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 THURSDAY 1ST MARCH 2018

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
2-1	To receive apologies for absence	Chair of the Trust Board	Verbal
2-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
2-3	Minutes of the Part 1 meeting of 25th January 2018	Chair of the Trust Board	1
2-4	To note progress with previous actions	Chair of the Trust Board	2
2-5	Safety moment	Chief Nurse	Verbal
2-6	Report from the Chair of the Trust Board	Chair of the Trust Board	Verbal
2-7	Report from the Chief Executive	Chief Executive	3
	Presentation from a Clinical Directorate		
2-8	Diagnostics & Pharmacy	Clinical Director / General Manager, Pathology / Chief Pharmacist	Presentation
2-9	Review of the Board Assurance Framework 2017/18	Trust Secretary	4
2-10	Integrated Performance Report for January 2018 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. mortality) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce)	Chief Executive Chief Operating Officer Chief Nurse Medical Director Dir. of Infect. Prev. & Control Director of Finance Director of Workforce	5
2-11	Emergency Care Improvement Programme (ECIP): report of acute site visit to Maid. & Tun. Wells hospitals, Jan '18	Chief Operating Officer	6
2-12	The approach to managing patients experiencing a long waiting time: interim report on recovery plan	Chief Operating Officer	7
	Quality items		
2-13	Update on engagement plan	Deputy Chief Executive	Verbal
2-14	Staffing (planned and actual ward staffing for January 2018; and 6-monthly review of Ward and non-Ward areas)	Chief Nurse	8
	Planning and strategy		
2-15	Update on the Trust's 2018/19 planning	Director of Finance	9 (to follow)
2-16	The development of Strategic Clinical Service Plans	Deputy Chief Executive	Verbal
2-17	Update on the working capital loan	Director of Finance	10 (N.B. The full document has been issued as a supplement to the main reports)
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
2-18	Workforce Committee, 25/01/18 (incl. approval of revised Terms of Reference and quarterly report from the Guardian of Safe Working Hours)	Committee Chair	11
2-19	Quality Committee, 06/02/18	Committee Chair	12
2-20	Trust Management Executive (TME), 21/02/18	Committee Chair	13
2-21	Audit and Governance Committee, 26/02/18	Committee Chair	Verbal
2-22	Finance and Performance Committee, 27/02/18 (incl. quarterly progress update on Procurement Transformation Plan)	Committee Chair	14 & 15 (to follow)
2-23	Charitable Funds Committee, 27/02/18	Committee Chair	Verbal
2-24	To approve revised Terms of Reference for the Remuneration & Appointments Committee	Committee Chair	16
2-25	**To consider any other business**		
2-26	**To receive any questions from members of the public**		
2-27	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 meetings:

- 29th March 2018, 10am, Education Centre, Tunbridge Wells Hospital
- 26th April 2018, 10am, Academic Centre, Maidstone Hospital
- 24th May 2018, 10am, Academic Centre, Maidstone Hospital
- 28th June 2018, 10am, Education Centre, Tunbridge Wells Hospital

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH JANUARY 2018, 10A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Angela Gallagher	Chief Operating Officer	(AG)
	Tim Livett	Non-Executive Director	(TL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive	(MS)
In attendance:	Simon Hart	Director of Workforce	(SH)
	Nazeya Hussain	Associate Non-Executive Director	(NH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Jenny Cleary	Head of Midwifery (for item 1-9)	(JC)
	Sarah Flint	Interim Clinical Director, Women's & Sexual Health (for item 1-9)	(SF)
	Michele Gordon	Service Manager, Integrated Sexual Health Services (for item 1-9)	(MG)
	Rita Joseph	Lead Matron, Outpatients & Community (Women's & Sexual Health) (for item 1-9)	(RJ)
	Fiona Martin	General Manager (Women's and Paediatrics)	(FM)
	Angela Savage	Complaints & PALS Manager (until item 1-10)	(AS)
	David Wyld	Patient relative (until item 1-10)	(DW)
Observing:	Annemieke Koper	Staff Side representative (until item 1-9)	(AKo)
	Darren Yates	Head of Communications	(DY)

[N.B. Some items were considered in a different order to that listed on the agenda]

1-1 To receive apologies for absence

Apologies were received from Sarah Dunnett (SDu), Non-Executive Director; and Alex King (AK), Non-Executive Director.

DH welcomed MS to his first Trust Board meeting starting in post as Chief Executive on 08/01/18.

1-2 To declare interests relevant to agenda items

No interests were declared.

1-3 Minutes of the 'Part 1' meeting of 20th December 2017

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

1-4 To note progress with previous actions

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

- **12-5 ("Arrange for the development of an appropriate Key Performance Indicator for Acute Kidney Injury, for inclusion in the monthly "Trust Performance Dashboard"")**. PM firstly gave assurance that the Outreach team were notified of any occurrence of Acute Kidney Injury (AKI), and alerts were added to the Patient Administration System (PAS) for all AKI patients. PM continued that AKI 'bundles' were also in place, and all patients with AKI had this automatically recorded on their Electronic Discharge Notification (eDN). PM also noted that teaching on AKI took place at induction, and an ongoing AKI audit was underway. PM then

explained that an AKI Task and Finish group had been established, but this had not met since the last Trust Board meeting, so he intended to attend the next meeting of the Group to discuss the AKI Key Performance Indicator (KPI), as much of the current KPI-related data was collected manually, including that for fluid balance. COB asked whether it was possible to quantify the number of patients with AKI. PM confirmed this was possible, but questioned the benefit of just reporting an overall number. It was therefore agreed that PM would discuss the development of the requested KPI with the AKI Task and Finish group.

