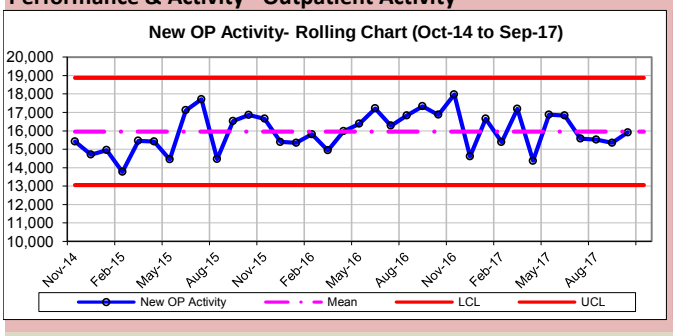


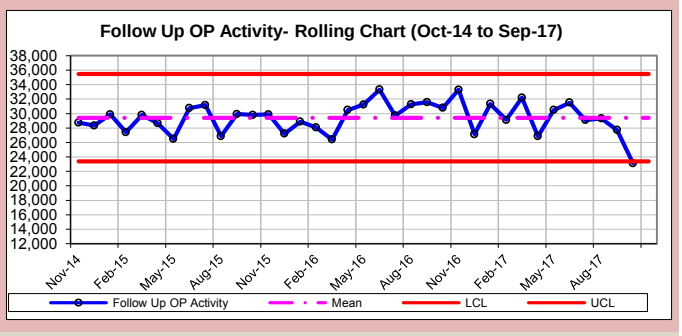
Performance & Activity - Referrals



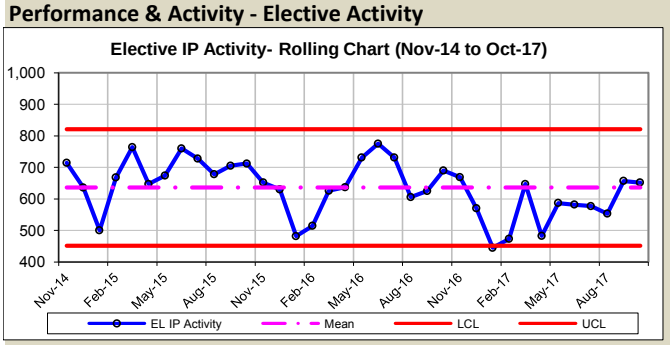


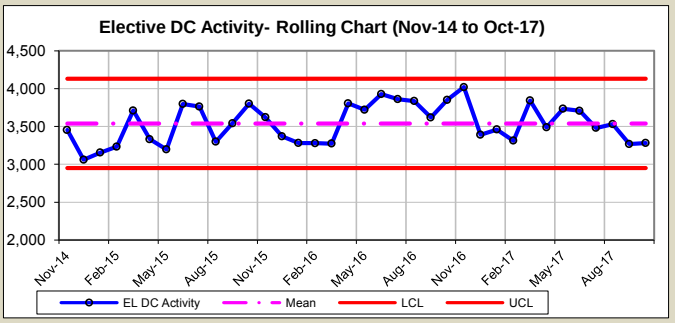
Performance & Activity - Outpatient Activity



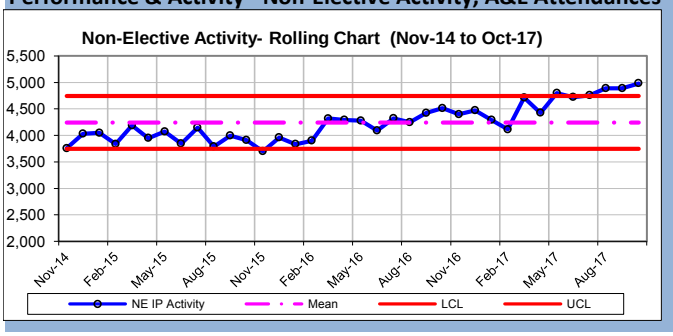


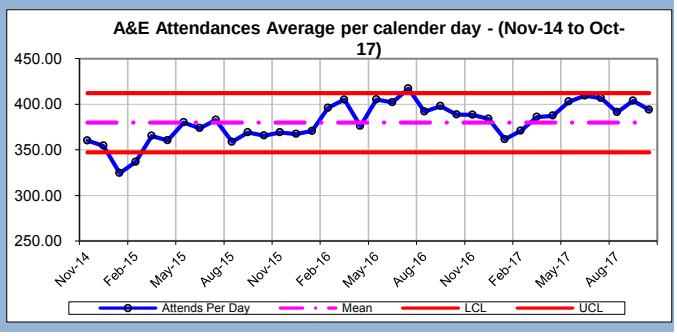
Performance & Activity - Elective Activity





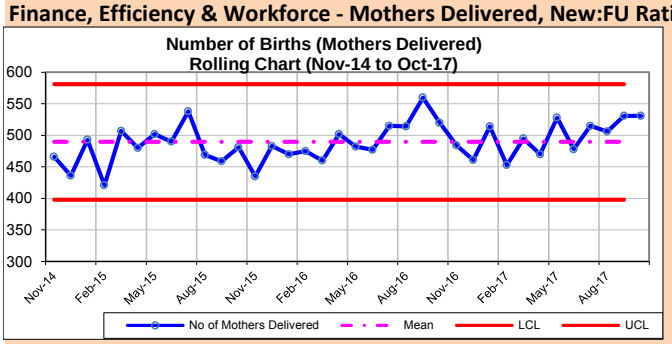
Performance & Activity - Non-Elective Activity, A&E Attendances

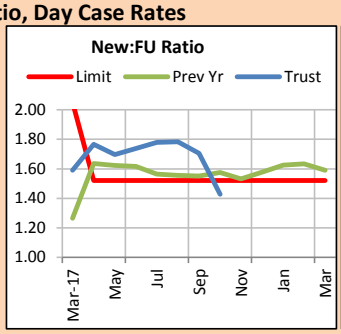


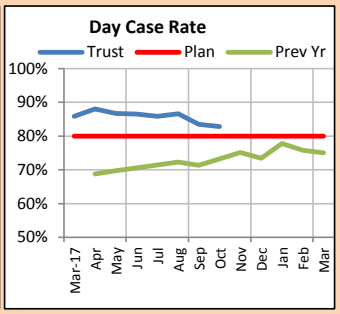


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

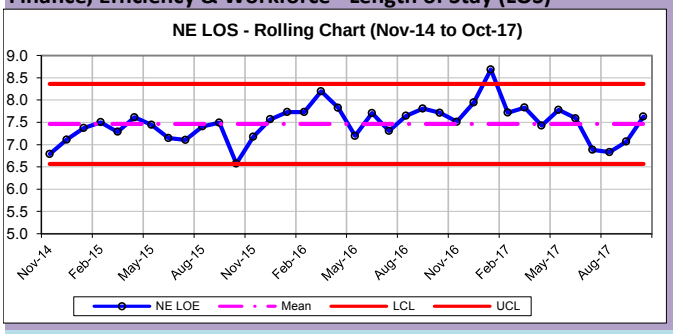
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

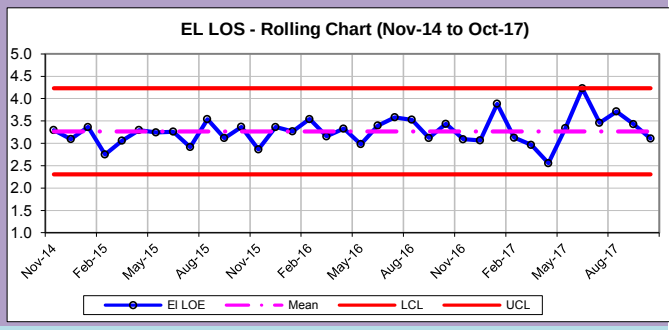




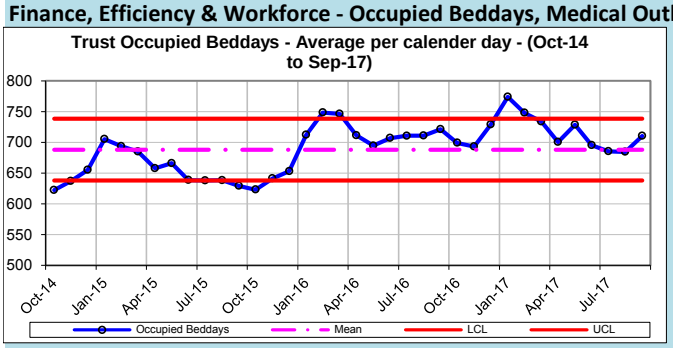


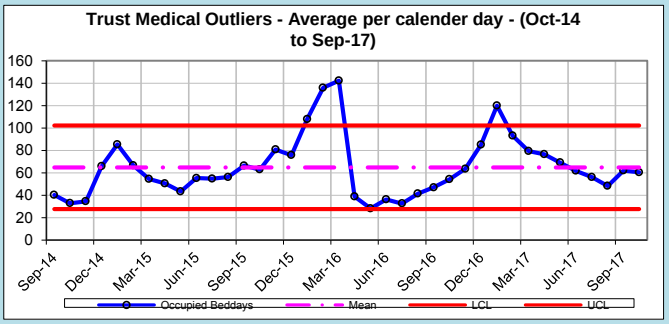
Finance, Efficiency & Workforce - Length of Stay (LOS)



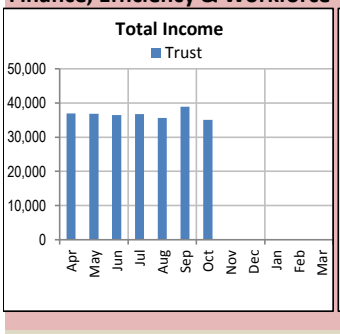


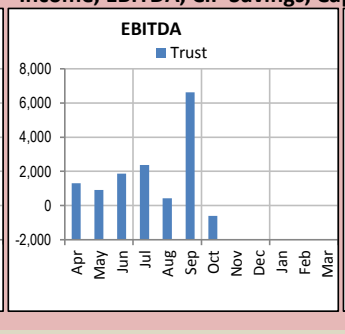
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

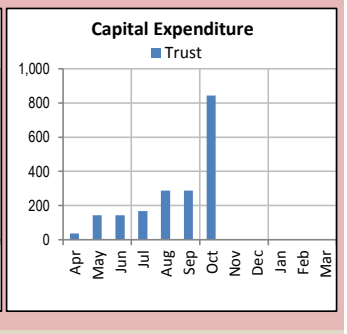




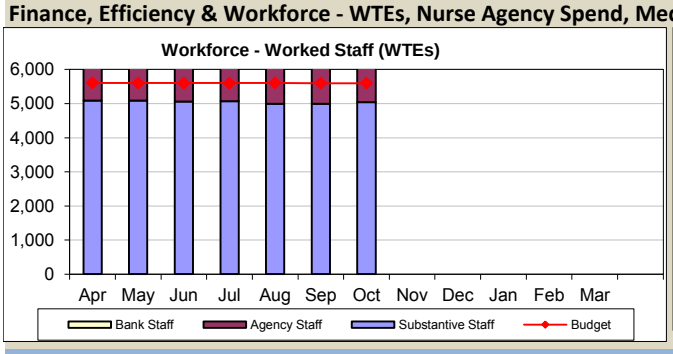
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

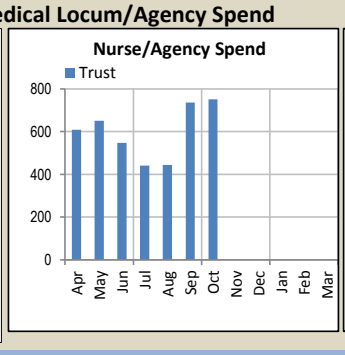


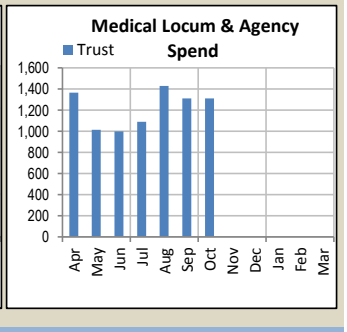




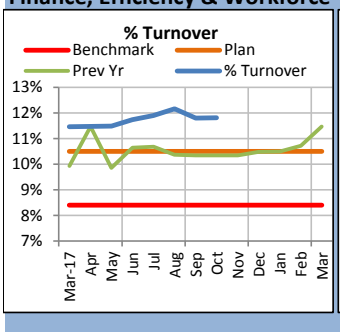
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

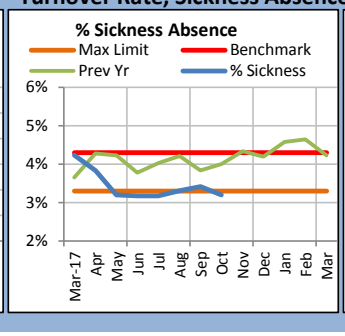


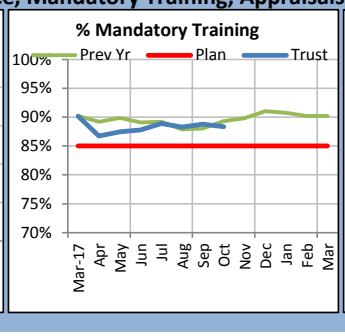


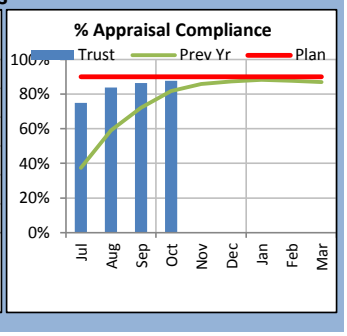


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 7
2017/18

mtw

Content

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack for October 2017

mtw

1.Executive Summary

Maidstone and Tunbridge Wells NHS Trust

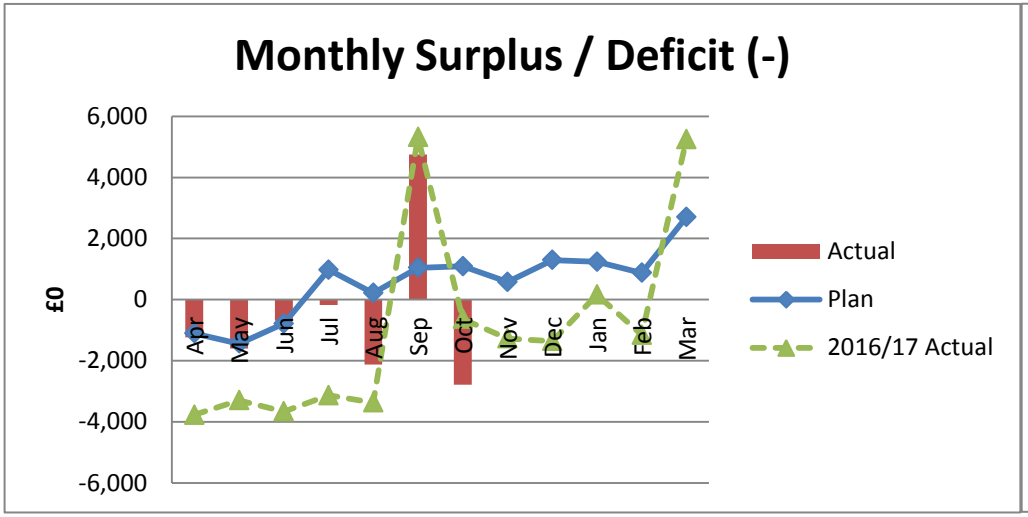
1a. Executive Summary October 2017

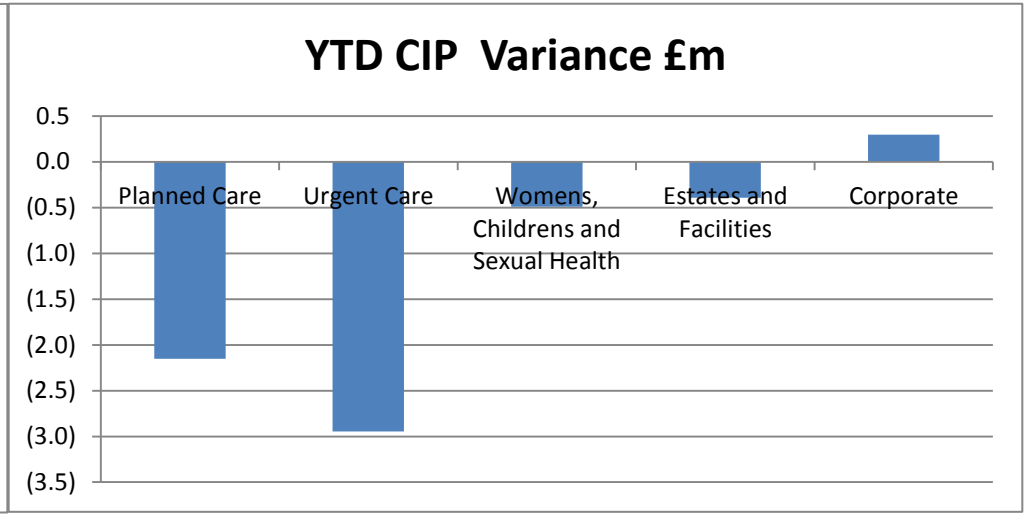
Key Variances £m

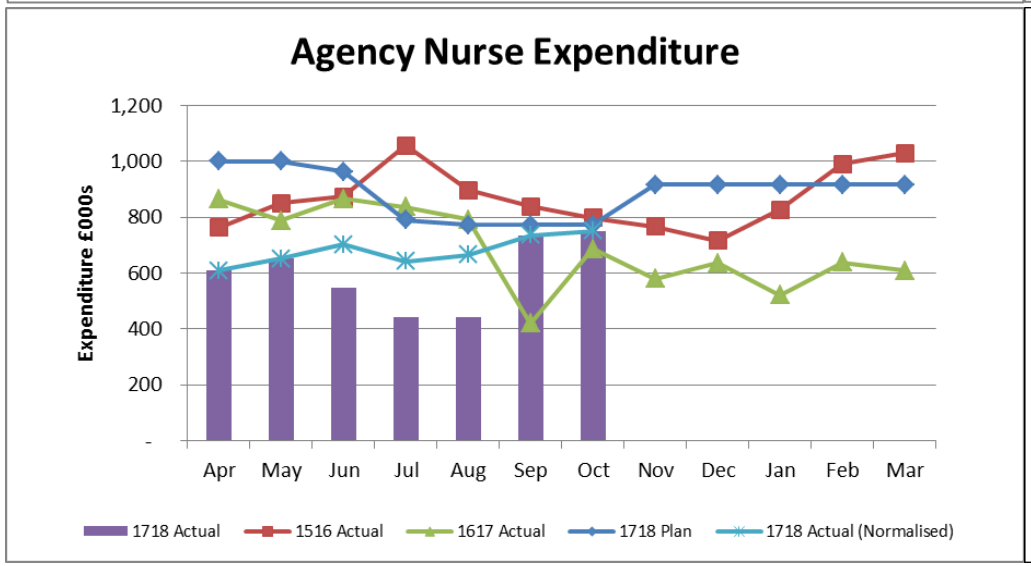
	October	YTD		Headlines
Total Surplus (+) / Deficit (-)	(3.9)	(3.9)	Adverse	The Trusts deficit including STF was £2.8m in October which was £3.9m adverse to plan, £1.1m STF slippage relating to non delivery of financial performance for October, £1.5m slippage against CIP and £1.3m overspent against budget.
Clinical Income	0.1	0.0	Favourable	Clinical Income excluding HCDs was £0.1m adverse in October . The key adverse variances in October were Elective & Day Cases (£0.4m) and Out Patient Activity (£0.7m) offset by favourable variances within non elective (£1.7m).The position included an adverse adjustment of £0.9m relating to the aligned incentive contract (£1.3m positive YTD).
Elective IP and DC	(0.4)	(4.6)	Adverse	Elective and Day Case activity is adverse to plan in month by £0.4m in month and £4.6m year to date.
Sustainability and Transformation Fund	(1.1)	(1.1)	Adverse	The Trust did not deliver its financial performance and A&E trajectory in October therefore was not eligible for STF income.
Other Operating Income	0.1	4.1	Favourable	Other Operating Income £0.1m favourable in the month, £0.6m favourable relating to STP costs (offset by additional costs), partly offset by adverse variance within Private Patient Income (£0.3m), Injury Cost Recovery (£40k) and Overseas visitor income (£30k).
Pay	(1.2)	(0.9)	Adverse	Pay was £1.2m adverse in the month, total pay spend (excluding reserves) was £106k less than September and in line with last months forecast. Medical Staffing costs remain consistent with last month. Nursing costs reduced by £140k between months mainly due to a reduction in bank payroll weeks between months however agency hours increased to the highest level for 12 months. Compared to October 16 there has been a 9% increase in total agency hours used. The Trust nursing workforce in October was 16% temporary staffing which equated to 20% of total pay, the highest areas using temporary staffing are T&O (27%), Surgery (25%) and Specialist Medicine (23%). Specialist Medicine in October ran with the highest agency usage (10%) which equated to 51% of the Trust agency hours. Scientific and Technical staff spend increased by £90k between months mainly within Pharmacy (£50k) due to catch-up in invoices, increase in agency usage to cover vacant posts and higher grade agency staff being used to cover core vacancies. Support staff costs within Estates and Facilities reduced by £70k with spend returning to normalised levels.
Non Pay	(2.1)	(7.7)	Adverse	Non Pay was overspent by £2.1m in October, £0.6m adverse relating to pass through costs for STP, Clinical Supplies £1m adverse (mainly due to unidentified CIP) , £.0.4m due to recoding adjustment between other non pay and depreciation partly offset by £0.2m favourable variance relating to reduction of outsourcing costs.
Depreciation	0.4	0.4	Favourable	Depreciation is underspent to budget by £0.4m
CIP / FRP	(1.5)	(5.7)	Adverse	The Trust achieved £2m savings in October which was £0.1m higher than September however this was £1.5m adverse to plan. The Trust has delivered £11.2m savings YTD and is £5.7m adverse to plan.