- **12-8 ("Submit, to the Trust Board, the recovery plan arising from the impending review of the approach to managing patients experiencing a long waiting time")**. It was noted that an item had been scheduled for the Trust Board meeting in February 2018
- **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").** DH noted the decision not to introduce a 'finder fee' arrangement. SH confirmed this, and explained that a high fee value was required to achieve a reasonable return, and the evidence of success was limited, so he and COB had instead determined it would be better to support existing staff to progress, and therefore support retention. COB elaborated that the Trust had circa 40 Clinical Support Workers who had not been able to pass the requirements of the International English Language Testing System (IELTS), but who had expressed a desire to take the alternative Overseas English Test (OET), so the Trust was considering investing the £7,000 needed to support this (i.e. to enable them to be employed as Nurses). MS asked if such staff would be required to repay the invested funds if they left the Trust's employment within a certain period. COB and SH confirmed this was the case.

1-5 Safety moment

COB reported that the theme for January was the importance of documentation in healthcare and highlighted the following points:

- The subject was a key issue for all staff, and staff had been reminded of their responsibilities, focusing on legibility, dating and signing, and maintaining an accurate record of events
- It had been identified that discussions regarding important decisions such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) & assessment of capacity were often not recorded
- Staff had also been reminded of their professional obligations, in relation to the expectations from the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC)
- Allied Health Professionals (AHPs) were generally exemplars
- The Corporate Nursing team were exploring incorporating documentation standards within Care Assurance audits and Corporate Quality Rounds

PM concurred with the need to improve, noting that the poor documentation had been identified via a 7-day services audit, and he was committed to assisting Doctors to improve their practice.

SO asked whether it was feasible for specific groups or areas to be targeted, to hone the key messages beyond just emphasising the legal and regulatory requirements. COB replied that the standards from the previous Essence of Care initiative were being reviewed, to consider whether more regular audits of documentation could be undertaken. PM added that he understood documentation audits had previously been a regular feature of the clinical audit programme, but despite poor findings, documentation standards had not improved, and therefore just carrying out further audits would likely have a predictable outcome. PM continued that he understood that documentation problems did not however exist in Independent Sector hospitals, as when a documentation audit identified poor practice, a letter was sent to the relevant Consultant informing them that their practice privileges would be withdrawn unless they improved. PM noted that he believed the compliance in such hospitals was therefore close to 100%, so he was minded to adopt a similar approach, which meant that some audit data would be required. PM clarified that although the Trust's Consultants did not have practice privileges, they had employment contracts and professional codes of practice. PM then acknowledged that the issue was not limited to Consultants, and that work was therefore also required with Junior Doctors.

MS asked whether there was an opportunity to formally include documentation within appraisal and revalidation processes. COB replied that she would expect Ward Managers to regularly review

documentation standards as part of their routine monitoring. COB also reiterated the opportunity to learn from AHPs, and use such staff as role models. PM added that the appraisal process for Doctors was different to Nurses, so he would need to give MC's suggestion further thought, but his initial view was that the Job Planning process would be a more appropriate mechanism.

DH remarked that the appropriate strategic response to such issues would be the introduction of an Electronic Patient Record (EPR). The point was acknowledged.

1-6 Report from the Chair of the Trust Board

DH firstly commended the Trust's staff for their work and response to the significant pressures that continued to be faced, particularly over the Christmas period, and asked MS to ensure the sentiment was reflected in his weekly update to staff. DH then reported that there had been no Advisory Appointments Committees (AACs) since the last Trust Board meeting, and he understood that the next scheduled AAC was in March 2018.

DH concluded by stating that following a meeting of the Chairs and Chief Executives of the 4 acute provider Trusts in Kent and Medway that was held in November 2017, a further meeting would take place on 30/01/18. DH added that the intention was to establish an Acute Partnership Board, to provide a mechanism by which the 4 acute Trusts could work together more effectively.

1-7 Report from the Chief Executive

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

- He had undertaken many visits to clinical (& other) areas, & it was important that this continued
- COB and PM had communicated to staff regarding the issues requiring continued focus following the Care Quality Commission (CQC) inspection. It was important that when the inspection report was received, the Trust responded quickly so that the issues requiring improvement were prioritised
- MS had been struck by the inability to use the resources and talents of staff at Tunbridge Wells Hospital (TWH) for the originally intended purpose, because of capacity pressures. A number of staff had questioned this, as they had joined the Trust expecting to undertake different work. It was important not to 'normalise' this situation, and to therefore regard it as an exception
- JL would be developing proposals regarding a 'Best Care' programme, to aim to improve quality as well as efficiency
- Building effective relationships was important, including with other providers across Kent and Medway, building on the good relationships that had been developed over the last 2 years, and focusing on the actions that needed to arise from such relationships

1-8 A patient's experiences of the Trust's services

DH and COB welcomed DW to the meeting and invited him to recount the experiences he and his late wife, Deborah, had had with the Trust. DW first stated that he and Deborah had experienced many positive aspects, but there were some areas requiring improvement, and he hoped that his attendance at the meeting would assist in this. DW the reported the following points:

- On 26/01/17, Deborah had to attend the Outpatient Department for a blood test (at 5pm), and at 6pm, Dr Wykes stated that Deborah needed to attend A&E, for a blood transfusion. When DW and Deborah arrived at A&E 1 hour later, no one knew about their need to attend
- After waiting 2 hours, Deborah was taken to the Majors area. Deborah was assessed but her history had to be given verbally as there were no healthcare records (even though Deborah's Cancer had been diagnosed at TWH)
- A sore was identified on Deborah's left thigh and antibiotics were prescribed. DW specified the list of medications that had been provided by King's College Hospital NHS Foundation Trust, which included granulocyte-colony stimulating factor (G-CSF). However, the details of the G-CSF medication were not passed on and the following day, DW discovered this had not been administered (which implied that there was no documentation following a patient)
- Deborah had to stay at TWH overnight, and that night she experienced severe diarrhoea. She had been left in her own faeces overnight, despite requesting assistance via the call bell

- The staff on Ward 31 were very stressed and overworked, and when DW asked to speak to the manager, he was encouraged to do so by staff (which DW interpreted as a sign that the staff needed support)
- The following morning, Deborah needed to have a blood sample taken, and she wanted this to be done via a Peripherally Inserted Central Catheter (PICC) line, rather than a hypodermic needle, but the Doctor was insistent that the latter be used, as the PICC line was blocked. DW had to argue vigorously for the PICC line to be unblocked. This was eventually done, but DW should not have had to argue for this to occur
- Deborah's blood test results did not arrive for several hours, and it was later discovered that the blood sample had been mislaid. However, DW had confidence in the Nurse that took the blood sample, who had been very helpful and thorough
- On 27/01/17, Deborah came home tired, pale and suffering from diarrhoea. She was in a distressed state
- On 09/10/17, Deborah needed to return to TWH, as her GP wanted her to attend A&E. When Deborah arrived, the A&E Nurse did not have Deborah's records. Deborah was also not fast-tracked. After 1 hour, a CT scan was taken & platelets were administered. However, there were then delays of 3-4 hours, which DW was told related to 'sketchy' information having been taken
- The following day, a Doctor again referred to 'sketchy' information, and asked for a full history. DW had to provide the Doctor with the name of Dr Wykes. An MRI request form was completed, but the Doctor was unable to say when the scan would be done
- Deborah was not given the antiviral medication that had been prescribed by King's College Hospital NHS Foundation Trust, and DW was told that this was because because it had not been prescribed by a Doctor at TWH

DW then stated that the experiences highlighted a lack of communication, which added to staff pressure, in that they had to ask patients or relatives why they were at the hospital and their history. DW noted that although the former request was reasonable, the latter request should not be necessary.

DW then continued to summarise that information on medication had not been recorded, the Nurse manager had not introduced herself as the manager, information on handover was 'sketchy', and the issues seemed to be systemic. DW also noted that the patient number used within the Haematology-Oncology Day Unit (HODU) was different to the number used with the ambulatory Ward and there was no cross-referencing, which led to delays within the ambulatory Ward (as the staff did not recognise the number from the HODU).

DW then opined that the Trust's record-keeping appeared to based in the mid-20th Century and electronic information would improve the situation greatly, noting that this had been the case in the industry in which he had worked. DW continued by stating that staffing and resource shortages were not new problems, but such shortages may not in fact be real because of the inefficiencies DW had witnessed. DW also noted that taking 4 months to respond to a compliant was a further area for improvement.

DW then concluded by highlighting that despite the issues he had raised, some very good staff worked at the Trust, and the Trust should be proud of this.

DH thanked DW, and emphasised the importance of the Trust Board hearing about patients' negative, as well as positive, experiences. NH also thanked DW, and confirmed the need for the Trust to seek to learn and improve. DW welcomed this, but stated that having heard the comments made by PM under item 1-5 in relation to the approach to be taken to improve Doctors' documentation, he questioned whether it would be more appropriate to reward positive behaviour than to punish negative behaviour. The point was acknowledged.

MS also commended DW and stated that he had told Deborah's story in a way that had made the areas requiring action very clear. MS committed to providing a response to DW explaining the action the Trust had taken. COB agreed, adding that many of the issues raised by DW would be incorporated within the Trust's updated Quality Strategy.

[N.B. DW and AS left the meeting at this point]

DH then stated that many of the issues raised by DW may be related to the fact that the Trust had 2 sites, but he was interested why the Trust would not give a medication that had been prescribed by King's College Hospital NHS Foundation Trust. AG speculated that this may have been related to absence of clear documentation. DH suggested that the aforementioned report to be prepared in response divide the issues into the specific points raised by DW, and the general learning points.

NH then noted that she had recently spent a day on a Ward, and the main frustration of the longstanding staff member NH had spoken to was the availability of healthcare records from Paddock Wood. NH stated that she would therefore welcome an understanding of the process in place. DH repeated the comment he had made under item 1-5, that the appropriate strategic response would be to have an EPR, and although the Trust had not defined its strategy regarding this, such a strategy was required. DH acknowledged that the issues raised by NH were however short-term operational matters that needed to be addressed. MS asked AG to comment. AG explained that Paddock Wood had been the location of the Trust's healthcare records store for circa 6 years, but a recent deterioration in accessing records had been identified via the Trust Management Executive (TME).

DH then drew the discussion to a close by asking COB to develop a report responding to the specific points and general themes arising during the item, and to circulate this before the next Trust Board meeting, to enable the actions to be considered at that meeting. This was agreed.

Action: Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the "A patient's experiences of the Trust's services" item at the Trust Board meeting on 25/01/18 (Chief Nurse, January 2018 onwards)

Presentation from a Clinical Directorate

1-9 Women's and Sexual Health

DH welcomed JC, SF, MG, RJ and FM to the meeting. SF then gave a presentation which highlighted the following points:

- SF had been interim Clinical Director for Women's & Sexual Health for just over 2 months
- Obstetrics & Gynaecology had 15 Consultants (12 substantive, 2 locums, plus 1 part-time Consultant, and fertility support)
- Over 6000 deliveries were carried out in mixed settings, including community births
- One to One Midwifery care was provided on the labour ward, with a 75 hour per week Consultant presence at TWH. There were 6 Consultant-led caesarean section lists per week (which related to approximately 18 women)
- There was a strong culture of multi-professional working, teaching and training, which included Human Factors training
- The Sexual Health service involved 3 Consultants, one of whom was on Maternity leave

MG referred to the latter point, and added that the Sexual Health service was commissioned by Kent County Council (KCC) and NHS England for HIV care, prison care, and some service was sub-contracted to Kent Community Health NHS Foundation Trust (KCHFT).

SF then continued, and highlighted that the Directorate also incorporated Gynaecology. DH asked whether this included Gynae Oncology. SF replied that Gynae Oncology was provided by the Surgical Directorate, but she was keen to strengthen relationships with that service.

SF then showed an overview of the latest financial position. SO pointed out that the Directorate had found it very challenging to identify large-scale Cost Improvement Programme (CIP) schemes. SF agreed, but pointed out that there was however an opportunity to reduce the Clinical Negligence Scheme for Trusts (CNST) subscription by £900k, by meeting the requirements of 10 criteria (of which 6 were currently met). SO noted this, and also noted that this was the first year for some time that the Trust's CNST subscription had not increased.