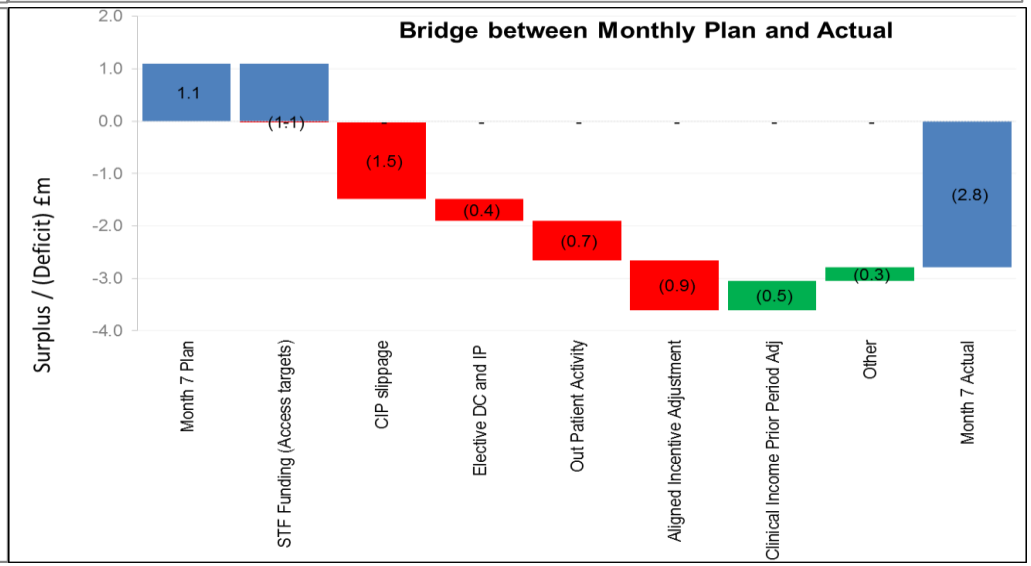
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's October 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure October 2017/18

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	27.8	27.7	0.1	198.1	198.1	0.0	319.4	339.7	(20.3)
	High Cost Drugs	3.5	3.6	(0.1)	25.1	24.0	1.1	60.2	42.2	18.0
	Total Clinical Income	**31.3**	**31.3**	**(0.0)**	**223.2**	**222.1**	**1.1**	**379.6**	**381.9**	**(2.3)**
	STF	0.0	1.1	(1.1)	3.9	5.0	(1.1)	11.2	11.2	0
	Other Operating Income	3.8	3.7	0.1	29.5	25.5	4.1	49.2	43.6	5.6
	Total Revenue	35.0	36.1	(1.0)	256.6	252.6	4.0	440.0	436.7	3.3
Expenditure										
	Substantive	(17.9)	(17.8)	(0.1)	(125.2)	(126.2)	1.0	(216.3)	(215.3)	(1.1)
	Bank	(1.3)	(0.5)	(0.8)	(7.4)	(3.8)	(3.6)	(12.6)	(6.1)	(6.5)
	Locum	(1.3)	(0.8)	(0.5)	(8.5)	(6.1)	(2.4)	(15.1)	(10.2)	(4.9)
	Agency	(0.8)	(1.0)	0.2	(5.5)	(7.8)	2.3	(9.8)	(13.4)	3.6
	Pay Reserves	(0.2)	(0.2)	0.0	0.2	(1.7)	1.9	10.3	(2.9)	13.2
	Total Pay	(21.6)	(20.3)	(1.2)	(146.4)	(145.5)	(0.9)	(243.6)	(247.9)	4.4
	Drugs & Medical Gases	(4.4)	(4.2)	(0.1)	(30.9)	(29.8)	(1.0)	(53.0)	(50.9)	(2.1)
	Blood	(0.2)	(0.2)	0.0	(1.5)	(1.4)	(0.0)	(2.5)	(2.5)	(0.0)
	Supplies & Services - Clinical	(2.5)	(1.6)	(1.0)	(18.1)	(14.2)	(3.9)	(30.4)	(23.7)	(6.7)
	Supplies & Services - General	(0.5)	(0.4)	(0.1)	(3.3)	(3.0)	(0.3)	(5.5)	(5.1)	(0.4)
	Services from Other NHS Bodies	(0.6)	(0.6)	(0.0)	(4.7)	(4.4)	(0.3)	(8.5)	(7.6)	(0.9)
	Purchase of Healthcare from Non-NHS	(0.4)	(0.6)	0.2	(2.5)	(5.0)	2.5	(4.3)	(7.9)	3.6
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(12.0)	(12.0)	(0.0)	(20.6)	(20.6)	(0.0)
	Establishment	(0.3)	(0.3)	0.0	(2.0)	(2.2)	0.2	(3.5)	(3.7)	0.3
	Premises	(1.8)	(1.8)	(0.0)	(12.8)	(12.7)	(0.1)	(22.4)	(21.5)	(0.8)
	Transport	(0.2)	(0.1)	(0.0)	(0.8)	(0.8)	0.1	(1.4)	(1.4)	(0.1)
	Other Non-Pay Costs	(1.5)	(0.4)	(1.1)	(8.3)	(2.9)	(5.4)	(14.2)	(4.9)	(9.3)
	Non-Pay Reserves	(0.0)	(0.1)	0.0	0.2	(0.5)	0.7	5.9	(0.9)	6.8
	Total Non Pay	(14.1)	(12.0)	(2.1)	(96.6)	(88.9)	(7.7)	(160.4)	(150.7)	(9.7)
	Total Expenditure	(35.7)	(32.4)	(3.3)	(243.0)	(234.4)	(8.6)	(404.0)	(398.6)	(5.3)
EBITDA	**EBITDA**	(0.6)	3.7	(4.3)	13.6	18.1	(4.6)	36.1	38.1	(2.0)
		(0.0)	*0.0*	*0.0*	*5.3%*	*7.2%*	*-113.0%*	*8.2%*	*8.7%*	*-60%*
Other Finance Costs										
	Depreciation	(0.8)	(1.2)	0.4	(8.1)	(8.5)	0.4	(14.0)	(14.8)	0.8
	Interest	(0.1)	(0.1)	(0.0)	(0.7)	(0.7)	0.0	(1.3)	(1.3)	0.0
	Dividend	(0.1)	(0.1)	(0.0)	(0.9)	(0.9)	(0.0)	(1.5)	(1.5)	(0.0)
	PFI and Impairments	(1.1)	(1.5)	0.3	(8.0)	(8.4)	0.3	(13.8)	(14.9)	1.1
	Total Finance Costs	(2.2)	(2.9)	0.7	(17.7)	(18.4)	0.8	(30.5)	(32.4)	1.9
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(2.8)	0.8	(3.6)	(4.1)	(0.3)	(3.8)	5.5	5.7	(0.1)
Technical Adjustments	**Technical Adjustments**	0.0	0.3	(0.3)	0.2	0.3	(0.1)	1.2	1.0	0.2
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(2.8)	1.1	(3.9)	(3.9)	(0.0)	(3.9)	6.7	6.7	0.0
	Surplus/ Deficit (-) to B/E Duty Excl STF	(2.8)	(0.0)	(2.8)	(7.8)	(5.0)	(2.7)	(4.5)	(4.5)	0.0

Commentary

The Trusts deficit including STF was £2.8m in October which was £3.9m adverse to plan, £1.1m STF slippage relating to non delivery of financial performance for October, £1.5m slippage against CIP and £1.3m overspent against budget.

The Financial plan for October included £2m unidentified CIP, this was split £0.1m income, £1m pay and £0.9m nonpay.

The Trust's normalised pre STF run rate in October was a deficit of £2.5m which was £0.3m higher than September.

The Trusts deficit in October was £0.5m higher than the forecast, the key adverse movements to forecast were: Clinical Income (£0.6m adverse), mainly due to Adult Critical Care Income (£0.2m) and PP and Injury recovery income (£0.1m) less than forecast. Pay was £0.1m favourable to forecast and non pay was £0.2m adverse to forecast mainly due to an increase in bad debts.

Clinical Income excluding HCDs was £0.1m favourable in October . The key adverse variances in October were Elective & Day Cases (£0.4m) and Out Patient Activity (£0.7m) offset by favourable variances within non elective (£1.7m).The position included an adverse adjustment of £0.9m relating to the aligned incentive contract (£1.3m positive YTD).

STF income £1.1m adverse in October, the Trust did not deliver the financial performance or A&E trajectory in October .

Other Operating Income £0.1m favourable in the month, £0.6m favourable relating to STP costs (offset by additional costs), partly offset by adverse variance within Private Patient Income (£0.3m), Injury Cost Recovery (£40k) and Overseas visitor income (£30k).

Pay was £1.2m adverse in the month, total pay spend (excluding reserves) was £106k less than September and in line with last month's forecast. Medical Staffing costs remain consistent with last month. Nursing costs reduced by £140k between months mainly due to a reduction in bank payroll weeks between months however agency hours increased to the highest level for 12 months. Compared to October 16 there has been a 9% increase in total agency hours used. The Trust nursing workforce in October was 16% temporary staffing which equated to 20% of total pay, the highest areas using temporary staffing are T&O (27%), Surgery (25%) and Specialist Medicine (23%). Specialist Medicine in October ran with the highest agency usage (10%) which equated to 51% of the Trust agency hours. Scientific and Technical staff spend increased by £90k between months mainly within Pharmacy (£50k) due to catch-up in invoices, increase in agency usage to cover vacant posts and higher grade agency staff being used to cover core vacancies. Support staff costs within Estates and Facilities reduced by £70k with spend returning to normalised levels.

Non Pay was overspent by £2.1m in October, £0.6m adverse relating to pass through costs for STP, Clinical Supplies £1m adverse (mainly due to unidentified CIP) , £.0.4m due to recoding adjustment between other non pay and depreciation partly offset by £0.2m favourable variance relating to reduction of outsourcing costs

3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Change between Months
Revenue	Clinical Income	27.9	28.0	27.5	26.9	26.4	28.7	31.9	31.8	32.3	32.1	31.2	32.6	31.3	(1.3)
	STF	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	0.4	0.6	0.3	0.0	2.2	0.0	(2.2)
	High Cost Drugs	3.5	3.4	4.4	3.7	3.3	3.6	(0.1)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0
	Other Operating Income	3.2	3.2	3.3	4.5	3.9	8.4	4.7	4.6	3.5	4.3	4.5	4.1	3.8	(0.3)
	Total Revenue	**35.4**	**35.3**	**35.7**	**35.1**	**33.5**	**41.5**	**37.0**	**36.8**	**36.5**	**36.7**	**35.7**	**38.9**	**35.0**	**(3.9)**
Expenditure	Substantive	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(18.1)	(17.8)	(17.7)	(17.8)	(17.9)	(0.1)
	Bank	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	(0.9)	(1.1)	(0.9)	(1.3)	(1.3)	0.0
	Locum	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	(1.0)	(1.1)	(1.4)	(1.3)	(1.3)	(0.0)
	Agency	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	(0.8)	(0.5)	(0.6)	(1.0)	(0.8)	0.2
	Pay Reserves	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	1.5	(0.2)	(1.7)
	Total Pay	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	(21.1)	(20.8)	(20.8)	(20.0)	(21.6)	(1.6)
Non-Pay	Drugs & Medical Gases	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(4.6)	(4.2)	(4.8)	(4.1)	(4.4)	(0.3)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(2.7)	(2.7)	(2.7)	(2.2)	(2.5)	(0.4)
	Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	(0.3)	(0.5)	(0.5)	(0.0)
	Services from Other NHS Bodies	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.6)	0.0
	Purchase of Healthcare from Non-NHS	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	(0.3)	(0.3)	(0.3)	(0.4)	(0.1)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	0.0
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	0.0
	Premises	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(1.6)	(1.7)	(1.9)	(1.5)	(1.8)	(0.3)
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)
	Other Non-Pay Costs	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	(0.7)	(1.4)	(1.6)	(0.5)	(1.5)	(1.0)
	Non-Pay Reserves	0.0	0.0	0.0	0.0	0.0	1.3	(0.1)	(0.1)	(0.1)	0.2	0.0	0.3	(0.0)	(0.4)
	Total Non Pay	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(13.5)	(13.6)	(14.4)	(11.7)	(14.1)	(2.4)
	Total Expenditure	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(34.6)	(34.3)	(35.2)	(31.6)	(35.7)	(4.0)
EBITDA	EBITDA	1.4	0.9	0.6	0.8	0.3	7.8	1.3	0.9	1.9	2.4	0.4	7.3	(0.6)	(7.9)
		4%	*2%*	*2%*	*2%*	*1%*	*19%*	*4%*	*2%*	*5%*	*6%*	*1%*	*19%*	*-2%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.8)	0.4
	Interest	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	PFI and Impairments	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(0.0)
		(2.9)	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.6)**	**(2.6)**	**(2.2)**	**0.4**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(1.5)	(2.0)	(1.8)	0.1	(42.4)	5.4	(1.3)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(7.5)
Technical Adjustments	Technical Adjustments	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(1.4)	(1.9)	(1.9)	0.3	(2.0)	5.3	(1.2)	(1.6)	(0.7)	(0.2)	(2.1)	4.8	(2.8)	(7.5)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.3)	(2.6)	(2.5)	0.3	(2.0)	4.5	(1.6)	(2.0)	(1.3)	(0.4)	(2.1)	2.5	(2.8)	(5.3)

4. Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.2	0.2	(0.0)
Critical Care	0.2	0.2	(0.1)
Diagnostics	0.1	0.2	(0.1)
Head and Neck	0.1	0.1	(0.0)
Surgery	0.1	0.2	(0.1)
Trauma and Orthopaedics	0.4	0.6	(0.2)
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**1.1**	**1.6**	**(0.6)**
Urgent Care	**0.4**	**0.9**	**(0.4)**
Womens, Childrens and Sexual Health	**0.2**	**0.4**	**(0.3)**
Estates and Facilities	**0.1**	**0.3**	**(0.3)**
Corporate	**0.3**	**0.2**	**0.1**
Total	**2.0**	**3.5**	**(1.5)**

Comment

The Trust achieved £2.0m savings in October which was £0.1m higher than last month however this was £1.5m adverse to plan. The plan includes £2m unidentified savings phased from July.

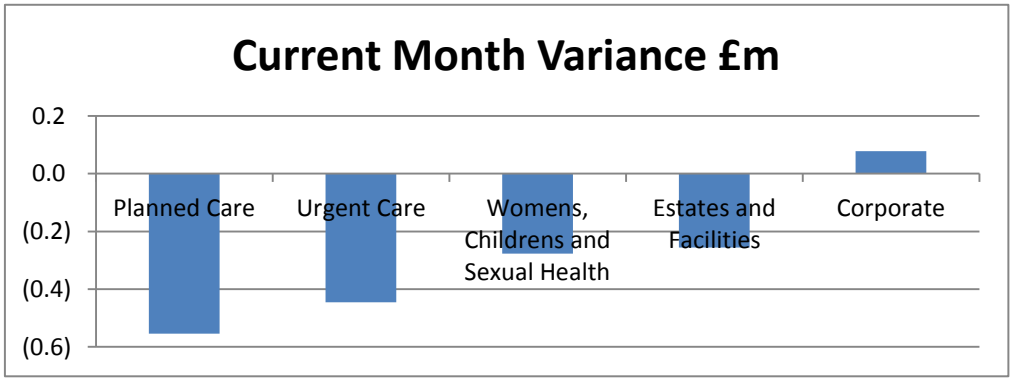
The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in September were £1.8m below plan.

Planned Care: £0.55m adverse compared to original CIP planned and to the 'live' plan. The main directorates adverse to plan (Live) Diagnostics (£140k) which relates to £72k unidentified savings and procurement savings (£38k) and Surgery Directorate (£115k) mainly due to unidentified savings (£80k) slippage relating to pay schemes (job planning and WLI reduction).

Urgent Care: £0.4m adverse compared to the original plan, when compared to the 'live' plan the directorate are £1m adverse in the month which is mainly due to £0.45m unidentified savings , slippage in closing 2 ward (£0.3m) and slippage in deep dive savings plan (£0.15m).

Womens, Childrens and Sexual Health: £0.3m adverse compared to the original plan and £0.2m adverse to the 'live' plan, the slippage relates to unidentified savings.

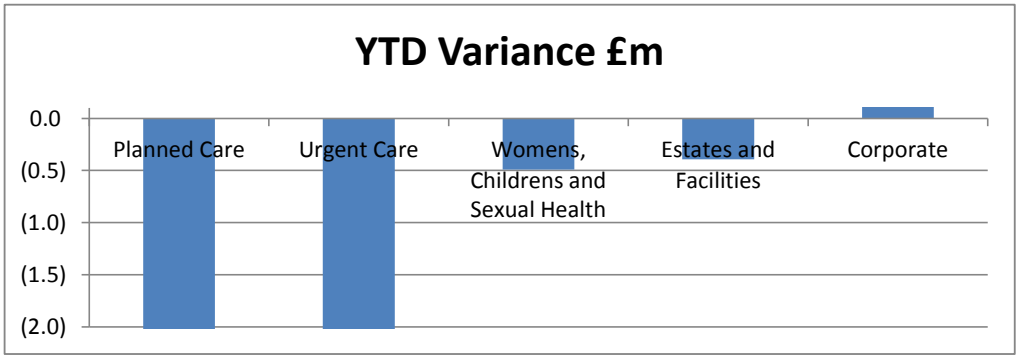
Estates and Facilities: £0.3m adverse to the original and £0.2m adverse to the 'live' plan. The main slippage relates to EPC energy business case (£70k per month) , rental income (£34k) and bus service contract review (£20k).



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.9	1.0	(0.1)
Critical Care	0.6	1.2	(0.6)
Diagnostics	0.5	1.1	(0.6)
Head and Neck	0.4	0.5	(0.1)
Surgery	0.5	0.9	(0.4)
Trauma and Orthopaedics	3.0	3.2	(0.2)
Patient Admin	0.1	0.0	0.0
Private Patients Unit	0.1	0.1	(0.0)
Total Planned Care	**5.9**	**8.1**	**(2.2)**
Urgent Care	**1.8**	**4.8**	**(2.9)**
Womens, Childrens and Sexual Health	**1.2**	**1.7**	**(0.5)**
Estates and Facilities	**0.9**	**1.3**	**(0.4)**
Corporate	**1.3**	**1.0**	**0.3**
Total	**11.2**	**16.9**	**(5.7)**



Comment

The Trust has achieved £11.2m savings YTD which is £5.7m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved YTD were £7.3m below plan.

Planned Care: £2.2m adverse compared to original CIP planned phasing, £2.6m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£681k adverse) which is due to £289k unidentified, procurement 10% savings target (£267k) and £50k delay in implementation of the new MLS contract. Surgery Directorate (£551k) adverse which is due to unidentified savings (£321k), deep dive review (£83k) and medical pay savings (£123k) relating to job planning and WLI savings.

Urgent Care: £2.9m adverse compared to the original plan, when compared to the 'live' plan the directorate are £3.4m adverse YTD. This is due to £1.8m unidentified savings, delay in closing wards (£1m), slippage in procurement savings (£0.35m) and slippage in pharmacy savings (£0.2m).

Womens, Childrens and Sexual Health: £0.5m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.8m adverse YTD. The YTD adverse variance (£0.8m) is due to unidentified savings.

Estates and Facilities: £0.4m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.7m adverse YTD. This is due to £0.2m Energy Savings, £0.1m Bus Service contract, £0.1m delay in sale of Springs, £0.1m Laundry contract savings and £0.1m Rental income from East Kent.

Corporate: Corporate directorates are £0.3m favourable to the original plan and are £0.2m favourable to the 'live' plan. The main slippage relating to the live plan relates to HR (£50k) due to the savings plans associated with restricting advertising (£50k) no longer being explored.

mtw

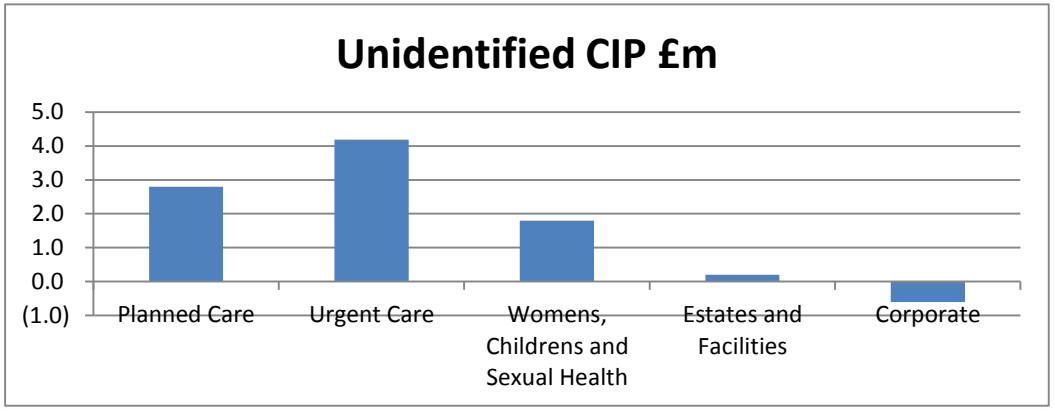
Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	*Unidentified (Risk Adjusted)*	*Plan*	*% Unidentified*
	£m	£m	£m	
Cancer and Haematology	2.0	0.3	2.3	15%
Critical Care	1.6	0.6	2.2	28%
Diagnostics	1.0	0.8	1.8	45%
Head and Neck	0.8	0.2	1.0	21%
Surgery	1.0	0.8	1.8	46%
Trauma and Orthopaedics	5.2	(0.1)	5.1	-2%
Patient Admin	0.1	0.0	0.1	16%
Private Patients Unit	0.1	0.0	0.2	22%
Total Planned Care	**11.7**	**2.8**	**14.5**	**19%**
Urgent Care	**4.7**	**4.2**	**8.9**	**47%**
Womens, Childrens and Sexual Health	**1.9**	**1.8**	**3.7**	**49%**
Estates and Facilities	**2.7**	**0.2**	**2.9**	**7%**
Corporate	**2.5**	**(0.6)**	**1.9**	**-32%**
Total	**23.4**	**8.4**	**31.7**	**26%**

Savings as per 7th September



The Trust has a £31.7m CIP plan for 2017/18 and has identified £24.6m (non risk adjusted) , £7.1m unidentified. The current forecasted risk adjusted identified savings is £23.4m, a shortfall of £8.4m.

Planned Care Division have identified £12.8m savings which is risk adjusted to deliver £11.7m. The division has £2.8m risk adjusted shortfall (19%).

Urgent Care Division have identified £4.8m savings which is risk adjusted to deliver £4.7m. The division has £4.2m risk adjusted shortfall (47%).

W&CH Division have identified £1.9m savings which is risk adjusted to deliver £1.9m. The division has £1.8m risk adjusted shortfall (49%).

5. Balance Sheet and Cash

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

October 2017

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

	October			September	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	274.8	277.4	(2.6)	274.7	277.7	(3.0)
Intangibles	2.7	2.8	(0.1)	2.7	2.8	(0.1)
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.7	1.2	0.5	1.5	1.2	0.3
Total Non-Current Assets	**279.1**	**281.4**	**(2.3)**	**278.9**	**281.7**	**(2.8)**
Current Assets						
Inventory (Stock)	7.2	8.3	(1.1)	7.6	8.3	(0.7)
Receivables (Debtors) - NHS	46.2	38.7	7.5	45.8	36.2	9.6
Receivables (Debtors) - Non-NHS	16.2	9.5	6.8	14.8	9.5	5.3
Cash	4.1	4.8	(0.7)	2.2	2.4	(0.2)
Assets Held For Sale	0.8	0.0	0.8	0.7	0.0	0.7
Total Current Assets	**74.5**	**61.3**	**13.2**	**71.1**	**56.4**	**14.7**
Current Liabilities						
Payables (Creditors) - NHS	(5.8)	(5.4)	(0.4)	(5.4)	(5.4)	(0.0)
Payables (Creditors) - Non-NHS	(70.7)	(43.2)	(27.5)	(64.3)	(40.1)	(24.2)
Capital & Working Capital Loan	(1.1)	(2.2)	1.1	(2.2)	(2.2)	0.0
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.0)	(0.0)
Provisions for Liabilities and Charges	(1.8)	(1.2)	(0.6)	(1.8)	(1.2)	(0.6)
Total Current Liabilities	**(84.4)**	**(57.0)**	**(27.5)**	**(78.7)**	**(53.9)**	**(24.8)**
Net Current Assets	(9.9)	4.3	(14.3)	(7.6)	2.5	(10.0)
Finance Lease - Non- Current	(195.0)	(198.5)	3.5	(195.5)	(197.7)	2.3
Capital Loan - (interest Bearing Borrowings)	(12.3)	(11.2)	(1.1)	(11.2)	(11.2)	0.0
Interim Revolving Working Capital Facility	(30.7)	(29.0)	(1.7)	(30.7)	(29.0)	(1.7)
Provisions for Liabilities and Charges	(1.2)	(0.5)	(0.6)	(1.1)	(0.6)	(0.6)
Total Assets Employed	**30.0**	**46.4**	**(16.4)**	**32.8**	**45.6**	**(12.8)**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(205.0)	0.0	(205.0)	(205.0)	0.0
Revaluation reserve	(30.3)	(30.3)	0.0	(30.3)	(30.3)	0.0
Retained Earnings Reserve	205.3	188.9	16.4	202.5	189.7	12.8
Total Capital & Reserves	**(30.0)**	**(46.4)**	**16.4**	**(32.8)**	**(45.6)**	**12.8**

Commentary:
The balance sheet is £16.5m or 35% less than plan, primarily due to variations in current assets and current liabilities. Key movements to October are in working capital where Total Current Liabilities is 48.2% over plan. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets (PPE) - The value of PPE has decreased from the September position as assets are depreciated. The in-year capital programme has been prioritised and the majority of business cases have been approved.

Current Assets - Inventory has decreased from the reported September position by £0.4m primarily due to Pharmacy stock. Inventory reduction is a cash management strategy.

NHS Receivables have increased by £0.4m compared to the September reported position, being above the plan value by £7.5m. Of the £46.2m balance, £19.2m relates to invoiced debt of which £7.0m is aged debt over 90 days. Debt over 90 days has decreased by £0.2m compared with the September reported position. The remaining £27.0m relates to Block income raised in advance (£21.7m) for cash flow purposes and accrued income. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned. Trade receivables has increased compared with the September reported position by £1.5m, and is above plan by £6.8m. Included within this balance is trade invoiced debt of £3.1m which has increased by £0.7m compared to September and private patient invoiced debt of £0.3m.

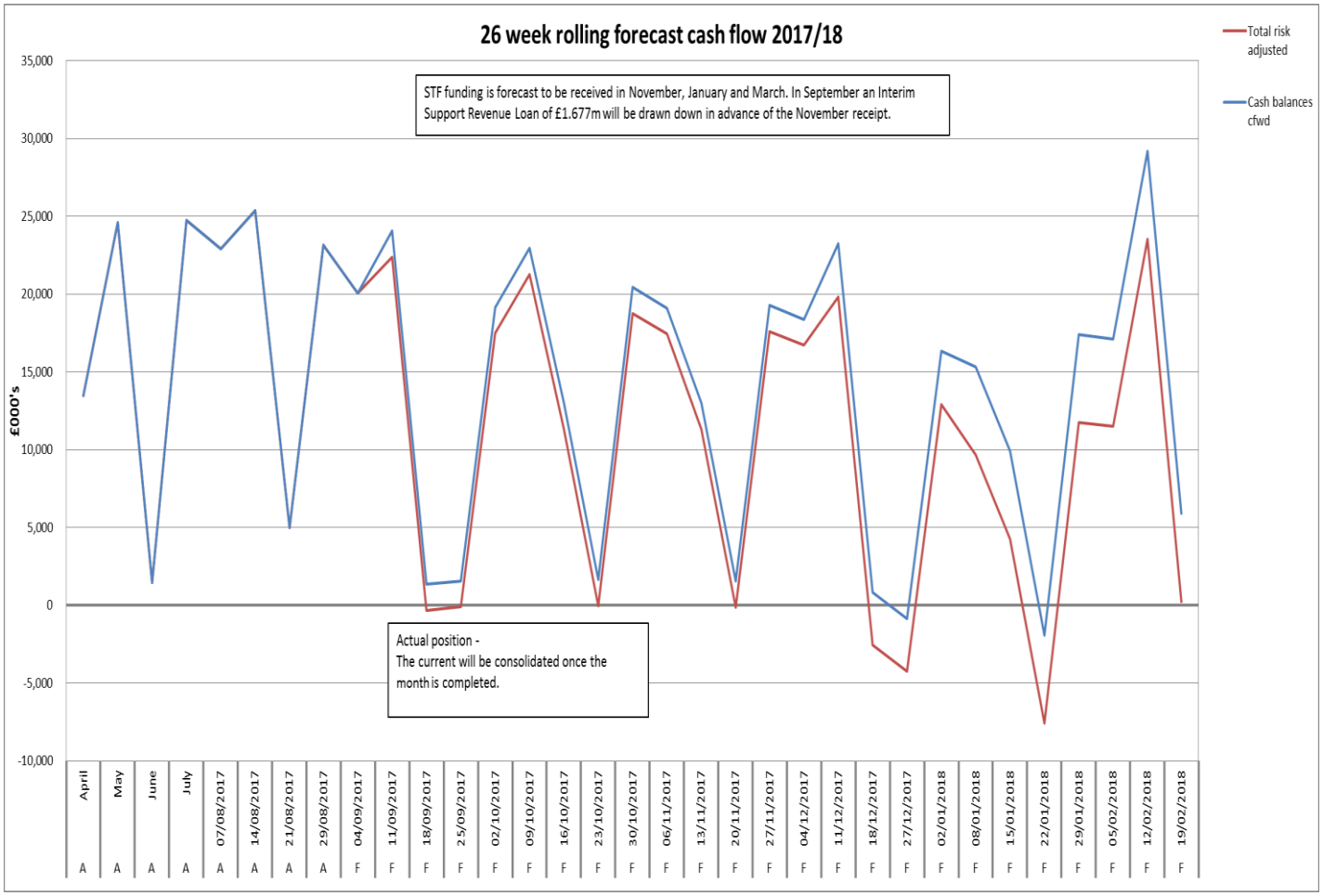
Current Liabilities - NHS payables have increased from the September reported position by £0.36m. Non-NHS trade payables has increased since September by £6.45m and remain significantly above the plan of £43.2m.

Of the £76.5m creditor balances, £27.1m relates to invoices, £28.0m is deferred income primarily relating to double block from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA. The remaining £21.4m relates to accruals, including TAX, NI, Superannuation, PDC .

5b. Liquidity

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Commentary

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

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

The risk adjusted items on the graph relate to STF Funding for Qtr 3, along with £0.5m asset sales forecast for receipt in January 2018 . If this income is not received these will be mitigated by proposed strategies.

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

The Trust is currently up to date with agency and pharmacy supplier payments.

6. Capital

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	966	7,973	7,007	8,873	5,012	3,861
ICT	892	1,240	348	1,664	1,664	0
Equipment	225	1,804	1,579	5,909	4,015	1,894
PFI Lifecycle (IFRIC 12)	268	268	0	502	502	0
Donated Assets	0	250	250	450	450	0
Total	**2,351**	**11,535**	**9,184**	**17,398**	**11,643**	**5,755**
Less donated assets	0	-250	-250	-450	-450	0
Asset Sales (net book value)	-994	0	994	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**1,357**	**11,285**	**9,928**	**15,221**	**9,466**	**5,755**

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

Build work on Linac 1 bunker at Maidstone started in mid May, the Linac machine was delivered onsite on 29th July, commissioning the equipment is in progress ready for clinical use by Dec17. The Trust requested additional PDC funding for the next 2 Linacs, however, only 1 Linac has been approved for 17/18 (£1.7m). The equipment will be put into storage until ready for delivery to the Trust in 18/19.

The Trust has been awarded £645k for GP A&E Streaming works, as additional PDC. The donated equipment is mainly made up of the remaining Cardiology legacies. The Trust disposed of the Hillcroft property for £1.04m gross receipts generating a small profit on sale of c.£20k. The Spring property is expected to complete as a sale on the 1st December. The originally planned Salix loan of £4m has been reduced to £744k as plans for CHP plant would no longer meet the Salix metrics. All three phases have now been approved by Salix and NHSI are agreeing CRL cover with the DH.

The Trust is planning an underspend in depreciation to support the Income & Expenditure position which needs to be matched by a corresponding reduction in the planned capital spend. Additionally some major schemes (e.g. Energy infrastructure) have taken longer to initiate than planned which will reduce the in year depreciation. The current FOT shown below of £11.65m (before donations and asset sales) reflects the maximum reduction if all the potential depreciation underspend occurs - this is subject to confirmation during the third quarter. The NHSI return FOT is reflecting a lower expected depreciation reduction on a prudent basis.

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-11 Update on the Care Quality Commission (CQC) inspection — Chief Nurse

The purpose of this report is to provide the Trust Board with a further update on the unannounced and announced inspections by the CQC.

The Trust has now undergone three unannounced CQC inspections:

First Inspection: 18th October 2017 at Tunbridge Wells Hospital and 19th October 2017 at Maidstone Hospital. Areas inspected: SSSU, Elective Theatres, Pre-op, Critical Care, Stroke, Control room and site meeting, Charles Dickens Day Unit, Peale ward, Cornwallis ward, Theatres, Lord North ward, Endoscopy, Whatman ward, Mercer ward, ITU and Eye Day Care.

Second Inspection: CQC inspectors present across both sites for four days including 7th and 9th November 2017 at Tunbridge Wells Hospital, 8th and 10th November at Maidstone Hospital. Inspectors focused on paediatric services visiting Hedgehog ward, Children's A+E both hospital sites, ambulatory care, Riverbank, Paediatric outpatients, paediatric theatre / recovery pathway, case note reviews and interviewed key personnel.

Third Inspection: 16th November at Tunbridge Wells Hospital and 17th November at Maidstone Hospital. Inspectors focused on Emergency services visiting A+E and associated pathways and AMU across both sites. Tunbridge Wells was escalated by 33 patients at the time of the inspection including escalation into recovery 1 x 3 patients. No patients were boarding, hospital at Opel level 3. Maidstone Hospital was escalation by 8 patients at the time of inspection and Opel level 2.

Key themes: Following the first unannounced inspection the CQC provided limited feedback to the Trust. They identified some opportunities for us to review practice in relation to medicines management, waste management and information governance.

CQC inspectors noted the way in which they were welcome by staff and how staff responded to questions as part of the inspection.

No red flag / immediate concerns raised following paediatric or A+E focussed inspections.

Central project team: The team continues to manage the overarching project plan and remains on schedule with Phase 1 completed and Phases 2– 4 running con-currently. Activities for preparation to the mapped key objectives and activities within the 6 Phase model of delivery continue and in addition to October 2017 board report include the following:

- **PHASE 1** - **Provider Information Request (PIR) Data Collection/Submission** - Completed on schedule and submitted 14th August 2017.
- **PHASE 2A** - **Replies to Phase 1 Data Submission** – Following the CQC's unannounced inspections there has been an increase in additional data requests. To date a total of 87 additional data submissions have been provided to the CQC. 27 hard copies of evidence for review whilst the inspectors were present on site and 60 submissions via the CQC secure portal.

  Good communication has been maintained with the CQC and responses have been submitted on or before time through the secure portal.
- **PHASE 2B** - **Preparation for Unannounced CQC Visit** –. The CQC hub room has been established and provides a central point to manage the CQC preparation and during times of inspections.

  The cascade information and hospitality alert plan for the arrival of inspectors was developed and trialled prior to the first unannounced inspection. It has since been utilised successfully on all three occasions ensuring communication is shared quickly and widely. The out of hours cascade has been agreed and shared with switchboard, Gold and Silver On call Managers and Site teams.

The internal mock inspections have continued with dates mapped out for the remainder of the year.

- **PHASE 2C** – **Communication** – As described in the October 2017 Board report the CQC were provided with a welcome guide; "Your Guide to Maidstone and Tunbridge Wells NHS Trust" in advance of both the unannounced and announced inspection to welcome them to the Trust and to provide some guidance on infection control expectations, site locations and key contacts. This has been received very well with a request from the CQC Inspectors to showcase this as an example of good practice for another Trust.

  The Board Handbook, which includes the Trusts key Initiatives guide, has been through executive approval and shared for comments. This has now been finalised to reflect the additional recommendations.

  Informal CQC drop sessions are held at alternative hospital sites on a weekly basis which is open for ALL staff to come and discuss any concerns or share experiences.

  The Take 5 Talk 5 campaign is now well established in the Friday CEO Newsletter. This continues to raise awareness of key focus areas and is an ongoing reminder of the 5 Key Lines of Enquiry (KLOEs). Themes have included; CQC Feedback and action taken, Medicines management, Making Families Count and a focus on Health and Well Being for staff.

  The Central project team also provide a weekly executive summary report on progress, next steps, issues and findings.
- **PHASE 2D** – **Project Group** - The Daily CQC huddle is now fully embedded into practice providing a daily process for monitoring the risks and issues log. The CQC project group meets weekly with a standing agenda and provides a forum for escalation of any risks / issues requiring the nominated directorate lead to progress outside of the huddle. The Quality Improvement tracker and action plan has been revised to provide a robust form of monitoring, evaluation and assurances against actions in progress with review against "Must do's", "Should do's" and the addition of "New do's".
- **PHASE 3** - **Well Led Domain Self-Assessment** (in preparation for Announced Visit) – The Trust's self-assessment was completed and shared with the Trust Board in October. NHSI have been working closely with the Trust in reviewing this document and associated Trust wide documents; they have provided some objective perspective which has been welcomed.
- **PHASE 4** - **Announced Visit** – This has now been confirmed for 12th and 13th December 2017. In addition to the above progress, provisional room bookings are in place and hospitality plans are being progressed. The Inspection will be based on the Maidstone Hospital site over the course of the 12thand 13th December and will be undertaken by 12 inspectors. The inspection will commence with an informal style "meet and greet" chaired by our CEO and handout which has previously been well received by the CQC team. An interview schedule is being mapped to accommodate the key personnel who will be asked to attend the CQC interviews.

  The Central project team are also collating the additional documents requested by the CQC to be available for review on their arrival. These are aligned to the Well led KLOE requirements.
- **PHASE 5** - **Post Inspection** – Not due
- **PHASE 6** - **Wrap up/Handover/BAU** – Not due

The aspiration and intention of this project plan remains as before; to ensure that MTW can transition from a 'Requires Improvement' status to one of 'Good' but most importantly to ensure that we continue to strive to improve the standard of care that we provide to our patients and improve work processes which will benefit our staff in the way they deliver this care.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information

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

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-12 Planned and actual ward staffing for October 2017 Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for October 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.

1. Wards of note this month include:

Pye Oliver Ward: whilst the fill rate has been within expected limits there has been an increase in the number of falls sustained. As a consequence of the increase in patient falls we have RAG rated the ward as amber.

Ward 12: similarly overall fill rates have been within expected limits, there has been an increase in the number of falls and again as with Pye Oliver the ward has been RAG rated as amber.

Ward 20: this ward remains on amber; this ward has had a sustained requirement for additional staff to manage cohorted groups of patients with either cognitive impairment, high risk of falls or both. This month whilst the staffing fill rate was within anticipated limits, there were 9 additional shifts which were unable to be filled. The falls rate remains higher than the agreed threshold.

Wards 10 and 11 both had need for enhanced care. Ward 10 had a cohort of patients requiring increased observation. There was a change with the RN: CSW ratios at night to account for this. This decision was reviewed and supported by the matron.

Ward 11 had 1 patient requiring 1:1 care throughout the month.

Delivery Suite had a lower than planned fill rate for Registered Midwives however all women in established labour received 1:1 care.

Whatman ward: 1:1 care required for a psychiatric patient for 19 days/nights.

ICU Maidstone had a lower than planned fill rate. This was a considered action taken on the day during the course of the month, as acuity and dependency was low. Staff were redeployed to ICU TWH, Critical Care Outreach and ward areas.

2. 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 have remained stable over the last month with 9.2 for Maidstone and 8.9 for Tunbridge Wells Hospital.

3. 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.

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

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

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

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

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

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

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

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned

	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

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

October'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	101.9%	88.7%	100.0%	127.4%	15.9	30.0%	100.0%	6	1		7 nights of enhanced care requirements	132,329	139,895	(7,566)
MAIDSTONE	Cornwallis	109.7%	85.5%	97.8%	95.5%	7.9	57.6%	95.8%	1	0		CSW fill rate an accepted risk.	72,057	76,913	(4,856)
MAIDSTONE	Coronary Care Unit (CCU)	96.8%	83.9%	100.0%	N/A	11.4	70.0%	100.0%	1	0		CSW fill rate an accepted risk, as CCU is co-located on Culpepper Ward. Staff move between areas according to clinical/patient need.	106,475	114,623	-8,148
MAIDSTONE	Culpepper	100.0%	101.6%	104.8%	100.0%	7.5	83.3%	96.0%	1	0					
MAIDSTONE	John Day	97.6%	113.7%	101.3%	98.4%	7.2	62.7%	95.2%	5	0			127,486	125,383	2,103
MAIDSTONE	Intensive Treatment Unit (ITU)	89.1%	N/A	86.3%	N/A	40.5	100.0%	100.0%	0	0		RN Fill rate an accepted risk as low occupancy/dependency (18 days/nights). Staff moved to TWH ICU/wards as required.	174,246	149,554	24,692
MAIDSTONE	Pye Oliver	97.2%	90.3%	98.9%	98.9%	6.9	35.1%	96.3%	12	1	↓	Rated as amber due to high falls (threshold set at 5)	100,557	112,729	(12,172)
MAIDSTONE	Chaucer	95.1%	94.1%	103.2%	106.5%	9.4	13.3%	94.1%	2	0			109,535	103,948	5,587
MAIDSTONE	Lord North	87.7%	125.8%	96.8%	96.8%	6.7	50.0%	95.8%	2	0		5 RNs short on days during the course of the month, reflected in RN:CSW ratio shift to ensure sufficient headcount to meet care needs.	101,913	95,750	6,163
MAIDSTONE	Mercer	110.0%	96.0%	100.0%	100.0%	6.6	22.6%	85.7%	5	3			101,227	102,672	(1,445)
MAIDSTONE	Edith Cavell	98.9%	94.0%	96.8%	122.6%	5.8	90.9%	90.0%	4	2		10 enhanced care episodes over night.	72,020	74,162	(2,142)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	87.9%	93.9%	128.0%	180.6%	10.1	18.8%	95.7%	5	0		Escalated throughout the month.	104,359	128,437	(24,078)
TWH	Stroke/W22	92.5%	94.2%	98.1%	96.8%	10.3	52.6%	90.0%	2	0			163,074	144,116	18,958
TWH	Coronary Care Unit (CCU)	101.0%	93.5%	100.0%	N/A	12.9	71.8%	89.3%	0	0			61,501	66,564	(5,063)
TWH	Gynaecology/ Ward 33	98.3%	98.5%	100.0%	100.0%	8.0	0.0%	0.0%	1	0			74,602	76,089	(1,487)
TWH	Intensive Treatment Unit (ITU)	102.8%	N/A	100.8%	N/A	30.8	83.3%	100.0%	0	0			179,243	175,751	3,492
TWH	Medical Assessment Unit	96.1%	94.4%	120.0%	105.4%	7.6	49.9%	94.1%	12	0		Escalated throughout the month	162,759	187,236	(24,477)
TWH	SAU	100.0%	96.8%	100.0%	100.0%	7.0	0.0%	0.0%	1	1			54,121	51,405	2,716
TWH	Ward 32	96.2%	97.9%	102.2%	104.5%	7.1	0.0%	0.0%	8	0			122,788	137,266	(14,478)
TWH	Ward 10	93.0%	91.9%	76.6%	167.7%	7.0	27.8%	95.0%	3	0		20 nights requiring enhanced care for a cohort of patients. Reduced RN at night an accepted risk given overall clinical needs. Decisions reviewed daily by matron.	112,453	107,738	4,715
TWH	Ward 11	96.8%	122.6%	90.3%	156.5%	7.4	7.9%	100.0%	7	0		1:1 care required for a named patient	110,018	151,224	(41,206)
TWH	Ward 12	91.5%	100.0%	100.0%	100.0%	6.9	12.9%	100.0%	10	0	↓	Rated as amber due to high falls (threshold set at 6)	122,915	126,593	(3,678)
TWH	Ward 20	90.3%	92.7%	100.0%	98.9%	5.3	43.5%	100.0%	14	0	↔	Rated as amber due to high falls (threshold set at 7). Whilst fill rates this month are within expected range, there were 9 additional shifts which unable to be filled.	106,506	110,291	(3,785)
TWH	Ward 21	98.9%	97.8%	81.3%	143.5%	6.7	38.3%	88.9%	5	2		4 nights of enhanced care needs. 4 RNs downgraded to CSW to ensure sufficient staff to meet care needs.	133,012	124,493	8,519
TWH	Ward 2	96.8%	100.0%	101.1%	112.9%	6.8	53.8%	90.5%	4	1		6 nights of enhanced care needs.	124,028	117,814	6,214
TWH	Ward 30	92.8%	92.2%	103.2%	93.5%	6.5	4.2%	80.0%	12	0			108,041	116,416	(8,375)
TWH	Ward 31	98.4%	89.1%	97.6%	101.1%	7.4	0.0%	0.0%	6	1	↑		129,736	131,448	(1,712)
Crowborough	Birth Centre	101.6%	96.8%	95.2%	100.0%				0	0			85,997	68,641	17,356
TWH	Ante-Natal	98.4%	100.0%	96.8%	74.2%	6.6	13.6%	97.6%	0	0		Fill rate an accepted risk. Staff move between antenatal, postnatal and delivery following the woman. All women in established labour received 1:1 care.	615,173	657,399	(42,226)
TWH	Delivery Suite	84.6%	100.0%	91.4%	95.2%	23.3			0	0					
TWH	Post-Natal	100.0%	61.3%	96.8%	56.5%	6.6			0	0					
TWH	Gynae Triage	91.9%	96.8%	96.8%	93.5%				0	0			11,974	6,094	5,880
TWH	Hedgehog	102.2%	61.3%	109.7%	122.6%	8.5	18.3%	100.0%	0	0		CSW fill rate during the day an accepted risk to ensure cover for additional capacity at night.	197,856	185,314	12,542
MAIDSTONE	Birth Centre	98.4%	90.3%	100.0%	96.8%				0	0			63,527	55,568	7,959
TWH	Neonatal Unit	102.7%	100.0%	103.8%	64.5%	10.7			0	0		CSW fill rate at night an accepted risk. Unit also had post-reg course nurses available both night and day to support.	167,377	175,087	(7,710)
MAIDSTONE	MSSU	104.1%	87.5%	84.1%	N/A	9.5	18.3%	100.0%	0	0			40,769	37,921	2,848
MAIDSTONE	Peale	117.2%	64.6%	100.0%	96.8%	8.5	12.2%	100.0%	1	1		RN:CSW ratio shift to ensure appropriate levels headcount. Skill mix shift due, in part, 'natural adjustment' from skill mix review.	70,239	75,159	(4,920)
TWH	SSSU	100.0%	100.0%	100.0%	100.0%				1	0			66,725	132,102	(65,377)
MAIDSTONE	Whatman	122.6%	92.7%	133.3%	101.6%	12.0	60.0%	88.9%	6	1		RMN required for 19 days & nights.	90,070	107,016	(16,946)
MAIDSTONE	A&E	99.2%	71.0%	99.5%	100.0%		14.7%	93.4%	1	0		CSW fill rate an accepted risk due to inability to fill with temporary staff.	205,145	181,689	23,456
TWH	A&E	96.5%	87.1%	100.0%	93.5%		21.4%	86.0%	3	0			311,865	302,049	9,816
												Total Establishment Wards	**4,893,718**	**5,032,550**	**(138,832)**
												Additional Capacity beds	39,307	31,597	7,710
												Other associated nursing costs	2,194,669	2,553,893	(359,224)
												Total	7,127,694	7,618,040	(490,346)