FM then noted that there had been vacancies in a number of Middle Grade i.e. Specialty and Associate Specialist (SAS) posts. DH asked whether these vacancies were related to the allocation of posts by the Deanery. FM confirmed that some of the vacancies were related to this.

SF then continued, and highlighted the following points relating to performance:
- For Obstetrics and Gynaecology, there were pressures on the 18 week Referral to Treatment (RTT) performance. There was ongoing validation and utilisation of Theatres at Maidstone Hospital (MH), but a high number of urgent cases took priority
- There had also been a reduction in inpatient activity due to Theatre closures at TWH
- There was ongoing daily validation of follow-up Outpatient appointments and 'cashing up' of clinics to ensure data was accurate
- Theatre utilisation was good, with Turnaround Times (TATs) over 90%
- For Sexual Health, there were currently 22 KPIs determined by the commissioners (i.e. KCC), and the service was compliant for all 22 KPIs in December 2017

DH asked how the Trust benchmarked against the percentage of Day Case procedures. SF replied that the 'Getting It Right First Time' (GIRFT) data showed the Trust performed very well, which reflected the work FM had undertaken over the past few years and the 2 Outpatient procedure suites the service had.

SF then continued, and highlighted the following points in relation to ongoing actions and projects within Obstetrics & Gynaecology:
- For caesarean sections, the Trust was not an outlier, and the National Maternity and Perinatal Audit (NMPA) confirmed this, with the exception of caesarean sections on multiparous women (multips) pre-labour. SF had however allocated a lead person to work on that aspect
- The Listening into Action (LiA) pulse survey had provided some negative feedback in a number of areas, including antenatal and triage. A meeting was therefore held and an action plan developed. There had been good engagement from staff, and some of the work regarding antenatal clinics was one of the Trust's LiA projects. Triage was also now the subject of a Task and Finish group
- Action had also been taken to address the issues raised regarding caesarean section Theatre lists. This related to the lack of available Theatre sessions for caesarean sections, which had adversely affected team working. The number of concerns raised had however now reduced considerably
- The pulse survey also raised concerns regarding the leadership development of senior Midwives and Medical staff, and the response to this was ongoing
- There had been historical issues regarding team working and leadership in Obstetrics & Gynaecology, and the support provided by the Trust had been very well received. There were now monthly Consultant meetings and at the most recent such meeting, every Consultant had attended, which was a very positive sign

MG then continued and reported the following points in relation to ongoing actions and projects within for Sexual Heath:
- The IT projects for the service included Order Communications and an EPR
- The service was involved in the PrEP, a national HIV health prevention trial
- Work was continuing with Public Health Kent to lower teenage pregnancy targets, reduce the late diagnosis of HIV, and increase asymptomatic Chlamydia screening

SF then continued and stated that the Risks/Challenges in Obstetrics & Gynaecology included:
- Demand and capacity for increasing antenatal care, triage, scanning etc., for which a project group had been established
- The increased RTT Gynaecology Surgical backlog (due to winter pressures)
- The implementation of the Allscripts PAS
- The implementation of 7 day services

SF then reported that the opportunities for Obstetrics & Gynaecology included the following:
- Developing services within fertility
- Developing closer professional relationship with the Gynae Oncology Medical Team
- Involvement in the Maternal and Neonatal Health Safety Collaborative wave 2
- Reviewing the support staffing within Medical staffing, with the potential of employing Physicians' Associates
- Reviewing demand and recruiting to the remaining vacant Consultant posts

DH referred to the latter point and noted that a recent schedule of interviews had resulted in 3 appointments being made in a single day.

MG stated that the Risks/Challenges in Sexual Health included:
- Managing flexible demand and capacity for the population
- Recruiting and training Specialist Nurses and Medical staff to deliver the service
- Retaining the Sexual Health contract, for which a decision was due later in 2018

SF then continued and highlighted the following future improvements in Obstetrics & Gynaecology:
- Leadership development (involving continual support and development of all Consultant Medical staff, to encourage teamwork)
- Evaluation and sharing of all learning from Serious Incidents (SIs) and complaints to ensure continual learning. SF had appointed a new Clinical Governance lead to drive improvement in this area

JC added that the Trust was a Maternity Choice pioneer, and positive progress had been made regarding this. JC continued that this aligned with the need for a Kent & Medway Maternity plan covering the next 5 years, which related to the Sustainability and Transformation Partnership (STP), and included how learning was shared across the region.

JC also noted that the national Maternity survey would be published on 30/01/18, and there was a desire within the service to improve research. It was highlighted that the service had applied (at short notice) for funding for a Darzi Fellowship and although this had been unsuccessful, the process had been positive as the bid had been submitted in liaison with Medway NHS Foundation Trust (MFT).

MG then highlighted that future improvements in Sexual Health included the following:
- To deliver a robust and sustainable bid in order to retain the Sexual Health contract
- To continue to work with Public Health England and KCC to maintain and improve the sexual health for the local population
- To share the service's knowledge and experience with the wider community (following the embedding of a 'hub and spoke' model), to improve the health of the population and establish the Trust as the leaders in Sexual Health
- Electronic prescribing

MS commended the online response given to patients of the Sexual Health service, and stated that other services could learn from that system. MS then asked for a comment on the point at which the Maternity service would likely need an increase in delivery rooms or a large increase in staff. JC replied that local population projections did not indicate a significant further increase, and activity was being managed at present, within a robust escalation plan (although the Maternity Unit had not needed to be closed). SF added that it was however important to continue to monitor capacity as the current bed situation was extremely tight. MS acknowledged the point.

DH then thanked JC, SF, MG, RJ and FM for their presentation.

1-10 Integrated Performance Report for December 2017

MS referred to the circulated report and highlighted the following points:
- The response to the continued emergency pressures had been fantastic & it was clear that staff were working incredibly hard to keep patients safe & promote the best patient experience
- The Trust had not however experienced the influenza-related pressures seen in other parts of the country, and a surge of influenza cases would severely challenge the Trust
- The knock-on effect of current pressures on waiting lists and budgets was however severe, & MS was pleased to see that PM was leading on an audit of those currently on the waiting list
- MS would like the Trust Board to focus its attention on falls and pressure ulcers, as these were the 2 quality indicators most sensitive to Nurse staffing levels
- In terms of finances, having submitted a revised financial forecast, the key implication for the Board was that there was an underlying stability & therefore the Board needed to focus on the major issues that would improve underlying sustainability (rather than on 'firefighting' actions)

- MS was pleased to see the good Friends and Family Test (FFT) response rates and positive responses

Effectiveness / Responsiveness (incl. DTOCs)

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

- The A&E 4-hour waiting time trajectory had been missed for December but there was an improvement on the performance from the same time in 2016/17, despite increased patient volume and acuity. However, Length of Stay (LOS) had also reduced by 0.5 days.
- There was continued focus on discharge planning, and more patients had been discharged than expected, which was in large part due to the various enabling schemes, including Hilton and Home First Pathway 3. Medical staffing had also been improved to assist patient flow
- January had also seen a high volume of patients and high acuity, and the Trust remained in escalation
- Acute Ambulatory Care at TWH had now developed and progress was being made. This was an enabler to the Trust's efforts to remove escalation capacity
- The rate of Delayed Transfers of Care (DTOCs) had again improved in December, to 3.7%. There had also been an increase in packages of care. There were still however circa 100 'Medically Fit For Discharge' (MFFD) patients, and these were therefore the subject of focus

DH commended the fact that many issues had improved compared to the previous year, but remarked that the rolling chart of activity showed that the Trust needed to normalise at such levels, and perhaps therefore raise the control lines on the Statistical Process Control (SPC) charts. AG acknowledged the point, and noted that the same issue had been discussed at the Trust Board before DH became the Chair.

AG then continued, and highlighted the following points:

- Performance against the 62-day Cancer waiting time target had reduced in November, which reversed the recent trend. Some substantive Medical vacancies had reduced capacity and hence increased the interval between referral and diagnosis. The 31-day target was still being met however, so treatment was occurring quickly once a diagnosis was made
- More staff had been recruited in Surgery, including Clinical Nurse Specialists (CNSs) in Colorectal Surgery
- AG was confident that the actions being taken were the correct actions, but NHS Improvement (NHSI) would soon undertake a review of the Trust's processes, as a 'critical friend'
- 17 patients in November were referred late from other Trusts. The Trust had in turn made 1 late referral (to Guy's and St Thomas' NHS Foundation Trust)

NH noted the trend in beaches within Upper and Lower Gastrointestinal (GI) and asked for a comment. AG stated that there had been a CNS vacancy, but the post had now been filled, so improvement was expected. AG added that some patients did not want to be treated in December, so the number of treatments had been reduced, which had had an impact. AG did however note that significant improvement had been made within Lower GI in the recent past.

AG then continued, and highlighted the following points:

- Performance against the 18 week RTT target was a concern, as a result of a number of factors, including having the capacity to undertake elective activity. NHSI had issued a directive to reduce elective activity in January in response to non-elective demand
- The Trust's response was concentrated on risk summits. AG was also keen to see the outcome of the aforementioned audit of patients on the waiting list, which was being led by PM

DH referred to the directive issued by the National Emergency Pressures Panel (NEPP), and stated that he presumed that plans were being developed to enable elective activity to recover. AG confirmed this was the case, but noted that the Trust had already planned some reductions, so it was possible to increase activity more quickly at MH, but there was less scope to do this at TWH. DH asked whether dates were being given to individual patients. AG confirmed this was the case.

MC noted that implementing Waiting List Initiative (WLI) activity could be seen as rewarding waiting list backlogs, but asked whether there were opportunities to improve. AG replied that the

Trust was focusing on theatre efficiency, but the WLIs that were planned would use internal capacity. AG added that WLIs were only used for specialties that absolutely had to have capacity over and above their baseline levels.

AG then continued, and highlighted that there had been 13 52-week waiting time breaches, in Trauma & Orthopaedics, but AG expected 1 of these to be removed after validation. AG elaborated that the breaches had been affected by Consultant sickness absence, the implementation of the Allscripts PAS, and cancellations due to capacity challenges. AG stated that there would be a full report once the Root Cause Analyses (RCAs) had been completed, but mitigating actions had been introduced, and the patients had been reviewed by the Clinical Director to make sure they had not been adversely affected.

DH then stated that he believed JL had held discussions with other providers to reach agreement for the Trust to use their facilities rather than outsource activity. JL confirmed there had been some positive discussions, but no agreement had yet been finalised, and it was likely to be circa 2 months before any such activity commenced. SO added that West Kent Clinical Commissioning Group (CCG) was keen to be involved in these discussions. JL acknowledged this, and noted that the Accountable Officer for West Kent CCG had been invited to a meeting regarding this.

Safe / Effectiveness / Caring

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

- Patient falls and pressure ulcers were Nurse sensitive indicators, and these were attempted to be triangulated with the “Planned and actual ward staffing” report submitted under item 1-11
- The year-end target for falls was a rate of 6 per 1000 bed days, and the rate was currently at 5.84. Efforts were also being focused on preventing harm following a fall, and this had reduced compared to the previous month. COB had received assurance that this was not related to a reduction in reporting
- There had been 28 falls-related Serious Incidents (SIs) for the year to date
- The Trust had engaged with a Trust in Devon and also with Surrey and Sussex Healthcare NHS Trust, and the key theme was ensuring that falls was regarded as everyone’s business
- The learning from SIs was noted in report, which included documentation as a key theme
- The Trust was keen to support patients who had fallen outside of hospital, and in the absence of a community falls service, was aiming to identify the type of support required
- The level of pressure ulcers was now below the Trust’s internal plan, but there would be no complacency as no patient should experience skin damage whilst in the Trust’s care
- FFT performance was slightly below target, but this could be expected in December, given the capacity challenges. However, the external company, iwantgreatcare, had confirmed that the Trust’s responses compared favourably
- The complaints response rate had reduced, to 53.8%, and DW’s experience had demonstrated this. The Divisions were being supported by the Central Complaints Team to reduce the number of open complaints as well as responding to new complaints
- There had been 8 mixed sex accommodation breaches for the month, for 1 night only on Chaucer Ward. The breaches had occurred despite staff working hard to protect patient dignity, but the situation had been resolved the following day

NH then asked what action was being taken to learn lessons from complaints. COB stated that the themes from complaints were considered each month at the Trust Clinical Governance Committee via the Complaints, Legal, Incidents, PALS, Audit (CLIPA) report. COB continued that the ‘main’ Quality Committee also received such details, but it had been acknowledged that mistakes had been repeated, so the challenge was how to collectively work to improve. COB added that making changes was the key issue, and work continued with Divisions regarding this, although some of the broader themes were being driven across the organisation.