RAG Key

Under fill

Over fill

Trust Board meeting – November 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

11-14	**"Operational management of winter – expectations and communication" letter from NHSI, and the Trust's response**	**Chief Operating Officer**

The enclosed "Winter briefing 1" was issued by the National Urgent and Emergency Care Director and the Regional Director (South East) from NHS Improvement and NHS England.

The letter sets out further detail of the implementation of this year's winter operating model, as well as expectations of local clinical escalation planning and local winter teams. The Trust was required to submit its response/plans by 20/09/17. The plans the Trust submitted are therefore also enclosed.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 22/11/17

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

Information

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

NHS England and NHS Improvement

Trust CEOs, CCG Accountable Officers, LAEDB Chairs

cc. Regional ADASS Chairs, LGA CHIA, PHE regional lead

Winter briefing 1

Operational management of winter – expectations and communication

I am aware that in recent weeks you have received a number of communications with regards to the management of winter. Over the next few months clarity of communication will be vital, so I have agreed with NHS England, NHS Improvement and other key stakeholders that working with your Regional Director (for Urgent and Emergency Care), I will provide you with regular winter briefings. If you would like to raise any questions related to these briefings, or make any comments and suggestions, then I ask that you email your Regional Director and me directly at nhsi.uecdirector@nhs.net.

This briefing sets out further detail of the implementation of this year's winter operating model, as well as expectations of local clinical escalation planning and local winter teams.

1. Winter operating model

As we have talked about previously, we are developing a new winter operating model this year, focused on continuous monitoring and supporting improvement with a national, regional and local presence. The winter operations infrastructure is being built on a series of principles, based on learning from previous winters both through experience and formal reviews. These are:

- We need to ensure that patient flow in the UEC pathway is maintained 7 days per week.
- We will be more proactive in managing the risks to A&E performance, delivery and patient safety through support, collaboration and transparency.
- There will be a greater emphasis on continuous monitoring and support using information shared at all levels and an emphasis on forecast measures, looking ahead to deploy 'levers' to prevent deterioration in performance or risks to safety.
- There will be a step change in the levels of cover and period of response that matches local expectations and adds value in terms of support to local systems, maintaining safety and improving performance.
- A dedicated team and supporting infrastructure, that are separate from Emergency Preparedness, will be in place to operate this model.
- These teams will be jointly led across NHSE/I with representatives from key partner agencies and functions: ADASS, LGA, PHE, primary care.

The national and regional infrastructure to deliver this operating model is currently being put in place and should be in contact with you in the coming weeks, if not already. In our next briefing we will provide more details on how we see the model working at a local, regional and national level.

2. Local winter teams

We believe that at the heart of the winter operating model should be a supportive interaction with local teams, for this reason we are asking you to establish under the auspices of the Local Delivery Board, if not in place already, a local operational model with the following features:

- A hospital doctor, nurse & operating manager who are accountable for the management of urgent and emergency care and who have a direct relationship with the CEO of the Trust.
- A local cross-system winter operations team, consisting of the following roles, with sufficient capacity released to operate the joint local arrangements and at a level of seniority sufficient to commit organisational resources:
    - A senior manager responsible for UEC in the CCG.
    - Local Authority Social Care Director – nominated by the Local Authorities.
    - Community Provider Senior Operational Lead.

This team will need to be supported to ensure that rapid decisions can be made to meet operational pressures based on a shared set of data and agreed triggers for escalation.

Your Regional Directors and/or Winter Operations Directors will ask you to give assurance that these arrangements are place as we enter the winter period.

3. Local escalation plans

We recognise that local system planning is already well underway to manage the pressures of winter. Further, we have in recent letters, set out the need to develop clinical escalation plans that detail the actions your local system will take in anticipation and response to times of pressure.

Our expectation is that this clinical component is a core part of your local winter escalation plan and that they set out the actions that will need to be taken to consistently ensure that safety is maintained during times of significant pressure. Clinical escalation will need to ensure that:

- All patients who are to be admitted have a timely ‘Decision to Admit’ to ensure they do not need to remain in the ED for any longer than is clinically necessary.
- Patients are not cared for on hospital corridors.
- Escalations beds have the necessary staffing and equipment to ensure safe care.
- 12 hour trolley waits in the ED never happen.
- Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital.
- The hospital can manage increasing demand because of flu, norovirus, etc.

We are asking that every acute trust with a Type 1 A&E department have a real dialogue with all of their clinical staff in order to develop this element of the plan and that they are signed off by your Boards. This should also be shared across your system given that managing escalation is a system-wide responsibility.

We would like you to share your plans with your Regional Director by the 20th November.

Finally, as in previous years, we will be collecting additional information about the availability of services (particularly out of hospital) during the holiday period. This collection will be launched next week.

Across the South East, we know that all local systems have recently completed or are planning local table top exercises to test their winter plans and specifically the inter-play between local organisations' plans at times of escalation. These sorts of exercises and wider contingency planning are good practice and an important part of winter planning for the NHS and we expect you to take forward all of the recommendations from them in your system to ensure possible action is being taken to ensure safe, timely and dignified care for our patients.

We hope that this briefing is helpful and please do provide feedback. Once again thanks for all of the efforts underway to prepare for and manage the pressures of winter.

Pauline Philip
National Urgent and Emergency Care Director

Anne Eden
Regional Director (South East)
NHS Improvement and NHS England

Winter Operating Model – Maidstone and Tunbridge Wells NHS Trust

Executive Lead - Angela Gallagher, Chief Operating Officer

Response to Pauline Philip, Anne Eden Letter re Winter Briefing, Operational Management of Winter – expectations and communications.

What is required	Current position / actions already in place	Further Actions as applicable	Measures of success
We need to ensure that patient flow in the UEC pathway is maintained 7 days per week	• Both EDs open 7 days • Diagnostics and support services available • IDT available	• Additional Medical Staff will be appointed (process underway now) to manage and oversee medical patients outlying on other wards and in escalation areas. • Transfer of elective activity from TWH to Maidstone site to relieve pressure and to facilitated sufficient elective activity to treat clinically urgent and cancer patients and limit the increase of RTT backlog and avoid risk of 52 week breaches in early 2018. • SAFER bundle in place on all wards • Daily DTOC huddle & Stranded patient review by ward.	• NEL LOS not increasing by more than 1 day during winter period. • Increased level of Ambulatory and zero LOS activity in all specialties • Daily OPEL levels at 2 or max 3 • No 12 hour trolley breaches as a result of capacity constraint • No 60 minute ambulance breaches • No ED diverts requested • No capacity related 52 week breaches.
We will be more proactive in managing the risks to A&E performance, delivery and patient safety through support, collaboration and transparency.	• Internal escalation policy in place which reflects OPEL system. • Exec leadership very visible • Collaboration in place within the system and escalation triggers clear – good relationships exist between partners and appropriate access to senior leaders when required. • Predictive attendance and admission modelling. We actively use predictive figures to drive the number of	• Daily winter safety huddle commenced 13-11-2017.	

What is required	Current position / actions already in place	Further Actions as applicable	Measures of success
	discharges needed to meet expected demand		
There will be a greater emphasis on continuous monitoring and support using information shared at all levels and an emphasis on forecast measures, looking ahead to deploy 'levers' to prevent deterioration in performance or risks to safety.	Although this is an area for further development internally re access to more detailed daily analysis, we do have and use • SHREWD • CUR • Daily Sitreps	Daily Emergency Dashboard (to support the huddle) being agreed.	
There will be a step change in the levels of cover and period of response that matches local expectations and adds value in terms of support to local systems, maintaining safety and improving performance.	The winter resilience plan includes additional staffing for ED and AMU as well as additional OOH support from on-call managers (on-call manager on site Sat & Sun from 1st November)		
A dedicated team and supporting infrastructure, that are separate from Emergency Preparedness, will be in place to operate this model.	An MTW winter team (to mirror the system infrastructure) has been established led by the COO and the Trust will commence a daily "winter huddle" to assess flow and patient safety risks that exist, or could arise as a result of capacity and flow issues. In addition we will start a daily "DTOC huddle" with system leads and led by the CEO	Daily winter huddle and DTOC huddle in place from 13-11-2017.	
These teams will be jointly led across NHSE/I with representatives from key partner agencies and functions: ADASS, LGA, PHE, primary care.			

Local Escalation Plan

What is required	Current position / actions already in place	Further Actions as applicable	
All patients who are to be admitted have a timely 'Decision to Admit' to ensure they do not need to remain in the ED for any longer than is clinically necessary.	Capacity and Flow is overseen at director level on a daily basis with 4 times daily site review meetings that assess all current issues with capacity and flow including monitoring DTAs from ED.		
Patients are not cared for on hospital corridors.	This is a situation that we work to avoid through our intensive oversight of the overall capacity and flow issues – if the situation does arise that there is overflow then there are processes and people deployed to manage this.		
Escalation beds have the necessary staffing and equipment to ensure safe care.	Yes – the escalation areas used are day surgery, assessment areas and theatre recovery areas which are equipped for managing overflow for a short period for each patient – maximum of 2 days.	• Daily Winter Huddle • 4 times daily site review meetings • Quality rounds in the ED with escalation • Application of SAFER • Application of OPEL / escalation intervention actions • All DTAs are managed to a 10 hour maximum wait	
12 hour trolley waits in the ED never happen.	This is a situation which we constantly work to avoid and when demand, capacity and flow reach such a stage when this is a real risk then we deploy the "boarding" element of our escalation policy.		
Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital.	We have initiated the actions that facilitate timely handovers – i.e Rapid Assess Process (RAP), however delays occur when demand exceeds our cubicle		

	capacity. MTW and SECAMB have agreed criteria for conveyance directly to MIUs and Urgent Treatment Centres.		
The hospital can manage increasing demand because of flu, norovirus, etc.	All efforts are made to cover each area and manage our absences with, additional hours by permanent staff, moving staff between wards and temporary staffing.	• Flu vaccination programme in place since September with ad-hoc and prearranged appointments available for all staff.	

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-15	**Business Case regarding the Trust's hosting of the Kent and Medway Sustainability and Transformation Partnership (STP)**	**Director of Finance**

At the 'Part 2' Trust Board meeting on 18/10/17, it was agreed to "Submit a brief Business Case to the 'Part 1' Trust Board meeting in November 2017 regarding the Trust's hosting of the Kent and Medway STP".

The enclosed Business Case has therefore been prepared in response.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and decision in relation to the preferred option.

[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

BUSINESS CASE

Title: **Business Case for the Hosting of the Kent and Medway STP's (K&M STP) financial and procurement services by Maidstone and Tunbridge Wells NHS Trust (MTW)**

Issue date/Version number	24.11.2017 V1.1
ID reference	525
Division	Corporate
Directorate	Finance
Department/Site	Maidstone Hospital
Author	Deputy Director of Finance
Clinical lead/Project Manager	Deputy Director of Finance

Approved by	**Name**	**Signature**	**Date**
Finance manager	Richard Sykes		24.11.17
Clinical Director	N/A		
Executive sponsor	Steve Orpin		24.11.17
Division Board	N/A		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	N/A		
Director of Informatics	N/A		
Deputy Chief Operating Officer	N/A		
EME Services Manager	N/A		
HR Business Partner	N/A		

Maidstone and Tunbridge Wells NHS Trust

Business Case Summary

Strategic background context and need

The Kent & Medway STP brings together Clinical Commissioning Groups, Provider bodies and Local Authorities to transform services across the footprint in accordance with the five year plans and published Case for Change. The area serves a population of c 1.8 million with combined Health and Social Care annual budgets of £3.6 billion.

MTW is a full partner in the Kent and Medway STP and has been involved in all areas of the programme including developing and implementing its strategic objectives for achieving optimal reconfiguration of models of care and patient pathways in the footprint and across organisational boundaries, ensuring appropriate strategies on enabling infrastructure (digital, estates, workforce), delivering shared productivity and corporate service efficiencies, and achieving the system-wide financial balance set out in the financial plan.

The STP's financial and procurement transactions and services have been increasingly hosted on an informal basis by MTW since 2016/17, driven in part by the SRO being then the MTW Chief Executive, who has subsequently been appointed as the STP CEO.

It is therefore important at this juncture that MTW considers the case for formally hosting the STP in line with the requirements of its SFIs for hosted services.

Objectives

1. The provision of effective procurement and financial transaction services to the STP to enable the exercise of the approved budget levels within the appropriate governance framework to ensure accountability and transparency to all STP partners and regulators.

2. The provision of financial management and budgetary control services that support the STP management to deliver the STP work plan to budget and to plan the use of resources, including reporting of performance to budget within the level of contributions agreed by all members.

3. Ensuring that the service provision operates in a way which conforms to the Host organisation's internal governance processes, and ensures that the Host is not disadvantaged in terms of unplanned and unfunded costs or working capital cash requirements. This requires clear agreements between all STP parties that the Host will be paid contributions in advance of the liabilities falling due to external contractors, suppliers and in-house payroll payments.

The preferred option.

The preferred option is for MTW to continue to provide the transactional and reporting support to the STP whilst placing this hosting service on a formal basis in terms of internal governance and in the STP agreements of the responsibilities to the Host of each of the participating members.

In practice this means that all contractor and supplier procurement will be actioned through MTW's Procurement team using MTW systems and in compliance with MTW's SFIs and Procurement procedures; the payments will be authorised and transacted through MTW processes and systems; MTW will raise the debtor invoices to participating organisations through its systems and manage cash inflows and liabilities. MTW will also report income and expenditure, and associated workforce and information, to STP management through appropriate

budgetary cost centres within the MTW ledgers.

This will involve workload for Procurement and Finance staff and other associated overhead costs which will need to be agreed in resource levels and financing through the setting of the annual STP budget.

Main risks associated with the investment

The main risks of hosting to the Host are:

1. Exposure to the risk of overspending of the STP budget within the Host's financial position;
2. Exposure to risk of cash shortfalls creating liquidity pressures for the Host if STP partners do not pay the agreed share of the budget funding in advance of the Host meeting external supplier liabilities;
3. Workload requirements on the Host not being matched by agreed funding e.g. tendering for services through the Procurement processes

The main risks of hosting to the STP are:

1. Financial and Procurement services not matching the expectations or needs of STP management in quantitative terms
2. The Host's overall financial position putting stress on liquidity and therefore its ability to discharge debts to STP creditors in accordance with contract terms

Financial impact of the preferred option

The K&M STP budget was reviewed at the November 2017 STP Programme Board and reduced to an agreed level for 2017/18 of £8.2m with clear attribution of each Partner body's contribution to this budget level. For 2017/18 the funding is provided by the 8 CCGs, 6 Provider Trusts, and 2 Local Authorities.

As part of this review it was confirmed that the STP wished to ask MTW to formally host the financial service for the STP as a whole but that this would require:

- That an agreement should be put in place to indemnify MTW as host from costs incurred on behalf of the STP so as that MTW should only be liable for its share of expenditure.

- That on agreement of the budget, invoices from MTW regarding the STP will be raised quarterly in advance and that invoices regarding STP finances will not be subject to normal organisation to organisation cash management approaches i.e. will not be subject to "like for like" payment approaches.

The Business Case

1. Strategic context *Strategic Case*

National

Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and 'final' plans were submitted in October. These plans are now going through a process of assessment, engagement and further development through to implementation.

Local

The Kent & Medway STP brings together Clinical Commissioning Groups, Provider bodies and Local Authorities to transform services across the footprint in accordance with the five year plans and published Case for Change. The area serves a population of c 1.8 million with combined Health and Social Care annual budgets of £3.6 billion.

MTW is a full partner in the Kent and Medway STP and has been involved in all areas of the programme including developing and implementing its strategic objectives for achieving optimal reconfiguration of models of care and patient pathways in the footprint and across organisational boundaries, ensuring appropriate strategies on enabling infrastructure (digital, estates, workforce), delivering shared productivity and corporate service efficiencies, and achieving the system-wide financial balance set out in the financial plan.

The STP's financial and procurement transactions and services have been increasingly hosted on an informal basis by MTW since 2016/17, driven in part by the SRO being then the MTW Chief Executive, who has subsequently been appointed as the STP CEO.

2. Objective(s) of the proposed investment *Strategic Case*

1. The provision of effective procurement and financial transaction services to the STP to enable the exercise of the approved budget levels within the appropriate governance framework to ensure accountability and transparency to all STP partners and regulators.

2. The provision of financial management and budgetary control services that support the STP management to deliver the STP work plan to budget and to plan the use of resources, including reporting of performance to budget within the level of contributions agreed by all members.

3. Ensuring that the service provision operates in a way which conforms to the Host organisation's internal governance processes, and ensures that the Host is not disadvantaged in terms of unplanned and unfunded costs or working capital cash requirements. This requires clear agreements between all STP parties that the Host will be paid contributions in advance of the liabilities falling due to external contractors, suppliers and in-house payroll payments.

Benefits of Hosting

A single Host for the financial and procurement services offers various benefits to the STP:

- Consistent approach to procurement and financial management and single lines of governance in authorisation and reporting;
- Clear "go to" relationships between STP staffing and Host service provider;

- Clarity for STP contractors and suppliers and avoidance of duplications and confusion;
- Larger sized Host more likely to be able to offer economies of scale and absorb some work without needing additional resource

3. Constraints and dependencies *Strategic Case*

The Host needs to be capable of handling the additional workload that hosting the STP will require. This may need additional resource that will require to be budgeted for in STP finances in order to ensure the Host is appropriately reimbursed for the additional costs incurred. A larger scale Host is more likely to be able to absorb additional workload with the minimum of additional resource.

The STP will need to comply with the Host's governance arrangements e.g. SFIs governing purchasing, financial authorisation and control, business case preparation where applicable, revenue and capital recognition principles and requirements around regulatory reporting (e.g. monthly and year end accounts). This will require the STP management and staff to complete necessary approval documentation and be authorised to utilise specific Host systems.

The STP partners will need to indemnify the Host against the risks of exposure to financial and cash liabilities as a result of STP budget overspending or STP members not fulfilling their funding commitments.

4. Short list of options *Economic Case*

Option 1 Title: MTW formalises the hosting of K&M STP financial and procurement services

Description

MTW continues to provide the procurement and financial services, including financial management reporting, to support the STP, utilising MTW staff and systems.

Key activity and financial assumptions

MTW as Host will operate on the basis that the STP manages its finances within the agreed STP budget, complying with the Trust's financial and procurement governance, and ensuring that the STP partners pay the Trust as Host the agreed contributions to financing.

Non-financial risk associated with the option

Issues in managing and supporting the STP might consume more resource than planned and divert management and staff time from MTW core issues;
There are risks of governance breaches arising from a more arms-length service within the organisation that is less integrated into the standard control systems.

Non-financial benefits associated with the option

The Hosting may promote a more active engagement from a wider range of staff in the STP programmes, as it is seen more as "business as usual" within the organisation rather than an add-on.
The STP management benefit from the advantages of the Host service ethos e.g. in the case of MTW, day one reporting, services that have recently won or been nominated for a number of awards locally and nationally. MTW also has experience of patch wide Hosting e.g. HIS.