Safe / Effectiveness (incl. Mortality)

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

- Validation was awaited to confirm that the reported Summary Hospital-level Mortality Indicator (SHMI) of 104 was indeed correct

- The Hospital Standardised Mortality Ratio (HSMR) was 104 for weekdays, but 110 for weekends, although this was a complex area
- The Mortality Surveillance Group continued to meet, but was focused on increasing the percentage of mortality reviews being completed. There was also a focus on embedding the process change referred to at the previous Trust Board meeting, and the Trust had improved its rate of mortality reviews. The Trust compared favourably in the regard with East Kent Hospitals University NHS Foundation Trust, but MFT performed better. MFT did however have a mortality coordinator, so this may be something the Trust wished to consider
- Only 1 of the completed mortality reviews involved suboptimal care (and was a definite SI)

Safe (infection control)

SM referred to the circulated information and reported the following points:

- The MRSA bacteraemia case had now been confirmed as being attributed to a third party so the Trust's performance was again at zero cases for the year
- The Clostridium difficile trajectory remained on course
- For influenza, SM had appealed for swabs to be taken more quickly. There had only been 1 positive patient in December, but 27 positive patients in January. The care of such patients involved significant resource. Influenza B seemed to be a major problem that year.
- Influenza outbreaks had also been seen in some community hospitals, and there had been some closures as a result
- The Trust had not experienced any cases of Norovirus thus far

Well-Led (finance)

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

- The Trust needed to ensure that the revised forecast was delivered, as a minimum
- The key mitigation against the plans for the aforementioned Outpatient (elective) increase was the Aligned Incentives Contract (AIC)
- The escalation required as a result of winter pressures had come at a cost, and the Trust now had a lower number of substantive staff, and a higher number of temporary staff, than last year. The Bank pay rate had also been increased over the Christmas period
- The delivery of the revised forecast required a marginal improvement in the run rate. The Cost Improvement Programme (CIP) also needed to continue to deliver
- Attachment 8 reported on the latest situation regarding the working capital support, and SO had now received confirmation that the second tranche of this had been approved
- Capital expenditure had reduced, but SO had been assured that the plan would be delivered. If there was slippage, schemes would be brought forward from 2018/19 and the plans would be adjusted accordingly

Well-led (workforce)

SH then reported the following points:

- The Trust had been recruiting more staff than were leaving, but this trend had slowed in December. However, work was continuing to attract staff, including the work on LiA
- Measures had been taken to incentivise staff to work on the Bank rather than for Agencies over the Christmas period
- Sickness absence remained a concern, but the Human Resources teams were working with the clinical teams to address this. A vacancy within Occupational Health had been filled, which would help with supporting staff, and also help the influenza vaccination programme. On 19/01/18, that programme had reached the milestone of 70% of clinical staff being vaccinated, but the campaign would continue until at least the end of February 2018. It was noted that some Trusts had achieved vaccination rates over 80% so more work was required
- There were lessons to be learned from the winter period, including liaison with partner organisations

Quality Items

1-11 Planned and actual ward staffing for December 2017

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

- The format had not changed for the last 2 reports and the table on page 4 was an extract from the Unify2 reporting system
- The red-rated areas reflected the difficulties that had been experienced in filling shifts. Staff were rotated and Matrons were also able to assist, but such circumstances were not currently captured and reported. However, this would be resolved by the eRostering IT system. Therefore the data in the report should be considered with some caution, as no area would be left unsafe
- Amber ratings usually related to areas experiencing a higher rate of falls (when compared to the challenging target rate that had been set)
- The "Overall RAG Status" was a professional judgement, but COB was considering reintroducing the Quality, Effectiveness & Safety Trigger Tool (QuESTT) system, which took into account SIs, sickness absence rate, whether a Ward Manager was new etc. The reintroduction of the QuESTT was being piloted for 2 months, and may therefore be used in future "Planned and actual ward staffing" reports

1-12 Board members' Quality Walkarounds

KR referred to the report that had been circulated and highlight that there had been an increase in Walkarounds. MC asked about the process for arranging such Walkarounds for Trust Board members. DH stated that he believed further action was required on this, but KR clarified that the current process relied on individual Trust Board Members organising their own Walkarounds, although these could be arranged by the Trust if required. It was however agreed that KR and DH should liaise to clarify the arrangements for the scheduling of Quality Walkarounds.

Action: Liaise to clarify the arrangements for the scheduling of Board members' Quality Walkarounds (Trust Secretary / Chair of the Trust Board, January 2018 onwards)

Planning and strategy

1-13 Update on the Trust's 2018/19 planning

SO referenced the report that had been circulated and drew attention to the fact that the national planning guidance was still awaited. DH acknowledged this, and added that a further discussion on 2018/19 planning would be held at the 'Part 2' Trust Board meeting scheduled for later that day.

1-14 Final Agreement for working capital support

The circulated report was noted. DH drew attention to the supplement that had been circulated, which contained the final Agreement for the working capital support.

Assurance and policy

1-15 Emergency Planning update (annual report to Board)

AG referenced the report that had been distributed and drew attention to the following points:

- The report was for assurance and information
- Business Continuity plans were a major part of Emergency Planning and a review of Business Continuity Plans had been undertaken earlier in the year
- A water shortage scenario had also been tested
- The Trust was fully compliant with the Emergency Planning, Response & Recovery (EPRR) standards
- The Trust had good relationships with local providers, and had a very active and diligent Emergency Planning Officer (John Weeks)

COB highlighted that one of the Emergency Planning Officer's initiatives was to share the experiences of the NHS staff who had responded to the Manchester Arena bombing, and the need to support staff in coping with such circumstances had been acknowledged.

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

1-16 Quality Committee, 18/12/18 & 10/01/18 (to include approval of revised Terms of Reference)

In SDu's absence, DH referred to the circulated report and stated that there did not appear to be any issues requiring specific attention. MC concurred, but noted that the work undertaken to ensure learning was taking place at the Trust had been discussed at the Committee, although it had been acknowledged that further work was required.

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

1-17 Trust Management Executive (TME), 17/01/18

MS referred to the circulated report and noted that a presentation had been given by David Evans, which had been very well received, and PM would therefore organise a visit to North Shields.

1-18 Finance and Performance Committee, 09/01/17 & 23/01/17

TL referred to the circulated summary and highlighted that the meeting on 09/01/18 had been focused on the forecast out-turn for 2017/18, which then informed the Financial Special Measures (FSM) review meeting with NHSI. TL continued that the meeting on 23/01/18 had covered many of the issues covered at that day's Trust Board meeting, but had also discussed the options being considered in relation to the PFI contract at TWH.

SO then referred to the FSM meeting with NHSI and noted that although MS had written to NHSI outlining the actions being taken by the Trust, formal feedback had yet to be received from NHSI. SO added that NHSI had however recognised that the Trust was on a journey and acknowledged the absence of significant differences in performance between the Trust and Trusts that were not in FSM. SO also noted that the Trust needed to provide NHSI with assurance that its plan for 2018/19 would be fully developed before the start of that year.

1-19 To consider any other business

PM referred back to the report he had given under item 1-10, and confirmed that the SHMI of 104 had been validated.

1-20 To receive any questions from members of the public

No questions were posed.

1-21 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Trust Board Meeting – February 2018

Maidstone and Tunbridge Wells NHS Trust

2-4 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]
12-5 (Dec 17)	Arrange for the development of an appropriate Key Performance Indicator for Acute Kidney Injury, for inclusion in the monthly "Trust Performance Dashboard"	Medical Director (N.B. this was originally allocated to the Chief Nurse , but transferred to the Medical Director by mutual consent)	December 2017 onwards	The matter has not yet been able to be considered by the AKI Task and Finish group (as was discussed at the Trust Board on 25/01/18)
12-8 (Dec 17)	Submit, to the Trust Board, the recovery plan arising from the impending review of the approach to managing patients experiencing a long waiting time	Chief Operating Officer	January 2018 onwards	Decision required A brief update report has been scheduled for submission to the February 2018 Trust Board meeting. However, it is proposed that a more detailed report be submitted to the 'main' Quality Committee in March 2018, and that the findings also be considered at that Committee (i.e. instead of the Trust Board)
1-8 (Jan 18)	Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the "A patient's experiences of the Trust's services" item at the Trust Board meeting on 25/01/18	Chief Nurse	January 2018 onwards	The report is being finalised, and will be circulated to Trust Board Members before the Trust Board meeting on 29/03/18
1-12 (Jan 18)	Liaise to clarify the arrangements for the scheduling of Board members' Quality Walkarounds	Trust Secretary / Chair of the Trust Board	January 2018 onwards	Liaison has occurred, and following discussion with the Chief Nurse, a report regarding the Trust's approach to Quality Walkarounds was discussed at the Executive Team Meeting on 13/02/18. Following this, Non-Executive Directors were then asked to comment. The approach will be refined in response to any comments received, and a proposal will be submitted for formal consideration by the Board.

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
N/A	N/A	N/A	N/A	N/A

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 – February 2018

NHS
Maidstone and Tunbridge Wells NHS Trust

2-7 Report from the Chief Executive — Chief Executive

- The leadership team at MTW is working closely with our clinical and non-clinical staff to collectively address our challenges, celebrate our achievements and support the opportunities our colleagues are identifying to positively improve our patient and staff experience.

  Part of my work since arriving at our Trust has also focused on meeting our partners to collaboratively deliver the transformational change required at all levels of health and social care to meet our patient needs.

- We are in the process of finalising a strong cohesive plan, through our Best Care programme, to achieve key clinically-led objectives for Maidstone and Tunbridge Wells NHS Trust in 2018/19. This is a collaborative approach that requires and proactively seeks out the ongoing involvement of our staff, patients, and stakeholders to make changes for the better on a daily basis.

  Best Care focuses on improvement-driven initiatives to provide financially sustainable, high quality care for our patients. We know that providing high quality, safe standards of care – through an unremitting focus on quality, safety and patient and staff experience – is cost-effective and transformational for those hospital trusts that get it right.

- We are also working more widely with health and social care providers throughout Kent and Medway, and are facilitating discussions with our own clinical teams to help shape our response to the stroke consultation. This is an opportunity to build on the improvements our Trust has seen in its stroke performance by creating a hub for 24/7 specialist care in our area.

  Much can be achieved by working in unison for our patients. I attended the official opening of the new PET CT scanner at Maidstone Hospital. This partnership development between our Trust and Alliance Medical is great news for our patients and creates future opportunities for medical research.

  I have also spent time with our staff at the Kent Oncology Centre in East Kent. I am hugely impressed with their work and the care provided by the Kent Oncology Centre as a whole.

  We have recently been commissioned to provide Stereotactic Ablative Radiotherapy for lung cancers. Previously, patients were travelling to London for this incredibly precise radiotherapy technique. Patients are also benefitting from our new technology for treating `moving' tumours.