Option 2 Title: An alternative partner STP organisation hosts the services

Description

An alternative STP body provides the procurement and financial services, including financial management reporting, to support the STP, utilising their staff and systems.

Key activity and financial assumptions
As per Option 1 for the alternative organisation

Non-financial risk associated with the option
As per Option 1 for the alternative organisation

Non-financial benefits associated with the option
The Hosting may promote a more active engagement from a wider range of staff in the STP programmes, as it is seen more as "business as usual" within the organisation rather than an add-on.

Option 3 Title: A formal vehicle is established to house the STP e.g. a subsidiary company or a Joint Venture Partnership

Description
A special purpose vehicle could be set up to house the STP services in the form of a company or a Joint Venture, with STP stakeholders owning shares or partnership proportions. The systems could be provided by one or more of the existing partners (and so resemble variously Options 1&2, or Option 4) or bought in specifically for this vehicle, though the cost of such an arrangement would be likely to be prohibitive unless it was integrated with an existing or emerging STP wide vehicle for other services.

Key activity and financial assumptions
As per Options 1 & 2 in principle, but the costs of managing a special purpose entity including the accounting for the ownership sharing would increase the likely costs of operation and compliance.

Non-financial risk associated with the option
A separate entity would need a clear constitution, governance arrangements, a legal contract and a range of other compliance and governance requirements that would be unlikely to be justified by the scale or complexity of the budget being managed.

Non-financial benefits associated with the option
This form of vehicle might arguably provide a greater degree of independence from any one member of the STP and be seen to be an example of partnership working in practice. The form of the vehicle might present other operational benefits in the form of flexibility and responsiveness.

Option 4. Title: No Hosting is undertaken but each Partner organisation agrees to manage some element of the STP processes

Description
No formal host but each, or a number of, organisations agree to undertake elements of the purchasing and financial management of the STP.

Key activity and financial assumptions
The level of exposure to compliance and financial risk would be shared, but there would remain a need to ensure no individual organisation was unduly exposed by the transactions they agreed to undertake.

Non-financial risk associated with the option
The main risks are inconsistency, duplication of effort and potentially serviced purchased, a lack of clear oversight and authorisation, reduced transparency and confused and complicated reporting of performance.

Non-financial benefits associated with the option
Spreading the risks so avoidance of undue exposure. Potentially engagement of all or multiple parties in the STP processes.

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 MTW Host – the Preferred Option	Existing experience of Hosting; size of Trust enables benefits from service capacities in finance and procurement. Risks are around financial impacts on Host, both I&E and Cash.	1
Option 2 Alternative Host	Similar to Option 1 but no alternative Host has come forward; might be less experienced in Hosting services than Preferred option but inherent financial position/cash availability might be stronger.	2
Option 3 Subsidiary/JV	Might promote more transparent "fair share" collective ownership ethos. Unless existing vehicle available to utilise this option is probably prohibitive in cost and governance set up;	3
Option 4 No single Host	Spreads the risk across multiple organisations and taps into potential strengths in different areas; but likely to lead to confused governance and reporting arrangements with risk of loss of financial control.	4

4b. Directorate decision on which option is preferred and why

The preferred option is a single organisation Host which simplifies requirements for governance and reporting, makes maximum use of existing services, systems and scale, and promotes consistent and standardised process and reporting. Options 1 and 2 both provide this facility. Option 1 is preferred because:

1) MTW is already providing the integrated services informally and has prior experience of managing Host arrangements within its governance structures;

2) No other organisation in the STP has volunteered to be a single body Host;

3) The alternative options are more complex, expensive or fragmented to be immediately workable.

5. Commercial considerations **(preferred option)** *Commercial Case*

5.a. Services and/or assets required

The preferred option will use MTW's financial and procurement systems and staffing (currently using Integra 2 system) and operate within MTW Standing Financial Instructions and governance arrangements. STP staffing will need to comply with MTW's governance requirements to access systems, conform as applicable to MTW procedures and policies, and use compatible hardware and software.

5.b. Procurement route

STP Programme Board approval to the Hosting arrangements.

5.c. Activity and service level agreement (SLA) implications.

Agreement of all STP partners to the requirements set out as part of the 2017/18 revised budget to protect the Host from exposure to I&E and Cash risks. Agreement to ensure the 2018/19 budget includes agreed resource as required for the level of service that the STP wishes to procure from MTW as Host including associated overhead.

6. Financial Affordability (preferred option) *Financial Case*

The K&M STP budget was reviewed at the November 2017 STP Programme Board and reduced to an agreed level for 2017/18 of £8.2m with clear attribution of each Partner body's contribution to this budget level. For 2017/18 the funding is provided by the 8 CCGs, 6 Provider Trusts, and 2 Local Authorities.

As part of this review it was confirmed that the STP wished to ask MTW to formally host the financial service for the STP as a whole but that this would require:

- That an agreement should be put in place to indemnify MTW as host from costs incurred on behalf of the STP so as that MTW should only be liable for its share of expenditure.

- That on agreement of the budget, invoices from MTW regarding the STP will be raised quarterly in advance and that invoices regarding STP finances will not be subject to normal organisation to organisation cash management approaches i.e. will not be subject to "like for like" payment approaches.

MTW will also request that the 2018/19 budget setting service levels take account of additional resources that may be required to fulfil the scale and pace of procurement or financial support that the STP requests to ensure that both the resource is available and that MTW is appropriately financed for this service.

7. Project management arrangements *Management Case*

The Hosting service is already in place. The STP CEO and Programme Director are established on the MTW authorised signatory list with provision in the MTW Scheme of Delegation to enable them to use the appropriate systems for procurement and authorisation. The existing financial services, financial management and procurement staffing is in place.

8. Arrangements for post project evaluation (PPE) *Management Case*

It is recommended that the formal hosting arrangement is reviewed after 6 months to ensure that the objectives of the Hosting are being met as set out in this case, and that the STP and the Host are both satisfied that the service from the Host, and the protection from risk exposure afforded to the Host by the partnership agreement, are working effectively.

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
V1.1	23.11.2017	Business case drafted	Stuart Doyle (DDoF)

Trust Board meeting – November 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

11-16 Ratification of revised Standing Orders **Trust Secretary**

The Trust's Standing Orders (SOs) are due their routine annual review. Having been reviewed a number of changes are proposed.

The SOs are directly linked to the Standing Financial Instructions and Reservation of Powers and Scheme of Delegation, which are featured as separate agenda items/reports at the November Trust Board meeting.

No significant changes are proposed to the Standing Orders, but the revision clarifies that Associate Non-Executive Directors should be regarded as Trust Board Members. A number of 'housekeeping' changes have also been made (for example, changing references to the "Finance Committee" to the "Finance and Performance Committee"). In keeping with changes to a number of formal documents over the past year, the document also replaces the gender-specific term "Chairman" with the non-gender-specific term "Chair" (and replacement of "his/her" with "their").

The Audit and Governance Committee reviewed and "approved" the full revised Standing Orders document at its meeting on 21/11/17. The Trust Board is therefore asked to "ratify" the revised Standing Orders.

In previous years, the full document, with the proposed changes shown as 'tracked' has been submitted as part of the formal 'pack' of Board reports. However, this year an alternative model has been adopted in that the full Standing Orders document (with the proposed changes shown as 'tracked') has been circulated as a supplement to the formal 'pack' of Board reports (i.e. Attachment 11a). Trust Board Members are therefore welcome to read the supplement (an electronic copy of which has been provided), to obtain the precise details of the proposed changes, but are not expected to do so.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 16/10/17 (summary of proposed changes)
- Audit and Governance Committee, 21/11/17 (full revised document, for approval)

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

Ratification

[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 – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-16 Ratification of revised Standing Financial Instructions (SFIs) Trust Secretary

The Trust's Standing Financial Instructions (SFIs) are due their routine annual review. Having been reviewed a number of changes are proposed.

The SFIs are directly linked to the Standing Orders and Reservation of Powers and Scheme of Delegation, which are featured as separate agenda items/reports at the November Trust Board meeting.

The main proposed changes to the SFIs are listed below:

- Updates of regulatory documents; most important here is probably the issue of the "Managing Conflicts of Interest in the NHS (NHS England, 2017)" which is changing our Trust Gifts, hospitality, sponsorship and interest's policy and procedure (currently going through the update process); also "Code of Practice for Records Management for Health and Social Care 2016".
- Inclusion of the Kent & Medway Sustainability and Transformation Partnership (STP) – currently this is drafting for a provisional position, pending Trust Board approval to formally host the STP.
- Excision of the Kent and Medway Health Informatics Service (KMHIS) elements that covered the closure and dissolution
- Updating the External Audit position as we are now past the transitional arrangements following dissolution of the Audit Commission
- Strengthening the text around the phasing out of written tenders (replaced by e-tendering) and zero acceptance of late tender submissions
- Amending the competitive quotation waiver requirement applying to single quote situations only (not situations where 2 quotes have been obtained from the 3 requested)
- Inclusion of IR35 compliance in agency contract sections
- Clarification of the Disposals process
- Inclusion of e learning requirement for authorised signatory rights
- Updating the wording on accessing DH working capital products
- Updating the PFI section
- Updating the Stock section to take account of the implementation of Omnicell (Inventory management system)
- Losses and special payments – update of write-off delegation, and clarification of the role of the Audit and Governance Committee
- Updating of the Trust process with Policies and the Equalities Impact Assessment requirements.

The Audit and Governance Committee reviewed and "approved" the full revised SFIs document at its meeting on 21/11/17. The Trust Board is therefore asked to "ratify" the revised SFIs.

In previous years, the full document, with the proposed changes shown as 'tracked' has been submitted as part of the formal 'pack' of Board reports. However, this year an alternative model has been adopted in that the full SFIs document (with the proposed changes shown as 'tracked') has been circulated as a supplement to the formal 'pack' of Board reports (i.e. Attachment 12a). Board Members are therefore welcome to read the supplement (an electronic copy of which has been provided), to obtain the precise details of the proposed changes, but are not expected to do so.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 16/10/17 (summary of proposed changes)
- Audit and Governance Committee, 21/11/17 (full revised document, for approval)

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

Ratification

[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 – November 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

11-16	Ratification of revised Reservation of Powers and Scheme of Delegation	Trust Secretary

The Trust's Reservation of Powers and Scheme of Delegation are due their routine annual review. Having been reviewed a number of changes are proposed.

The Reservation of Powers and Scheme of Delegation are directly linked to the Standing Orders and Standing Financial Instructions, which are featured as separate agenda items/reports at the November Trust Board meeting.

The main proposed changes to the Reservation of Powers and Scheme of Delegation are listed below:

- Use of non-gender specific term "Chair", rather than "Chairman" (and replacement of "his/her" with "their"
- Housekeeping changes (change of Committee names etc.)
- Clearer representation of the existing issues which the Trust Board has reserved for itself
- Formalisation that the Trust Board will be the forum that ratifies the Trust's Risk Management Policy and Procedure, Health & Safety Policy and Procedure and Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")
- The standardisation of certain approval values (that had previously differed without an obvious rationale)
- The inclusion of the Director of Finance's authorisation of monthly PFI unitary payment invoices
- Synchronisation of the Charitable Funds Committee's authorisation levels with the Policies and procedures for Charitable funds
- Clarification that the process of all disposals must be undertaken in conjunction with the Procurement Department (par 2.7)
- The inclusion of arrangements relating to the Trust's relationship with the Kent and Medway Sustainability and Transformation Partnership (STP) (enabling the Senior Responsible Officer of the Kent and Medway STP to authorise requisitions and invoices relating solely to the K&M STP up to the value of £250k; clarifying that the Programme Director and all other STP staff will follow the standard authorisation limits that apply to Trust staff; and clarifying that all STP procurement will follow the Trust's procurement processes, limits and governance arrangements).
- Raising of the threshold for the Trust Board's authorisation of Non-Budgeted Expenditure (i.e. any proposed expenditure, including overspending, which has not been provided for in an approved budget), from £200,000 to over £500,000; raising the threshold for authorisation by the Chief Executive from £200,000 to £500,000; and raising the threshold for authorisation by the Director of Finance from £100,000 to £250,000
- Allocating the authorisation of changes to the Capital Programme from the Trust Board to the Director of Finance
- Reducing the threshold for the Trust Board to authorise waiving of quotation or single tender action from £750,000 to £500,000
- Restriction of the authorisation of Orders, tenders and competitive quotations between £50,000 and £249,999 to "one of Director of Finance or Deputy Chief Executive" (rather than "one member of the Executive Team")
- Reducing the threshold for the Trust Board to authorise Orders, tenders and competitive quotations from over £750,000 to over £500,000
- Reducing the threshold for the Trust Board to approve Purchase/Expenditure contracts and SLAs from over £750,000 to over £500,000
- Removal of the Chief Executive from the authorisation of "Fruitless Payments (including abandoned capital schemes)"

The Audit and Governance Committee reviewed and "approved" the full revised Reservation of Powers and Scheme of Delegation document at its meeting on 21/11/17. The Trust Board is therefore asked to "ratify" the revised Reservation of Powers and Scheme of Delegation.

In previous years, the full document, with the proposed changes shown as 'tracked' has been submitted as part of the formal 'pack' of Board reports. However, this year an alternative model has been adopted in that the full Reservation of Powers and Scheme of Delegation document (with the proposed changes shown as 'tracked') has been circulated as a supplement to the formal 'pack' of Board reports (i.e. Attachment 13a). Trust Board Members are therefore welcome to read the supplement (an electronic copy of which has been provided), to obtain the precise details of the proposed changes, but are not expected to do so.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 16/10/17 (summary of proposed changes)
- Audit and Governance Committee, 21/11/17 (full revised document, for approval)

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

Ratification

[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 – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-17	Summary report from the Charitable Funds Committee, 16/10/17 (incl. approval of revised Terms of Reference)	Committee Chair (Non-Executive Director)

Summary / Key points

The Charitable Funds Committee met on 16th October 2017.

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

- Under the Safety Moment, the Trust Secretary reported that the month's theme was "Saying Sorry - our Duty of Candour" and highlighted that this would involve promotion of the Trust's statutory duty to notify patients that had been harmed under its care of the Trust's obligations to provide further information
- The committee agreed proposed changes to its ToRs, which provided for the inclusion of Associate Non-Executive Directors (NEDs) as formal members of the Committee, allowing them to vote and be counted towards the quorum
- The financial overview at Month 7 was considered and it was noted that:
  - There had been a small increase in the overall fund balance of approximately £35k since the beginning of the year
  - The most significant income in the period related to a legacy of £42.3k, restricted to the Peggy Wood Breast Care Centre; a restricted fund had been re-opened to receive this
  - Investment information would not be fully available until January 2018
  - Overall expenditure in the period was approximately £203k
  - No items of expenditure had been refused during the period
  - There had been no items of revenue expenditure in excess of £150k
  - The administration and audit fee had been calculated, but would not be applied until Month 7 and did not include provision for the new Fundraiser role
- The Committee agreed that there should be discussion between the Finance and Communications functions of how information on the contribution that charitable funds spend has made to the Trust could be used to encourage further donations by using the Trust website and intranet
- The status of the proposed new Fundraiser role was discussed and:
  - There was some concern about the banding of the role and the ability to attract a candidate of the required calibre, but it was ultimately agreed to proceed with recruitment for the Fundraiser post under the existing approved terms and explore the low-cost options for targeted advertising outside of the NHS Jobs job site
  - It was agreed that the role should be funded initially by charging out the cost pro rata across all funds in the same way that the administration charge was currently applied and to schedule a formal review of the funding arrangements for the Fundraiser post for the Charitable Funds Committee meeting in June 2018
  - The Committee agreed it should be kept apprised of the situation through standing fundraising updates at each of its meeting until further notice
  - It was agreed to clarify the current status and arrangements for the proposed campaign for the Cancer Health and Wellbeing Centre at Maidstone Hospital to ensure that they complied with the appropriate governance requirements and did not conflict with any activity planned by the Committee

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

- Care should be taken to ensure the term "Capital in Perpetuity" is listed in full against relevant funds to avoid confusion of terminology with cost improvement programmes (CIPs)

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- For information and assurance
- To approve the revised Terms of Reference for the Charitable Funds Committee (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

CHARITABLE FUNDS COMMITTEE

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

~~Maidstone and Tunbridge Wells NHS~~
~~NHS Trust~~

1. Purpose

The Charitable Funds Committee has been established as a sub-committee of the Trust Board to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors.

2. Membership

Membership of the Committee is as follows:

- The Committee Chair – a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Director of Finance
- The Director of Workforce
- The Head of Financial Services
- The Deputy Director of Finance (Financial Governance)
- The Trust Secretary

3. Quorum

The Committee shall be quorate when one Non-Executive Director (or Associate Non-Executive Director) and one Executive Director are present.

4. Attendance

The Committee Chair may invite other staff ~~or~~, Non-Executive Directors or (or Associate Non-Executive Directors to attend, as required, to meet the objectives of the Committee.

5. Frequency

The Committee shall meet at least three times per year (and more frequently if required to meet the objectives of the Committee).

6. Duties

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop and approve the strategy and objectives of the Charitable Fund
- Ensure that the Charitable Fund complies with relevant law, and with the requirements of the Charity Commission as regulator; in particular ensuring the submission of Annual Returns and accounts
- Oversee the development and delivery of the Trust's fundraising strategy
- Oversee the Charitable Fund's expenditure and investment plans, including:
  - Approving relevant policies and procedures
  - Agreeing approval and authorisation limits for expenditure from charitable funds
  - Considering applications for support (as recommended by the Head of Financial Services)
  - Approving and monitoring investment strategies

The specific duties of the Committee in relation to the Charitable Funds are to:

Policy matters

- To approve, on behalf of the corporate Trustee:
  - A Reserves policy (if considered by the Committee to be required)

- An Investment strategy (and to formally review the strategy annually)
- A Grant Making policy (if considered by the Committee to be required)
- Guidance for fund raising activities (if considered by the Committee to be required)

Operational matters

- Approve the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Approve proposals regarding the establishment of any new funds
- Authorise financial procedures and financial limits
- Receive details of any expenditure refused
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To authorise expenditure in accordance with the Trust's Reservation of Powers and Scheme of Delegation

Internal and External control

- Seek assurances that all income is secured and that expenditure is within the objects of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- Ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- Ensure there is adequate provision for the independent monitoring of investment activity
- Receive all relevant internal and external audit reports, and ensure compliance with any recommendations

Financial reporting

- Review income and expenditure reports for each of the reporting periods
- Review and agree the Principal Accounting Policies to be adopted
- Review, and agree the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive, where appropriate, the annual investment report
- Ensure the Director of Finance is compliant with the reporting requirements of the Committee and the Trustee
- To review Fundholders' spending plans

7. Parent committees and reporting procedure

The Charitable Funds Committee is a sub-committee of the Trust Board.

A summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chair of the Charitable Funds Committee will present the Committee report to the next available Trust Board meeting.

8. Sub-committees and reporting procedure

The Charitable Funds Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one either the Director of Finance or Director of Workforce~~Executive Director member~~. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

10. Administration

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

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

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

11. Review

The Terms of Reference of the Committee will be reviewed annually, and approved by the Trust Board

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015
Agreed at Charitable Funds Committee, November 2016
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-18	**Workforce Committee, 30/10/17** (incl. approval of revised Terms of Reference; quarterly report from the Guardian of Safe Working Hours; and annual report from the Director of Medical Education on work schedule reviews relating to education and training)	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 30th October 2017.

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

- The annual review of the **Terms of Reference** was undertaken and the suggested changes agreed. The Terms of Reference are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Board is asked to approve the changes. It was agreed to accept the Senior HR meeting as a sub-committee but to review this at the Committee in April 2018.
- In relation to Staff engagement, an **Equality and Diversity update report** was presented. The Cultural Diversity Network has reviewed the Workforce Race Equality Standard (WRES) data and developed an Action Plan. The Committee agreed the Action Plan and asked for it to be reviewed in 6 months. It was also agreed that all staff engagement action plans will be combined into one. Unconscious bias training will be available to support staff with recruitment and appraisal processes. Network groups for Cultural Diversity, LGBT+ and Workability have been established and a number of events and activities have taken place, including a week celebrating the diversity of staff. Senior clinicians involved in the Listening into Action programme have identified 10 improvements to take forward. Progress on these will be reported to Trust Board. Workforce Committee members agreed to support a Staff Charter. This will be discussed at the Joint Consultative Forum (JCF) and developed with input from staff.
- The Chief Nurse updated the committee on the **Care Quality Commission (CQC) inspections**, and it was noted that the pre-inspection review had been completed and submitted. Unannounced visits have already taken place at Maidstone and Tunbridge Wells hospitals. Issues were flagged on out of date medicines, resus trolleys, clinical waste disposal and patient information on whiteboards. These issues have been addressed.
- The **Nurse Recruitment Plan** was discussed. It was noted that there were currently 220 nursing vacancies in the Trust, of which, 116 are awaiting a confirmed start date. International recruitment is still continuing. Work is ongoing to release clinical staff for their clinical duties by engaging staff into new roles covering some of the non-clinical functions required on wards.
- The **Director of Medical Education** presented a report, which noted an improvement in the results of the GMC trainee survey this year, with the Trust now 55th of 131 Acute Trusts in the country. Action plans have been formulated for departments to monitor red & pink flags. A Physician's Associate programme has commenced and feedback is good from the first cohort of students. The report also confirmed **that no work schedules/rotas have been changed as a result of educational exception reporting** (this is part of the 2016 Contract for Doctors in Training). There is currently a number of Foundation posts unfilled. It was noted that the Department of Health has confirmed the Shape of Training for Medicine will start in 2021. The plan for implementation at Trust level is to be finalised.
- An **Apprentice Levy update** report was received. Activity has progressed, however some projects are on hold whilst we finalise procurement processes to avoid breaking Standing Financial Instruction (SFI) thresholds. The change to the recruitment panel screening process has had an impact on the identification of apprenticeship opportunities. The new Nurse Associate apprenticeship standard is still out for consultation; however the Trust has interest from 20 staff that are currently being supported to gain the necessary Level 2 functional skills ready to start. Learning and Development continue to actively raise the profile of the Trust and promote apprenticeships and NHS careers locally to schools, colleges and other stakeholders. The Trust will host the Careers in Health and Social Care event again in 2018

- The Head of Employee Relations presented the quarterly report from the **Guardian for Safe Working Hours**. It was noted the 2016 contract for doctors in training has been in place for 12 months and the Trust currently has 207 trainees on the new contract. The Guardian of Safe Working Hours is reviewing the level of engagement with educational/clinical supervisors as they are not all responding to Exception reports in a timely manner. National bench-marking data will be provided at the next Workforce Committee if this is available. The full report from the Guardian of Safe Working Hours is enclosed in Appendix 2.
- The Committee received a report summarising progress of the **e-Rostering deployment project**. Having completed migration to the new temporary staffing management module earlier in the year, a progressive rollout of the rostering system is in progress. A deployment timetable is in place to migrate units from the current rostering system by April 2018, in line with the renewal date of the support contract. Deployment to further areas (typically areas other than inpatient nursing) will be scheduled following this period. It was noted that the deployment timetable is ambitious, given that it takes place alongside expected winter pressures, but is being monitored by the Project Board
- The revised format **Workforce Dashboard** was presented and it was noted that the level of vacancies and the turnover rate were both higher than planned. While the Committee believed the new format to be an improvement on earlier versions, it was suggested that further work would be useful in order to highlight outliers or hotspots within the presented data.

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

- N/A

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

- The revised Terms of Reference were agreed, and these are submitted to the Board for approval (see Appendix 1)
- The Director of Medical Education confirmed that no work schedules/rotas have been changed as a result of educational exception reporting
- The full report from Guardian for Safe Working Hours is enclosed (The Junior Doctors' Contract requires that the Guardian to report to the Board each quarter)

Appendix 1: Revised Terms of Reference (for approval by the Trust Board)

Workforce Committee

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

The Committee will work to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.

2 Membership

- Non-Executive Director (Chair)
- Non-Executive Director (Vice Chair)
- Chief Operating Officer
- Director of Workforce
- Director of Medical Education (DME)

3 Quorum

The Committee shall be quorate when two Executive Directors and two Non-Executive Directors are in attendance.

4 Attendance

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

Other staff, including members of the Human Resources Directorate, may be invited to attend, as required, to meet the Committee's purpose and duties.

5 Frequency of meetings

The Committee will meet quarterly. The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Trust Board on:

- workforce planning and development, including alignment with business planning and development;
- equality and diversity in the workforce;
- employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement
- terms and conditions of employment, including reward;
- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;
- reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)

To convene task & finish groups to undertake specific work identified by the Committee ~~-~~or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7 Parent committees and reporting procedure

The Workforce Committee is a sub-committee of the Trust Board.

A summary report of each Workforce Committee meeting will be submitted to the Trust Board. The Chair of the Workforce Committee will present the Committee report to the next available Trust Board meeting.

8 Sub-committees and reporting procedure

The following Committees report to the Workforce Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:

- Local Academic Board (LAB) (reporting to occur via the report from the DME)
- Senior HR meeting

9 Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Workforce Committee may, when an urgent decision is required between meetings, be exercised by the Chairman of the Committee, after having consulted at least two Executive Director members. The exercise of such powers by the Committee Chair~~man~~ shall be reported to the next formal meeting of the Workforce Committee, for formal ratification

10 Administration

The Committee will be serviced by administrative support from the Trust Management Secretariat.

11 Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Workforce Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Workforce Committee: 29th September 2016
Terms of Reference approved by Trust Board: 19th October 2016
Terms of Reference agreed by Workforce Committee: 30th October 2017~~Terms of Reference to be reviewed: September 2017~~
Terms of Reference approved by Trust Board: 29th November 2017

Appendix 2: Guardian of Safe Working Hours report

Maidstone and Tunbridge Wells NHS
NHS Trust

WORKFORCE COMMITTEE – October 2017

30/10/17	GUARDIAN FOR SAFE WORKING REPORT	MATT MILNER, GUARDIAN FOR SAFE WORKING

Summary / Key points

Report covers the period July - September 2017 (2nd Quarter)

- Total of 64 Exception reports received in this period.
- A total of 53 reports are from the FY1 grade. Of which 18 were from one Medicine FY1
- The issues with regard medicine revolve around teams on Wards 2 & 20, for which 2 extra locums have been assigned to good effect.
- The issues around Surgery are resulting from a total of 18 junior doctor vacancies, the Clinical Director and senior managers are aware of the situation and are developing a strategy to deal with this.
- No fines incurred for this period.
- Bank usage for the Quarter is: £1,300,277.74
- Agency usage for the Quarter is: £1,012,080.44

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

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

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

Reporting Period: July – September 2017

Introduction:

This is the 4th report from the Guardian for Safe Working and outlines the period July to September 2017.

As from August all the doctors in training are now contracted to work on the 2016 TCS and therefore eligible to submit exception reports.

In total 64 reports were received by the Guardian for the period. All relate to working more hours than the hours set out in their work schedules. None of the reports referred directly to inadequate senior support.

Issues raised

From my last report my main area of concern was the lack of engagement I was receiving from certain Educational & Clinical Supervisors. This resulted in me sending multiple emails to the relevant supervisors reminding them of the duties to respond to the junior trainees and to resolve the underlying issues.

I discussed the issues with the Medical Director, who has raised the matter with the supervisors in question.

As Guardian for the first year it still continues to be my greatest challenge to get the engagement from our Clinical /Educational supervisors. This is highlighted in the fact that out of the 64 reports sited in this quarter, as of the 1st October 2017, 30 of these have not been responded to. I believe the root cause of this is the issue with the DRS reporting system itself.

The fact is that when a trainee logs an exception report, an email does not generate to their supervisor advising them of the report. Supervisors are only aware if trainees tell them directly, or if the supervisor logs on to the DR4S site to see if any reports are outstanding.

I have discussed this point with our Medical Staffing team, suggesting that this system is not fit for purpose and they have fed this back to NHS Employers.

To improve engagement I have regularly emailed the supervisors with information about the exception reporting process and also send reminder emails directly to supervisors who have “out of date” reports that require action.

At induction I also spoke to all new trainees and emphasised that if they file an exception report they need to also inform their supervisor, either in person or by email that a report will be in their DRS4 inbox.

Through this measure I envisage an improvement in response rate to reports in the next quarter.

Exception Reports

Of the 64 reports received for this quarter, 34 have been closed and 30 are currently still open.

The majority of exception reports, 53 in total, were from FY1s, split 26 in Surgery and 34 in Medicine. The remaining reports came from ENT, Haematology & Orthopaedics either FY2 or CT level. Of the 28 medicine FY1 reports, 18 came from one FY1 alone. The rest of the reports were mainly from FY1s in the same area.

The issues in Medicine were the fact that cover is provided for Wards 2 & 20. At the beginning of the new working year the wards each had a vacancy for a junior clinical fellow. The workload is significant as it is on both wards due to the throughput of patients.

On discussing the issues with the ward consultants and rota co-ordinator there have subsequently been two appointments to the vacant posts. This has improved working conditions significantly.

With regards specifically to the FY1 who submitted 18 exception reports on review it was seen that his reports were justified with regard to extra hours worked, with perhaps the doctor in question being over conscientious at work and definitely not a “trainee in need”.

In Surgery a total of 26 exception reports were raised, all from FY1 doctors. All related to excessive workload around covering multiple areas and senior doctors in clinics. Therefore, whilst there is a considerable amount, it was work to do.

This excessive workload stems from the fact that the Surgery directorate has a 37.5% vacancy rate of junior staff.

- 4 FY1 (1 Psychiatry FY1 covering weekends also)
- JCF/CT1 level 8 groups
- Registrar level, 6 (of total of 18)

I have been in regular communication with the college tutor for General Surgery and I am assured that she has been working tirelessly, to help resolve the issues raised.
She has confirmed that 3 middle grades have been interviewed and offered jobs, also that outstanding post have been readvertised.
She also suggested in future, that we need to be more savvy and close job adverts early, when a suitable number of candidates apply. Had we done this on the last round, we would have had 10 candidates to interview, not the 3 that attended, as they had already accepted job offers from other institutions.
She has also put a halt to FY1 doctors, being asked to help in theatre. This takes them away from their normal everyday work, adding extra pressure onto their normal work duties.

A small improvement will happen with the December intake, as Surgery will then only be short of 1 substantive FY1 and 1 Psychiatry FY1 who covers weekends on call.

In conclusion, the main area of concern in this report is the “staffing crisis” within the surgical directorate. Until this improves I envisage more exception reports from the directorate.

High level data:

Number of doctors in training (total):	344
Number of doctors in training on 2016 TCS (total):	207

a) Exception reports (with regard to working hours)

Exception reports by department: July – September 2017				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	35	26	9
Surgery	0	26	7	19
ENT	0	1	1	0
Orthopedics	0	1	0	1
Haematology	0	1	0	1
Total	**0**	**64**	**34**	**30**

Exception reports by grade: July – September 2017				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	53	31	22
F2	0	8	2	6
CMT	0	3	1	2
GP VTS	0	0	0	0
ST	0	0	0	0
Total	**0**	**64**	**34**	**30**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	21	32
F2	0	0	2	6
CMT	0	0	2	1
GP VTS	0	0		
ST	0	0		
Total	**0**	**0**	**25**	**39**

b) Work Schedule reviews July – September 2017

Work Schedule reviews by Grade	
CMT	0
CT	0
F1	0
F2	0
GPVTS	0
Obs & Gynae ST3+	0
Total	**0**

c) Fines July – September 2017

No fines were issued in the period.

d) Diary Card Exercises

Hours monitoring exercises (for doctors on 2002 TCS only)						
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**	**Percentage Return**
None undertaken from July – September 2017						

e) Locum bookings

i) Staff Bank: July – September 2017

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

Specialty	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover £**
Accident and Emergency	1208	6850.94	461465.50
General Medicine / Acute Medicine	491	4257.85	326639.94
Anaesthetics	229	2155.09	115139.50
Cardiology	5	20	1000.00
Cytology	0	0	0
ENT	20	338	20704.00
General Surgery	227	2301.92	103438.00
Haematology/Oncology	15	148	8288.00
Neurology	0	0	0
Obstetrics and Gynaecology	288	1731	110446.46
Occupational Health	4	30	3500.10
Oncology Consultants	21	169.33	10329.13
Ophthalmology	63	716.66	35508.26
Paediatrics	144	1100.5	84372.75
Radiology	2	18.98	2277.60
Trauma & Orthopedics	34	338.5	17168.50
Urology	0	0	0
Total	**2751**	**20176.77**	**£1,300,277.74**

Grade of Doctor	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover**
F1	58	478.29	17501.50
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	982	6600.05	353546.45
ST3+, Specialty Doctor	1205	8434.92	520684.39

(Registrar Level)			
Consultant	506	4663.51	408545.40
TOTALS	**2751**	**20176.77**	**£1,300,277.74**

ii) Agency July – September 2017

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

Specialty	**Number of shifts worked**	**Number of hours worked**	**Cost of Agency Cover**
Accident and Emergency	1309	10836.50	334403.00
General Medicine / Acute Medicine	1215	10118	227437.71
Anaesthetics	47	391.5	25311.40
Cytology			
ENT	54	455.5	14470.92
General Surgery	498	4102.5	150476.94
GU Medicine			
Histopathology			
Obstetrics and Gynaecology	75	660	31726.35
Occupational Health	4	30	2283.00
Oncology	24	190.5	13698.00
Ophthalmology	108	886.5	45594.19
Paediatrics	19	171	5643.24
Rheumatology			
Radiology	60	435.5	34245.00
Trauma & Orthopaedics	217	1879	48681.14
Urology	116	894.5	78109.55
Total	**3746**	**31,051**	**£1,012,080.44**

Grade of Doctor	**Number of shifts worked**	**Number of hours worked**	**Cost of Agency Cover**
F1	54	399	£5,072.28
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1694	14,270	£322,100.84
ST3+, Specialty Doctor (Registrar Level)	1260	10,620.5	£307,299.12
Consultant	738	5,761.5	£377,608.20
TOTALS	**3746**	**31,051**	**£1,012,080.44**

f) Vacancies WTE

Vacancies by month						
Specialty	Grade	July 17	Aug 17	Sept 17	Total gaps (average)	Comments
General Surgery/Gen Medicine	FY1	0	3	3	3	Vacancy rotating to Gen Med at next placement
General Medicine	FY2	0	1	1	1	
Emergency Medicine	FY2	0	2	2	2	
Oncology	ST3+	0	2	2	2	1 = Med Onc / 1 = Clin Onc
Ophthalmology	FY2	0	1	1	1	
Trauma & Orthopaedics	FY2	0	1	1	1	
Trauma & Orthopaedics	ST3+	0	2	2	2	
Obstetrics & Gynaecology	ST3+	0	3	3	3	
				Total Vacancies	**15**	

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-19	Summary report from Audit and Governance Committee, 21/11/17 (incl. approval of revised Terms of Reference)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 21st November 2017.

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

- Revised Terms of Reference were agreed (as part of their annual review), and are submitted to the Board for approval (see Appendix 1 – with proposed changes 'tracked')
- Under the Safety Moment, the Trust Secretary reported that the month's theme was information governance and highlighted the General Data Protection Regulation, due to come in to force across the European Union (including the UK) in May 2018
- There was discussion about the Trust's policy for allowing staff to accept bequests from patients and it was agreed that the Trust Secretary should seek the views of the Executive Team and the Trust's Ethics Committee on this matter
- A review of the Board Assurance Framework (BAF) and Trust Risk Register for 2017/18 was undertaken, and changes in status noted. It was agreed to amend Objective 2 within the BAF to reflect its relevance to the CQC's "Safe" domain
- An update on progress with the Internal Audit plan for 2017/18 (incl. progress with actions from previous Internal Audit reviews) was reported. The list of recent Internal Audit reviews, all at the draft report stage, is shown below (in section 2). It was noted that there were no outstanding ICT audit recommendations
- The intended process for the review/survey of the Internal Audit service, including the content of proposed survey documentation, was reviewed and it was agreed to amend the Internal Audit Survey to reflect the minor amendments suggested at the meeting. The Head of Internal Audit also agreed to provide a list of key contacts for Internal Audit reviews in the past 12 months to enable these to be included in the evaluation process
- A Counter Fraud update was reviewed, which included an update on progress against the recommendations from the recent NHS Protect "Focussed Assessment" on 'Prevent and Deter' and 'Hold to Account' activity. An update on recent and planned Counter Fraud training activity within the Trust was also given (which included the feedback from training participants)
- A 'Progress and emerging issues' report was received from External Audit. No matters of significance were raised, but there was discussion about the requirement for, and value of, the current arrangements for external audit of the Quality Accounts. It was agreed that the Trust Secretary would review the obligations for undertaking an external audit of the Quality Accounts (including consideration of any contractual commitments with Grant Thornton LLP and the approach taken by other NHS Trusts)
- The intended process for the review/survey of the External Audit service, including content of the proposed survey documentation, was reviewed. It was agreed to amend the External Audit Survey to reflect the comments made at the meeting, which included the addition of questions on the current audit arrangements for the Quality Accounts; and streamlining of the number of questions to ensure focus on key issues and making allowance for more free-text comments
- The losses & compensations data to month 7 was reviewed, which showed a similar volume and reduced value (by approximately 50%) from the same period in 2017/18. Comparative data (annually from 2013) on compensations under Ombudsman advice was provided, following a request at the previous Audit and Governance Committee meeting
- The latest single tender waivers (STW) data was reviewed, which showed an increase in value due to an increased volume of STWs, compared with the same period of the prior year. This was attributed to an increase in use of agency staff for PAS implementation. Data for Sustainability and Transformation Partnership (STP) waivers was presented as a subset of total activity. An update was also given on Purchase Order (PO) activity which showed that 75.29% of expenditure was covered by POs against a target of 80%
- A report detailing gifts, hospitality and sponsorship declared in the period 19/09/17 to

26/10/17 was considered. This showed a pro rata increase in the volume of declarations to that of the previous reporting period. Updates were also given on progress with the Trust's new Conflict of Interests Policy and Procedure; comparative Association of the British Pharmaceutical Industry (ABPI) disclosure data for 2016 and 2017; and Clinician interests in private hospital operators
- The Deputy Director of Finance (Financial Governance) provided a verbal summary of the latest financial issues, and confirmed that, although the Trust was still reporting to the agreed year-end control total, the Trust's contingency reserves had already been released
- The Chief Pharmacist attended to present a status update on the "Discrepancies in Inventory Values" item, which had been identified within the Audit Findings Report 2016/17, and gave assurance that the findings had been addressed
- Revised Standing Orders and Standing Financial Instructions (SFIs) were reviewed and approved for ratification by the Trust Board
- A revised Reservation of Powers and Scheme of Delegation was approved for ratification by the Trust Board. There was discussion about the appropriate thresholds for delegation for Cash Losses, Bad Debts and Abandoned Claims and Fruitless Payments and it was agreed to leave these unchanged. It was further agreed to undertake a review of the appropriate delegation thresholds for the authorisation of "compensation under legal obligation" for personal injuries and medical negligence
- The Committee agreed the method and timing by which it would undertake its next self-assessment and agreed to extend the circulation of the document to include all routinely invited attendees

2. The Committee received details of the following Internal Audit reviews:
- "Discharge Processes including Delayed Transfers of Care"
- "A&E Data Capture and Recording"
- "Cost Improvement Plan"
- "Non Patient Related Income"
- "CFA - Payroll"

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:
- N/A

4. The Committee agreed that (in addition to any actions noted above):
- None

5. 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
- To approve the revised Terms of Reference for the Audit and Governance Committee (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

NHS
Maidstone and Tunbridge Wells
NHS Trust

TERMS OF REFERENCE

Maidstone and Tunbridge Wells NHS
NHS Trust

Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of Eexternal Aauditors ~~(for appointments for 2017/18)~~, and on the maintenance of independent relationships with such Aauditors.

Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

1.5 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair~~man~~ of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to attend to address issues of specific concern at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant discussion or voting point.

Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[1].

Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- Director of Finance
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to be present~~attend~~ at all meetings of the Committee. Those listed in section 5.1 are expected to attend all meetings of the Committee.

5.3 The Chief Executive and other members of the Executive Team will be invited to attend when the Committee is discussing areas of risk or assurance that are the responsibility of that individual~~Director~~ and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will meet privately with the External and Internal Auditors regularly, at the start of each meeting.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor

[1] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by ~~the~~ NHS Protect (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from member of the Executive Team and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit f~~F~~unction is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor~~, as far as the rules governing the appointment permit~~
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other Assurance Functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Protect's standards and shall review the outcomes of Counter Fraud work.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Whistleblowing ("Speaking Out Safely")

7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Auditor Panel

7.17 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Aagreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Mmaking a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advisinge the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advisinge (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advisinge on (and approvinge) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advisinge the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

8.1 The committee is a sub-committee of the Trust Board.

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017

Trust Board Meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-20	Summary report from Quality Committee, 31/10/17 & 08/11/17	Committee Chair (Non-Executive Director)

The Quality Committee has met twice since the last Board meeting, on 31st October (a Quality Committee 'deep dive' meeting) and 8th November (a 'main' meeting).

1. The key matters considered at the 'deep dive' meeting on 31st Oct. were as follows:

- The **progress with actions** from previous meetings was noted
- A **further review of the actions to reduce Length of Stay** (LOS) was held, led by the Clinical Lead for LOS. This related to a previous review at the Quality Committee 'deep dive' meeting in April 2017. The issues discussed as part of the further review were as follows:
  - The progress with the plans to introduce a Frailty Unit at Tunbridge Wells Hospital (TWH), and the challenges to such plans (for which it was confirmed that staff workload was the predominant factor)
  - The recruitment issues that had prevented the full introduction of acute Physicians in the Emergency Department (ED)
  - The introduction of GP Streaming protocol in the ED
  - The analysis of data which showed that total attendances from the ED had increased from 13,082 in Sept. 2015 to 14,009 in Sept. 2017; Non-elective admissions had increased from 2,824 in Sept. 2015 to 3,867 in Sep. 2017; Non-elective LOS had reduced from 7.81 in Sept. 2016 to 7.08 in Sept. 2017; Bed occupancy had reduced from 91.6% in Sept. 2016 to 88.2% in Aug. 2017 (although it was noted that this data required validation); and 'Medically Fit For Discharge' (MFFD) patients had reduced from 114 in Dec. 2015 to 99 in Sept. 2017
  - The efforts being made regarding Medical engagement, and the fact that 'Rapid Improvement weeks' had been replaced by Plan, Do, Study, Act (PDSA) programmes
  - The Clinical Utilisation Review (CUR) system (an electronic programme that enables an objective, evidence-based assessment of whether patients were receiving the right levels of care, in the right settings, at the right time). CUR was now embedded on the Surgical, Medical, and Trauma & Orthopaedic Wards, and was completed 7 days a week by lunchtime. A pilot programme was also being established to use CUR at Board Rounds and Site Meetings
  - The 'next steps' included the 'Go Green for Winter' programme, where each patient had 'red days' (where they received no active treatment) and 'green days' (where they received active treatment and/or discharge planning). Patients who were suitable for an acute hospital bed would also categorised 'qualified' to be in hospital, whilst those who did not need to be in an acute hospital bed would be categorised as 'non-qualified'. 'Stranded' patients were categorised as those with a LOS of 7 days or more.
  - The oversight of the work programme was discussed, and it was agreed that the Clinical Lead for LOS would liaise with the Chief Operating Officer to consider whether a Programme Board should be re-established to oversee the various initiatives in place
- The second main item was a **further review of the actions being taken in response to the Trust's higher than expected mortality rates**, for which one of the Deputy Medical Directors attended. This related to a previous review at the Quality Committee 'deep dive' meeting in June 2017. The issues discussed as part of the further review were as follows:
  - Review of the latest Hospital Standardised Mortality Ratio (HSMR) data, which showed an improvement
  - Review of the latest Summary Hospital-level Mortality Indicator (SHMI), which at 'Level 2', was rated as 'as expected', but which had also improved.
  - The work being done in response to the 8 requirements of the "Learning From Deaths" report from the CQC and National Quality Board, which included the introduction of a Structured Judgement Review process, and the work of Mortality Surveillance Group, which was supported by the 'Learning Lessons Task and Finish Group'
  - The acknowledgement of the need to better understand the Trust's mortality data, and continue with the improvements and changes in Clinical Coding (as poor depth of

Coding could affect HSMR)
  - The "Making Families Count" joint learning event held with Kent Community Health NHS Foundation Trust on 03/11/17
- The third main item was a **review of the action plan in response to the findings from the 'Listening into Action' (LiA) pulse survey in Maternity services**, for which the Head of Midwifery, Gynaecology and Sexual Health; Deputy Medical Director, Women's, Paediatrics and Sexual Health; and Associate Director of Operations, Women's, Paediatrics and Sexual Health attended. The following issues were covered:
  - The Committee heard that the LiA pulse survey had been adversely affected by the ending of Midwifery supervision in April 2017 (as a result of a national legislative change). However, it had been acknowledged that the presence and visibility of leadership needed to be improved, and in response, all managers now had daily meetings at 10am to consider relevant issues, including staffing
  - The Committee was also told that much of the feedback provided by staff related to their frustration at the fact that increased activity had been accepted without changing the processes that had been in place when TWH opened in 2011. However, staff were said to be keen to engage and be willing to provide specific ideas for improvement
  - The limited administrative support for Midwives was raised, and the plans to address this were noted (some suggestions were also made regarding this)
  - It was noted that the LiA pulse survey would be repeated in June 2018, but it was intended to perhaps seek feedback earlier than this. It was agreed that such feedback should be included within the standard report the Directorate gave to the 'main' Quality Committee (i.e. and therefore be within the written report the Directorate submitted to the Trust Clinical Governance Committee), and only be subject to a further review at a Quality Committee 'deep dive' meeting if the Directorate considered this necessary

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

- A "Review of the strategy/plan for medical engagement" and an "Update on the proposal/case for improving the Trust's compliance with the Mental Capacity Act 2005" should be scheduled for the Quality Committee 'deep dive' meeting in December 2017

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

- Some of the initial findings of the desktop review against the Well Led Framework by the Quality Governance Associate from NHS Improvement were also discussed, and in particular whether the monthly oversight of quality metrics was adequate (as that the 'main' Quality Committee met every 2 months). The initial reaction to the challenge was that monthly performance metrics were already reviewed monthly at each Trust Board meeting, and therefore the monthly oversight of quality performance was sufficient. A further finding regarding the lack of monitoring of Directorate-level performance at the Board was also discussed, and it was noted that such monitoring took place at the 'main' Quality Committee, and also via the Divisional-level Executive Performance Review meetings.

4. The key matters considered at the 'main' meeting on 8th November were as follows:

- The **progress with actions** from previous meetings was noted
- The Medical Director reported on the **quality matters arising from the plans to exit Financial Special Measures (FSM)**, which included the recently-developed Quality Impact Assessment (QIA) dashboard. The dashboard was welcomed, but it was agreed that future reports should include details of any QIA schemes that had been rejected; and also be consistent in the application of the colours used to indicate the progress of projects and/or the status of QIA schemes
- The Clinical Lead for LOS reported on the **work being undertaken to reduce LOS**, which followed on from the review at the Quality Committee 'deep dive' meeting on 31/10/17 (see above). It was agreed to ensure that the next update report clarified how much of the reported "+20.7%" increase in non-elective admissions between Sept. 2015 and Sept. 2017 could be attributed to changes in data recording; and also contained details of readmission rates, to enable the relationship between LOS and readmission to be assessed
- A proposal regarding a **rolling programme of Directorate-based clinical outcome reporting** for 2018 was agreed

- A report of recent **Trust Clinical Governance Committee** meetings was discussed, and each **Directorate then highlighted their key issues**, which included the following:
  - Specialist Medicine & Therapies reported that their top 3 risks remained staff turnover and vacancies, the effective management of incidents, and shortfall against the Cost Improvement Programme (CIP) target
  - Acute and Emergency reported that their top risks included Nursing vacancies within A&E, but staff turnover had been reduced. It was also noted that building work on the GP Streaming service had commenced
  - Surgery reported that the high number of Medical staffing vacancies remained a challenge, but alternative options, including Resident Medical Officer (RMO) models, were being considered. It was also reported that Nurse staffing was in a better situation, but seemingly obvious solutions such as deploying staff to other areas had led to some Nurses leaving for other Trusts
  - Head and Neck reported that lack of capacity was the key issue, particularly in relation to diabetic retinal disease, and there was particular difficulty with the partial booking load, so consideration was therefore being given to reducing other activity to focus on those areas. The report prompted a discussion regarding the challenges in providing patients with information regarding their appointment and the Clinical Director expressed the opinion that the Head and Neck Directorate, which had only been established relatively recently, was under-resourced. It was agreed this should be reported to the Board
  - Trauma & Orthopaedics reported that activity was the key issue, as the activity being seen by the Maidstone Orthopaedic Unit (MOU) was reported as being very poor since the Unit had opened, so work was being done to increase the level of activity seen
  - Critical Care reported that recruitment and retention of Theatre staff was the key issue, but progress was being made, including the training of Operating Department Practitioners. It was also reported that there were now 15 Consultant Intensivists in post, following a recent appointment. and the Clinical Director was confident of recruiting a 16th Consultant next year (although there remained some problems with rota gaps)
  - Cancer & Haematology reported that 2 senior Consultants had retired and there had been challenges in recruiting replacements which meant that Locum appointments had had to be made. A new Clinical Lead for Haematology had however been appointed.
  - Pathology & Pharmacy reported that the risks regarding Blood Sciences and Pharmacy staffing had now been reduced (to amber- and green-ratings respectively). It was also noted that the Medicine Optimisation Over Night (MOON) service had been introduced
  - Women's & Sexual Health reported that the inability to cover Medical rotas was a key risk. It was also reported that the National Maternity and Perinatal Audit, which would be published on 09/11/17, showed the Trust as an outlier for third degree perineal tears, but the data related to 2015 and the Trust had seen a reduction in its tear rate since then
  - Paediatrics reported that the Registrar rota gap remained a considerable challenge and the Clinical Director was uncertain how the gaps would be covered over the next 3 months. Frustration was also expressed at the reported long delays in arranging interviews for candidates, during which they would be appointed by other Trusts. The Medical Director noted that he had raised this as a major issue with the incoming Director of Workforce. It was also reported that there had been another case of attempted suicide by a patient, and support was being obtained from the Child and Adolescent Mental Health Services (CAMHS)
- A **summary report of the Patient Experience Committee meeting** on 05/10/17 was noted
- A **Mortality update** report gave the latest position on HSMR and the Mortality Reviews undertaken by Directorates.
- The latest **Serious Incidents** were reported, and reports of the **Quality Committee 'deep dive' meetings** held on 11/09/17 and 31/10/17 were noted
- It was confirmed that a **Committee evaluation** should take place for 2017, using the same survey as in 2016, but with an additional question on the effectiveness of the relationship (& reporting) between the Trust Clinical Governance Committee and the Quality Committee

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

- The Chief Nurse should investigate the reasons for the delays affecting the functioning of the 'fast track' scheme that was intended to ensure patients nearing the end of their life

were expeditiously discharged to a more appropriate (i.e. non-acute hospital) setting
- The Trust Secretary should re-circulate (to members and attendees of the Quality Committee) the "Review of clinical outcomes" report that was submitted to the 'main' Quality Committee in September 2017
- The Associate Director, Quality Governance should request that the Legal Services Team use an alternative to the current statement that there were "No issues for Trust" in the "Closed Inquests" section of the reports that Clinical Directorates submit to the Trust Clinical Governance Committee

6. The issues from the meeting that need to be drawn to the attention of the Board are as follows:
- It was agreed to ensure that the Committee's summary report to the Trust Board highlighted the opinion expressed by the Clinical Director for Head and Neck that the Directorate was under-resourced

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 – November 2017

Maidstone and Tunbridge Wells NHS Trust

11-21	Summary report from the Trust Management Executive (TME), 22/11/17	Committee Chair (Acting Chief Executive)

The TME met on 22nd November 2017.

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

- The safety moment noted the work to mark the month's theme, information governance
- A request to appoint a replacement Consultant Acute Physician was approved
- A proposed configuration at Tunbridge Wells Hospital (TWH), in relation to the relocation of the Haematology-Oncology Day Unit (HODU) and the reallocation of the current HODU location to Cardiac Catheter Laboratory Recovery, was agreed. The proposal was to provide a new build facility for HODU at TWH. It was highlighted that the proposal was far more acceptable to the staff affected than previous proposals, but planning permission would be required. It was also noted that the proposal would be considered by the Finance and Performance Committee as part of the capital plan for 2018/19.
- The revised Terms of Reference for the Trust Cancer Committee (a sub-committee of TME) were approved
- The Trust's Strategy that was approved at the Trust Board on 18/10/17 was discussed, and a presentation was given on the latest position on the Kent and Medway Stroke review. A verbal update was also given on developments regarding the Kent and Medway Sustainability and Transformation Partnership (STP)
- The latest position regarding the CQC inspections was reported by the Chief Nurse, which included the 4 issues had been identified for improvement thus far (the use of whiteboards in clinical areas, adherence to clinical waste procedures, resuscitation trolleys, and the identification of out of date medication)
- The Chief Operating Officer reported on the "Operational management of winter – expectations and communication" letter from NHS Improvement (NHSI) and the Trust's response was discussed in detail
- The performance for month 7 was discussed, which included performance on the A&E 4-hour waiting time target, 62-day Cancer waiting time target, Referral to Treatment (RTT) targets, patient falls, the latest Never Event, Serious Incidents, Friends and Family Test (FFT), and the financial position
- The Director of Infection Prevention and Control (DIPC) supplemented their usual monthly update on MRSA/MSSA/gram negative bacteraemias; and Clostridium difficile; with key areas of work within the current year's Infection Prevention Team work plan, which included: ensuring high levels of compliance with infection prevention policies; an audit programme to ensure compliance with such policies; surgical site surveillance; mandatory surveillance of Clostridium difficile and bloodstream infections; the training of staff and maintenance of the Link Nurse network; and ensuring that policies were reviewed in a timely manner. Issues regarding compliance with the Trust's clinical waste processes were also discussed, and it was agreed that the DIPC would provide Clinical Directors with 3 to 4 key points regarding clinical waste, to enable these to be discussed at the next scheduled Directorate Clinical Governance meetings
- The key issues from the Divisions were reported, which included the work being done to improve patient flow (such as the concept of 'red and green days' and 'stranded' patients); the latest recruitment issues and challenges; and the positive outcome of the latest 'Getting It Right First Time' (GIRFT) visit by Professor Briggs. Problems with the availability of healthcare records at Outpatient clinics were also reported and it was agreed that the Chief Operating Officer should ensure that appropriate urgent action was taken
- The key issues discussed at the recent Clinical Directors' Committee meetings were noted, and the key issues from Executive Team meetings were reported, via receipt of the "Record of decisions and/or actions" from the meetings held since the last TME meeting
- The Director of Finance gave an update on the business planning for 2018/19
- The progress with "Listening into Action" was reported, via a brief presentation
- The latest position on the national 7 day service (7DS) programme was reported, which

included the key activities expected over the next month (which would see the conclusion of the National Survey casenote reviews). It was noted that the Directors of Operations (or their nominated deputies) would be invited to present progress against all actions at the 7DS Steering Group on 13/12/17

- The comprehensive summary report from the Trust Clinical Governance Committee (which is a sub-committee of the TME) was reviewed
- The project completion report for the PET/CT Unit at Maidstone Hospital was received
- Update reports were reviewed on the Out of Hours Care (Hospital at Night) programme and 'Developing primary care (GP streaming) and associated schemes' project
- The Chief Operating Officer reported the latest situation regarding the implementation of the replacement PAS+, which included the action take in response to the 2 remaining (of 4) "critical" issues that arose, one of which related to the mapping and set up of Outpatient clinics, which has led to certain clinics being underutilised). It was noted that the cause of the issue was still under investigation
- The Board Assurance Framework (BAF) for 2017/18 and Trust Risk Register was reviewed, and the RAG ratings were accepted as an accurate reflection of performance
- An update on the 2017/18 Internal Audit plan and outstanding actions was not
- The recently-approved business cases were noted
- Reports/exception reports were received from the recent meetings of the TME's sub-committees (which specifically included the Clinical Operations & Delivery Committee, the Information Governance Committee, the Informatics Steering Group, the Policy Ratification Committee, and the MTW Programme Committee)
- The meeting also discussed the contents of a report submitted by the Chief Nurse following the recent Quality Committee 'Deep Dive' review into Mental Capacity Act compliance and associated safeguarding issues. The report made some proposals to address the current issues, and following a discussion, TME agreed in principle that the issues needed to be addressed, although it was confirmed that a formal Business Case would be required to be produced and considered

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

- The Acting Chief Executive; Clinical Director, Children's Services; and Associate Director of Operations, Women's, Paediatrics and Sexual Health should liaise to agree whether to recruit to the vacant 'hybrid' Consultant Paediatric posts on an 'at risk' basis, in the context of the uncertainty regarding the potential adverse impact of such recruitment on the future allocation of Paediatric trainees

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

- The relocation of the HODU to a new build facility at TWH, and the reallocation of the current HODU location to Cardiac Catheter Laboratory Recovery, was agreed
- The implementation of the replacement PAS+ was in general, very successful, but 4 critical issues arose, of which only 2 remain (and which are being actively managed)

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board Meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-22	Summary report from Finance and Performance Committee, 14/11/17	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee held an extraordinary meeting on 14th November 2017. The focus of the meeting was the 2017/18 Cost Improvement Programme (CIP) delivery of each of the 3 clinical Divisions. Several representatives from each clinical Division attended. The meeting was also observed by a representative from NHS Improvement.

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

- Each Division presented the details of
  - The process each Division had to oversee and monitor their CIP
  - Their current overall delivery position
  - The progress and value of their green-rated schemes that had not yet delivered
  - The progress and value of their amber-rated schemes
  - The progress and value of their red-rated schemes
  - The status and value of their 'pipeline' schemes
- The adverse variance between the planned and actual delivery was acknowledged and discussed for each Division, along with the issues that had contributed to the variance
- The issues affecting progress with procurement-related savings was discussed, which included the staffing within the Procurement Department. The Director of Finance gave un update on the work taking place within the Kent and Medway Sustainability and Transformation Partnership (STP) on procurement
- The 'next steps' were discussed, which included considering alternatives to the current outsourcing of Radiology activity; and the importance of the Chairs of the Trust Boards of all providers within the STP supporting the work of the STP Productivity workstream (which was led by the Trust's Director of Finance)

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

- N/A

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

- It was confirmed that all 3 Divisions were confident with the delivery of their green-rated CIP schemes, but the fact that there were few additional green-rated schemes for the remainder of 2017/18 was also highlighted. It was noted that that the Planned Care Division had a larger CIP pipeline than the other Divisions
- The current forecast outturn for 2017/18 had the potential for delivery, but there would be gaps against each Division's target
- The impact of the CIP delivery in 2017/18 on the plan for 2018/19 would be significant, as any non-delivery against the 2017/17 plan would need to be achieved in 2018/19

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board Meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-22	Finance and Performance Committee, 27/11/17 (quarterly progress update on Procurement Transformation Plan)	Committee Chair (Non-Exec. Director)

The Procurement Transformation Plan (PTP) was approved by the Trust Board on 19th October 2016 and then submitted to NHS Improvement (NHSI) by 31st October, which was the deadline for Board-approved submissions.

It was a requirement that every Trust should have a PTP. The PTP is a document which outlines the procurement function within the trust and the key actions and activity within the trust to deliver the Lord Carter targets set within the document.

Each PTP must have an action plan at the end of the report and it is the expectation that PTPs are agreed, and signed off, by the Trust Board.

NHSI would then publish a review template in the autumn for the PTP and this would need to be reviewed by the Trust Board on a quarterly basis. The template was published in January 2017 with a view that reporting would commence from February and a dashboard will be published in April with data from January, February and March 2017 that will track and benchmark the Trust's progress.

This is the fourth report about progress against the PTP and further reports will be provided on a quarterly basis. These quarterly reports are submitted to the Finance and Performance Committee, and then onwards to the Trust Board.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee (27/11/17)

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

Review

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

FINANCE AND PERFORMANCE COMMITTEE – 27TH NOVEMBER 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-22	QUARTERLY PROGRESS UPDATE ON PROCUREMENT TRANSFORMATION PLAN	DIRECTOR OF FINANCE

Executive summary

The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and then submitted to NHSI by the 31st October, which was the deadline for Board approved submissions.

It was a requirement that every trust should have a Procurement Transformation Plan. The PTP is a document which outlines the procurement function within the trust and the key actions and activity within the trust to deliver the Lord Carter targets set within the document.

Each PTP must have an action plan at the end of the report and it is the expectation that PTPs are agreed, and signed off, by the Trust Board.

This report is the quarterly update to the Finance Committee about progress against the PTP.

Reason for receipt at the Finance Committee

For review

1. INTRODUCTION

1.1 The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and then submitted to NHS Improvement by the 31st October, which was the deadline for Board approved submissions.

1.2 The PTP guidance from NHSI states that "Trusts will be asked to provide regular progress updates on their PTPs to their Trust's board and NHS Improvement. These will take place quarterly…"

1.3 In February 2017, NHSI confirmed that they would like to receive monthly reporting against the metrics and that this reporting would cover from January 2017. Maidstone and Tunbridge wells have been submitting these reports every month as per the requirement.

2. DETAIL AND BACKGROUND

Background

2.1 The Procurement Transformation Plan was approved by the Trust Board on the 19th October 2016 and then submitted to NHSI by the 31st October, which was the deadline for Board approved submissions. At an update to Heads of Procurement, the Programme Lead – Carter Procurement confirmed that only 5 Trusts had submitted their plans. As of 19th January 2017, 100 plans had been submitted and so a new deadline was set that all plans, whether approved by the board or not, should be submitted by 31st January 2017.

2.2 The latest information from the Carter procurement team is that there will be no feedback regarding PTPs however there will be a presentation with guidance notes that will be sent to Trusts on what a good PTP should include. The date for this guidance is unknown but once received the Associate Director of Procurement will review the Trust's PTP to ensure all elements have been covered.

Carter Metrics

2.3 NHSI published a template for reporting which includes all of the metrics listed below apart from metric 7 which is submitted via a separate template. The template for submission in relation to metric 7 commenced in August 2016 and the template for metric 1 to 6 commenced in January 2017.

2.4 Metric 7 relates to NHSI's Purchase Prince Index Benchmarking tool which is a national benchmarking tool for measuring the prices paid by Trusts for the same items. This tool is the theme for one of ten regional category management groups that have been established for delivering savings across the STP footprint in 2017/18.

2.5 The table, overleaf, is an update on the metrics reported to the Committee in October 2016.

METRICS		PERFORMANCE					COMMENTARY
		ACTUAL			TARGET		
		SEPTEMBER 2016	DECEMBER 2016	SEPTEMBER 2017	SEPTEMBER 2017	SEPTEMBER 2018	
1	Monthly cost of clinical and general supplies per 'WAU' (Weighted Activity Unit)	£339 per WAU	£339 per WAU[1]	£280 per WAU	TBC by NHSI	TBC by NHSI	Outturn to be refreshed with model hospital data.
2	Total % purchase order lines through a catalogue (target 80%)	60%	91%	97%	72%	80%	This metric relates to the proportion of Integra POs that utilise the approved e-catalogues. The team now receive data from estates to include as part of this return.
3a	Total % of **expenditure** through an electronic purchase order (target 80%) up to and including PO issue	43%	47%	75%	60%	80%	The Trust has a No PO no Pay policy and this is strictly applied across the Trust. This has significantly improved the Trust's position in relation to the coverage of transactions. Big areas of expenditure such as the Trust PFI have been allocated a PO as this is approved spend. There is more to be done to ensure PO coverage is higher.
3b	Total % of **transactions** through an electronic purchase order (target 80%) up to and including PO issue	74%	89%	94%	80%	80%	

METRICS		PERFORMANCE					COMMENTARY
		ACTUAL			TARGET		
		SEPTEMBER 2016	DECEMBER 2016	SEPTEMBER 2017	SEPTEMBER 2017	SEPTEMBER 2018	
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	5%	TBC	Not Reported	50%	80%	The current payment system is not completely electronic with a number of invoices coming into the Trust as hard copy. Further guidance is expected on the calculation for these indicators as there is a large variance between Trusts.
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	63%	63%	Not Reported	70%	80%	
4	% of spend on a contract (target 90%)	61%	67%	62%	81%	90%	The Trust is reviewing this area and a programme of work is planned to ensure the contract info is captured on Integra.
5b	Inventory Stock Turns-dynamic	TBD	TBD	Days	Days	Days	
6	NHS Standards Self-Assessment Score (average total score out of max 3)	1.16	1.16	1.24	1	2	Peer review set for 8th December 2017

METRICS		PERFORMANCE					COMMENTARY
		ACTUAL			TARGET		
		SEPTEMBER 2016	DECEMBER 2016	SEPTEMBER 2017	SEPTEMBER 2017	SEPTEMBER 2018	
7	NHSI's Purchase Price Index Benchmarking (PPIB) Tool	N/A[2]	Variance to median[3] £185,676	Variance to median[4] £206,768	TBC	TBC	Targets have not been set for this due to the variance across trusts. NHSI has visited MTW to help us understand the calculation and use of the PPIB tool as Trusts are interpreting the data set differently. This is also an area being pursued as part of the STP Procurement group.

[2] PPIB tool was not published at this time.
[3] Based on £10,901,267 of spend with 778 suppliers for 8,128 products
[4] Based on £10,000,318 of spend with 773 suppliers for 9,077 products

RAG Rating Definitions:
Green = At, or better, than the target
Amber = Up to 10% less than target
Red = More than 10% below target

Action plan

2.6 A review of the action plan is in appendix one of the document. The action plan is confirmed below.

Procurement objective	Action
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard.
Procurement workplan	The Associate Director of Procurement is currently working on the 2018/19 procurement workplan. An STP work plan will also be agreed in December 2017 for 2018/19.
Procurement Savings	The 2017/18 target is £5.3million. This target is proving challenging on top of the £4.3m achieved in 2016/17. However the team have identified activity to achieve 85% of this target and this is being delivered. Target for 2018/19 is still to be confirmed for procurement.
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change. An annual review of the Trust procurement strategy was completed in Sept 2017.

Procurement objective	Action
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). Review of the discretionary spend controls is underway.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2016, rising to 60% by 2019.
	Alignment of procurement work plans across the region
	Review of external options for transactional procurement
	Integra financial system – working groups for agreement and alignment for the use of the system
	Market management engagement – 2 supplier events per year.
	Shared learning and collaboration of the FOM across the region
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market

3. Risks and issues

3.1 The previous report noted the risk of a shortage of procurement skills within the region. Two Interims have been supporting the MTW team in 2017/18 for the delivery of the CIP savings. There has been some success in the recruitment to the category management team however the team still has 2 vacancies. Work is still underway with the STP Heads of Procurement to share resource where possible to work together and remove any duplication of activity.

A new STP workplan will outline new areas where a lead within the STP will undertake a procurement or market activity on behalf of the STP.

4. RECOMMENDATION

4.1 It is recommended that the Finance Committee note and review the information in the report.

Appendix 1: Update about the action plan

Procurement objective	Action	Update
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard.	The Category Management team is 100% qualified.
Procurement workplan	Completion of 2017/18 and 2018/19 procurement workplan. These workplans will cover tail spend and improve the trust position on contract spend.	Current completed activity will deliver £3million across 2017/18 and 2018/19. There is still 4 months of the year activity to be completed but the majority of this saving will be seen in 2018/19. This has been a big change for the team were previous year agency staffing saving was counted towards the CIP and accounted for the main team saving.
Procurement Savings	Achievement of agreed 2017/18 CIP	Not all the CIP £5.3 million has been identified for 2017/18 however there has been a full review of all clinical spend to ensure the Trust is receiving the best value.
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.	Further communications plans for 2017/18 are set out in the sections below.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.	A procurement manual is being developed to support the team and any new starters.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). Re-launch of the Trust No Purchase Order, No Pay policy.	Integra is now live and supporting the re-launch of the Trust's No PO, No Pay policy. Metrics 3a and 3b demonstrate the progress in this regard.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.	A peer review is planned for 8 December 2017
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2016, rising to 60% by 2019.	42% of the Trust's spend is through collaborative arrangements.

Procurement objective	**Action**	**Update**
	Alignment of procurement work plans across the region	This is being progressed for 2018/19
	Review of external options for transactional procurement	This is part of the STP corporate services workstream.
	Integra financial system – working groups for agreement and alignment for the use of the system	This is part of the STP corporate services workstream.
	Market management engagement – 2 supplier events per year.	A supplier event is planned for Feb 2018 to share the STP workplan with the market.
	Shared learning and collaboration of the FOM across the region	Part of the National Health Service Procurement Alliance, they will be looking at how we can work together to deliver greater savings in advance of the FOM, with the expectation that the learning is taken back to respective STPs.
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market	A supplier survey is currently underway and expected to close on 30 November 2017.

Trust Board Meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-22	Summary report from Finance and Performance Committee, 27/11/17	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 27th November 2017.

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

- The actions from previous meetings were reviewed, and under the "Safety Moment", the Trust Secretary reported that November's theme was Information Governance
- The Medical Director attended to give a quarterly update on the Workforce Transformation programme, and reported that the revised Job Planning policy was due to be considered at the Joint Medical Consultative Committee before being submitted for approval and ratification
- The month 7 financial performance, including that on the Cost Improvement Programme (CIP), was discussed in detail
- The updated year-end forecast for 2017/18 was reviewed and it was noted that a further update would be submitted to the Committee (and most likely the Trust Board) in December
- Notification was given of the Director of Finance's use of their delegated authority to request an advance against the uncommitted single currency interim revenue support facility agreement (that had been approved by the Trust Board)
- The month 7 non-finance, non-quality, related performance was discussed, and the Acting Chief Executive reported the latest position in relation to the A&E 4-hour, 62-day Cancer waiting time and Referral to Treatment (RTT) waiting time targets
- The usual monthly update on the Lord Carter efficiency review was received
- An initial review of the financial aspects of the Trust's draft Planning submissions for 2018/19 was undertaken, including the further work planned. It was noted that a further update would be submitted to the Committee in December, with the final plans submitted to the Committee and Trust Board in January 2018. It was agreed that the update submitted to the December meeting should include examples of the posts included within the "Recruitment into Vacant Posts" review that had been requested by the Executive Team
- The quarterly progress update on Procurement Transformation Plan was reviewed (which has been submitted to the Board as a separate report) & it was agreed that the next update should include details of the financial values associated with the implementation of the Plan
- The updated financial aspects of the Board Assurance Framework & Risk Register were reviewed, as was the usual report on breaches of the external cap on Agency staff pay rate
- The interim Director of Health Informatics attended to give the Committee's 6-monthly update on IT strategy and related matters. The Committee heard that the implementation of the replacement PAS had gone reasonably well, although some issues remained unresolved. It was also noted that the recent external review of IT would inform the development of a revised IT Strategy for the Trust (which would support the Trust's wider Strategy). The need for the Trust to pursue an Electronic Patient Record (EPR) was highlighted
- The Committee agreed to undertake an evaluation in 2017 using the same method used in previous years (i.e. via a survey of Committee members and attendees)

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

- The Director of Finance should investigate the feasibility of the Trust's cash position being supporting by the receipt of a loan from a local Foundation Trust (rather than from the Department of Health)
- The Director of Finance should investigate the potential income opportunity relating to patients who received treatment from Genesis CancerCare UK Ltd having first been reviewed by the Trust

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

- None

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-23	Proposal regarding the Trust's Freedom to Speak up Guardian	Trust Secretary

In June 2014 the Secretary of State for Health commissioned Sir Robert Francis to carry out an independent review into creating an open and honest reporting culture in the NHS. Sir Robert's report ("Freedom to Speak Up") was published in February 2015, and included recommendations to introduce a "Freedom to Speak Up Guardian" in every NHS Trust.

In September 2015, the Trust Board considered a proposal regarding the appointment of the Trust's first Freedom to Speak Up Guardian. The proposal (that the Associate Director of Workforce be appointed as the Guardian) was rejected by the Board, on the basis that the post would not be seen by staff as being sufficiently independent from the Executive Team. A further proposal was therefore requested, and in October 2015 the Board approved the appointment of the Senior Independent Director (i.e. a Non-Executive Director) to the Guardian role.

The individual who was appointed held the role until they left the Trust Board on 27/07/17. At that point, following discussion with the Chair of the Trust Board and the incoming Director of Workforce, the Chair of the Workforce Committee (a Non-Executive Director) was asked, and kindly agreed, to take on the role of the Freedom to Speak Up Guardian role on an interim basis, pending a full review by the incoming Director of Workforce (who wished to consider whether the model in place at their current employer was appropriate for adoption/adaption by the Trust).

However, the need to implement alternative temporary arrangements has arisen, as a result of:

- The need for the Guardian role-holder to be easily accessible to staff and to have undertaken "Freedom to Speak Up Foundation Training" held by the National Guardian's Office (this Office had not been established when the Board made its appointment in October 2015). These requirements are difficult for a Non-Executive Director to meet, as they are only officially expected to undertake their Non-Executive duties for 2-3 days per month
- The evolution of the role since the Board appointed the Trust's first Guardian, and the clearer expectations regarding the role-holder (the example Job Description published by the National Guardian's Office is enclosed in Appendix 1)

Given the above, it is proposed that the Trust's Head of Employee Relations be appointed as the Freedom to Speak Up Guardian with immediate effect, on an interim basis, pending a full review by the incoming Director of Workforce (who starts in post on 01/12). The initial concerns held by the Board regarding the potential conflict of appointing a Guardian from the Human Resources department have not been universally reflected in the Guardian appointments made by other Trusts (for example, the Director of Workforce is the Guardian at North Tees and Hartlepool NHS Foundation Trust, whilst the Associate Director of Human Resources is the Guardian at Greater Manchester Mental Health NHS Foundation Trust). The Head of Employee Relations is both accessible (they work full time and are well known across the Trust); and very familiar with the Trust's "Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing)" (they are a "Designated Officer" under that policy). If the Board approves the proposal, the individual will also attend the "Freedom to Speak Up Foundation Training" on 01/12/17.

However, given the concerns expressed by the Board in September 2015, the Board is also asked to approve the appointment of a Non-Executive Director (or Associate Non-Executive Director) Freedom to Speak Up 'sponsor' (or 'champion' if that term is preferred). This role is not a formal requirement, but the intention would be that the Non-Executive Director:

a) Supports the appointed Freedom to Speak Up Guardian
b) Promotes and reinforces the implementation of the Trust's "Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing)"

If the Board approves this second proposal, the Chair of the Trust Board will liaise with the Non-Executive Directors/Associate Non-Executive Directors to appoint a person to the 'sponsor'/ 'champion' role.

Which Committees have reviewed the information prior to Board submission?

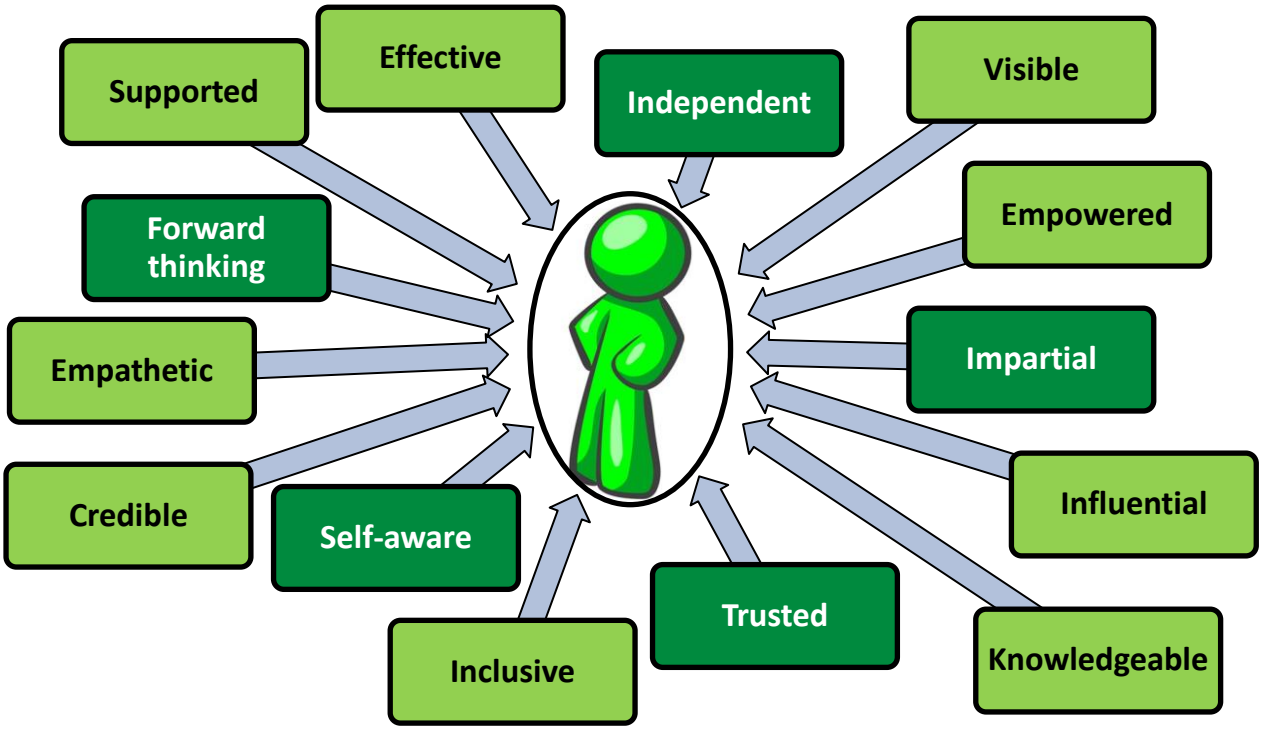
- N/A

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

To approve the proposals regarding the appointment of the Freedom to Speak Up Guardian (and Freedom to Speak Up 'sponsor' (or 'champion'))

[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

Example Job Description (Freedom to Speak Up Guardian) (September 2016)



Purpose of the role

The Freedom to Speak Up (FTSU) Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Outcomes

The FTSU Guardian role is designed to contribute to achieving the following outcomes:

- A culture of speaking up is instilled throughout the organisation
- Speaking up processes are effective and continuously improved
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up
- All staff are supported appropriately when they speak up or support other people who are speaking up
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up
- Safety and quality are assured
- A culture of speaking up is instilled throughout the NHS

Example Job Description (Freedom to Speak Up Guardian) (September 2016)

Role Description

The role of the FTSU Guardian is to:

Culture

- Develop and deliver communication and engagement programmes to increase visibility of the Freedom to Speak Up Guardian amongst all staff.
- Promote local speaking up processes and sources of support and guidance, demonstrate the impact that speaking up is having in the organisation, and celebrate speaking up.
- Ensure that all 'frontline' staff are aware of, and have access to, support to help them speak up.
- Where appropriate, develop and support a network of 'advocates' to ensure that Freedom to Speak Up reaches all parts of the organisation and everyone has easy access to someone outside their immediate line-management chain who can advise and support them.

Process improvement

- Work with HR professionals and others to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address any local issues that may hinder the speaking up process.
- Assess the effectiveness of Freedom to Speak Up processes and the handling of individual cases, intervening when these are failing people who speak up, and making recommendations for improvement.

Capability

- Assess the knowledge and capability of staff to speak up and to support people when they speak up.
- Ensure that all staff have the relevant skills and knowledge to enable them to speak up effectively, and those supporting, managing or investigating speaking up issues have the capability and knowledge to do this effectively.
- Ensure that appropriate items on speaking up are incorporated into induction programmes for all staff.
- Ensure that groups of staff and individuals who may find it difficult to speak up are given particular support.

Supporting staff

- Ensure that information and data are handled appropriately, and personal and confidential data are protected.
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are investigated, and the conclusion of any investigation.

- Where necessary, give extra support, including 1-2-1 support, to people who are experiencing difficulty with speaking up, or those who are experiencing difficulty in handling or supporting someone who is speaking up.

Working with and challenging the Board

- Develop strong and open working relationships with the CEO, NEDs and other Directors, with direct access to Trust leaders as required.
- Attend board meetings regularly to report on Freedom to Speak Up activities. Reports should include assessment of issues that people are speaking up about (and trends in those issues), and barriers affecting ability of people to speak up. Particular attention should be given to concerns which may suggest a link to patient safety and quality.
- Hold the Board to account for taking appropriate action to create a Freedom to Speak Up culture, assess trends, and respond to issues that are being raised.

Safety and quality

- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Develop measures, data sets, and indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

NHS culture

- Take part in National Guardian Office activities and training, actively supporting fellow Freedom to Speak Up Guardians, developing personal networks and peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.
- Raise issues that cannot be resolved locally with the National Guardian’s Office, including where Trusts appear to be failing in their obligations.
- Keep abreast of developments and best practice, assessing their own development and training needs, and seeking support in addressing these.

Example Job Description (Freedom to Speak Up Guardian) (September 2016)

Personal qualities:

FTSU Guardians are expected to have the qualities and experience that will enable them to uphold these key principles:

Key principles	…what this means
Independent	… in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture … and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up
Impartial	… and able to review fairly how cases where staff have spoken up are handled
Empowered	… to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder
Visible	… to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade
Influential	… with direct and regular access to members of trust boards and other senior leaders
Knowledgeable	…in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up
Inclusive	… and willing and able to support people who may struggle to have their voices heard
Credible	… with experience that resonates with frontline staff
Empathetic	… to people who wish to speak up, especially those who may be encountering difficulties … and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible
Trusted	… by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate
Self-aware	… and able to handle difficult situations professionally, setting boundaries and seeking support where needed
Forward thinking	… and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally
Supported	… with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities … with access to advice and training, and appropriate administrative and other support
Effective	… monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

Trust Board meeting – November 2017

NHS Maidstone and Tunbridge Wells NHS Trust

11-24 Trust Board development framework Chair of the Trust Board

The Trust Board has undergone some very significant changes over the last year i.e.

- The arrival of a new Chief Nurse and Medical Director in February 2017
- The arrival of myself as the new Chair in May 2017
- The appointment of 1 new Non-Executive Director, and 2 new Associate Non-Executive Directors, in July 2017
- The appointment of the Deputy Chief Executive as Acting Chief Executive in September 2017
- The transfer of one of the Associate Non-Executive Directors to the vacant Non-Executive Director position, in November 2017
- The appointment of a new Director of Workforce and new Non-Executive Director, who start in post on 1st December 2017

Therefore, the Board will be at its full complement by 1st December 2017. The collective knowledge, skills and capability of the Board provides a fantastic opportunity to lead the Trust on the next stage of its journey. Board development is a key enabler of this, by helping ensure that the Executive and Non-Executive Members work cohesively together.

A range of Board development activities are already in place. However, these activities have not previously been labelled as 'Board development', and not therefore been collated within an overall framework. The enclosed framework therefore aims to address this. The framework has been informed by the content of the frameworks in place at other NHS Trusts, and by some key external documents, including NHS Improvement's "Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts" and the NHS Leadership Academy's "The Healthy NHS Board 2013 - Principles for Good Governance".

The framework is submitted for approval, but it is intended to be dynamic, and therefore to be updated/revised as required. In this regard, the opportunity will be taken to discuss future Board development needs at the Trust Board 'Away Day on 7th December 2017.

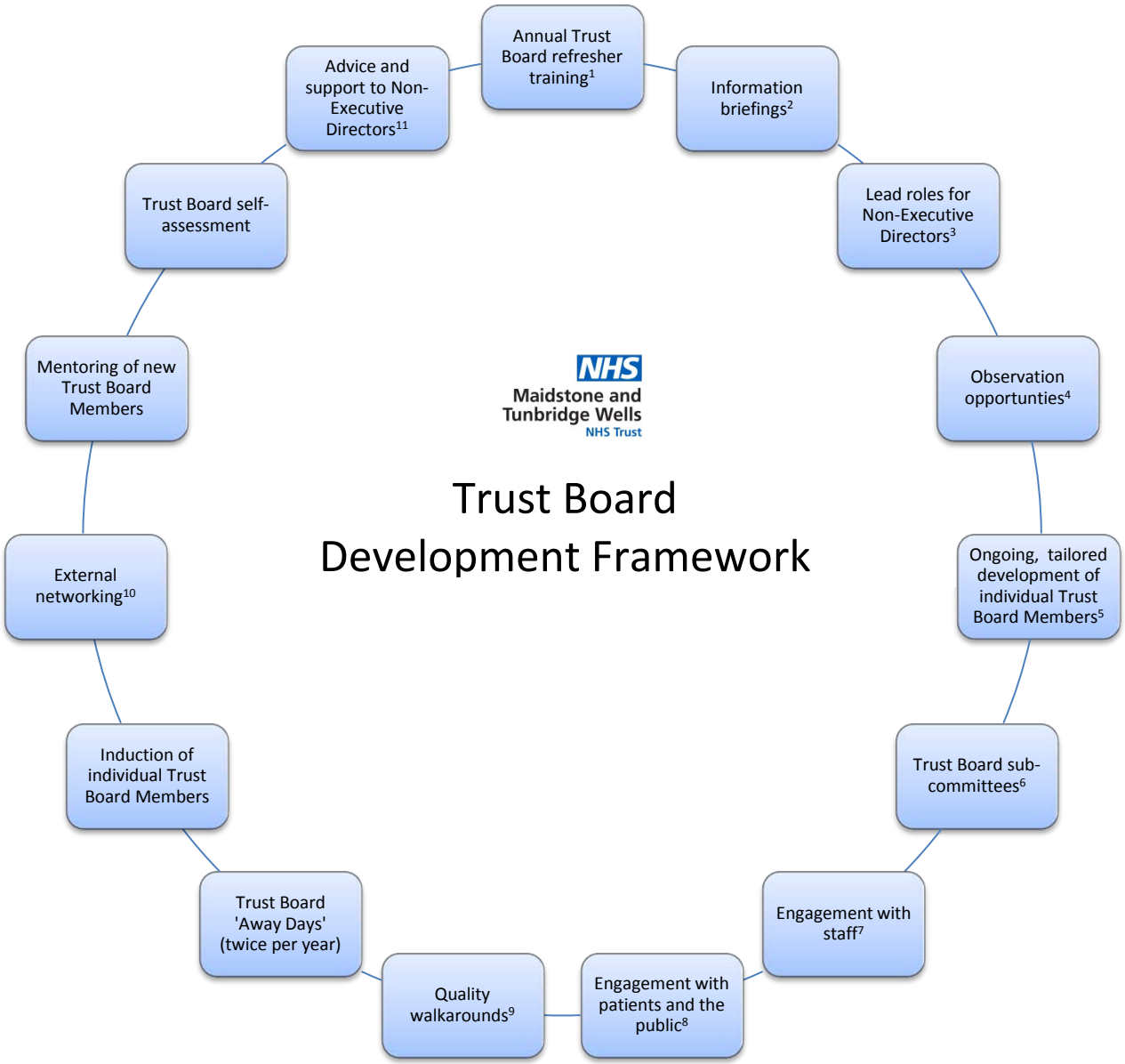
Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and approval

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



Notes

1. This is now provided as part of the review of the Annual Reports on Health & Safety, Moving and Handling, Fire, Infection Prevention and Control, Adult Safeguarding and Children's Safeguarding)
2. Including Client Briefings issued to Audit and Governance Committee members by Internal Audit; email newsletters from NHS Providers, NHS Improvement (NHSI), NHS England etc.
3. Including "Lay member on the trust Board with a responsibility/role for End of Life Care", "Non-Executive Lead for Resus" (a full list is maintained by the Trust Secretary)
4. Trust Board Members are welcome to observe any Committee, forum, working group etc., to aid their understanding of any particular issue, or gain assurance regarding processes/systems
5. Such development would be informed by appraisal
6. All Trust Board Members receive the agenda and reports of Trust Board sub-committees, and are able to attend any sub-committee meeting
7. This includes the Clinical Directorate presentations to the Trust Board, the Annual Staff Star Awards event, Quality walkarounds etc.
8. This includes the 'patient story' items at Trust Board Meetings, attending Patient Experience Committee meetings, the Annual General Meeting
9. The current Quality walkaround process/system will be reviewed at the Trust Board 'Away Day' on 07/12/17
10. Including NHS Providers network meetings, meetings with peers at other local NHS organisations etc.
11. The Trust Secretary is able to provide/obtain confidential advice/explanation on any aspect of the Trust's functions