- In the last few weeks I have been struck by the opportunities that exist, and which are being taken by our staff, to improve our patient and staff experience. Examples of the changes I have already seen take hold at MTW that very much reflect the ethos of Best Care, include:
  - Women who have completed their active treatment for breast cancer having a better experience thanks to more patient-friendly and less resource intensive ways of managing their annual check-ups
  - Creation of a virtual clinic to review diagnostics for patients with medical retina issues arising from diabetes. This is making better use of our clinical resources while reducing waiting times for high risk patients and potentially supporting better outcomes

  We have also seen one of the greatest improvements in sepsis recognition and treatment as monitored by NHS England. I have shared this news and thanked our staff for their hard work and commitment to this clearly vital area of care.

- We welcomed the Secretary of State for Health and Social Care, Jeremy Hunt, to Tunbridge Wells Hospital earlier this month. A large group of staff spent over an hour with Mr Hunt as part of an informal question and answer session. During his presentation, Mr Hunt told our staff that he was impressed with our infection control journey and that we had set an example for the whole of the NHS.
- Our A&E improve has continued into January with better experience for patients this year than last.

  The latest national figures for A&E waiting times have been reported as the worst ever for the NHS. I am pleased to say that, at MTW, we have bucked the national trend. While we have seen the same, and sometimes greater, increases in Emergency Department attendances as other Trusts, the hard work of our staff and changes we have made in practice on-site and with colleagues in the community have meant we have seen a significant improvement performance. In January 2017, we saw and treated 74.6% of all patients within four hours. In January this year, we saw and treated 85.9% of all patients within the four hour target time.

  Clinical leads for the national Emergency Care Improvement Programme have highlighted good practice at MTW following a review of quality, safety and patient flow in our Emergency Departments. While there is clearly more we can do and are doing to improve our emergency care pathways, our recent developments include the opening of a new primary care streaming area in the ED at Tunbridge Wells. Similar works have started at Maidstone.
- I would like to publicly recognise two of our clinicians who have received national awards for clinical excellence. Professor John Schofield, Consultant Pathologist, has received a gold award from the ACCEA (Advisory Committee on Clinical Excellence Awards). Ejaz Ansari, Ophthalmology Consultant, has received a bronze national Clinical Excellence Award. These awards bring great kudos to MTW and we can all be justly proud of their achievements.
- Looking ahead to March, it is our intention to work quickly through the recommendations in our pending Care Quality Commission report, and to finalise our Best Care programme to further improve the quality, safety and financial sustainability of our services in 2018 and beyond. This continues our most important organisational aim to make improvements in quality and safety that have a positive effect on our patient and staff experience.

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 – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-9 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.

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) & 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 (based on month 9 performance) 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	Amber
3. To maintain a vacancy rate of no more than 8.5%	Amber
4. To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)	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

Review by the Trust Board

This is the fourth 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

When the BAF was last reviewed by the Board, in November 2017, it was proposed (and agreed) that the Trust Secretary should liaise with the Director of Strategy to propose some strategic objectives for inclusion in the BAF. This work is not yet completed, and is therefore intended to feature as part of the BAF for 2018/19.

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-rated risks, 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.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 21/02/18
- Audit and Governance Committee, 26/02/18
- Finance and Performance Committee (for objectives 2, 4, 5 & 7), 27/02/18

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

Review and discussion

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

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

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

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

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

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

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

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

a. The issue has a high profile at the Trust Board and Quality Committee, and the response has been led by the Medical Director. One of the new Deputy Medical Directors will also be asked to take the lead on this (although responsibility will remain with the Medical Director) (1)

b. The Assistant Director of Business Intelligence is directly involved in the analysis to understand the situation, & there is close liaison with Dr Foster (2)

c. The Trust is following the investigation pathway recommended by Dr Foster (i.e. checking coding, casemix, structure, process, individuals & teams) (3)

d. The 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 10, the 12-month rolling average HSMR was 106.0 (the baseline/expected rate is 100), which continues the recent downward trend, and the 1-month HSMR was 99.4

[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

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, and the programme has been implemented (which has had a positive impact)
g. An external company, 2020 Delivery Ltd, were engaged to undertake a "Best care, best patient flow" review at Tun. Wells Hospital in Dec. '17, and the recommendations are being implemented (5)
h. The Emergency Care Improvement Programme (ECIP) undertook a review in January 2018, and the recommendations are being implemented (5)

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 month 9 performance was 84.82%. The year to date performance at month 9 was 89.2%. 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

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. Implementation of TRAC electronic recruitment system (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. Listening into Action (LiA) Crowdfixing events held during January and February 2018 (4)
h. HealthRoster KPIs have been implemented in order to report on effective rostering of staff and usage of contractual hours, & to challenge poor practice (4)

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 9, 2017/18) was 10.4%
- The actions already in place will continue, but TRAC KPIs are also to be implemented in order to identify the root cause of any 'bottlenecks' within recruitment, and identify opportunities for improvement

[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, which are being monitored via fortnightly reviews at Executive Team Meetings

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 date pre-STF deficit at month 9 was £13.3m, which was £7.9m adverse to the submitted plan
- The Trust is forecasting a pre-STF year-end deficit of £17.9m, which is £13.4m adverse to plan

[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

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)
l. A 'critical friend' review by the NHS Intensive Support Team (IST) was undertaken in Jan. 2018 and the recommendations will be implemented

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 8, 2017/18, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 71.3%. For MTW-only patients, performance was 74.4%.
- However, NHSI have authorised the submission of a revised trajectory (which will aim to achieve the desired performance by the end of September 2018)

[12] In July 2016, the Board approved a proposal to focus on a deliberately small number of higher-level objectives as proxy indicators (a 'litmus test') for broader performance. The Board approved the 17/18 key objectives 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"

[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)
3. Outstanding data quality issues following the implementation of the new Patient Administration System (PAS)

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

e. A revalidation team has been engaged to address the data quality issues arising from the implementation of the new PAS (including the duplicate records created for some patients)

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):

- The month 9 performance was 83.0%. The year to date performance at month 9 was 83.0%
- The Trust has requested that a revised trajectory be submitted, and NHSI are considering the request

[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 20/02/18, there are:
- 25 ‘red’ rated risks
- 42 ‘amber’ rated risks
- 21 ‘green’ rated risks
- 0 ‘blue’ rated risks

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

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

The issues covered by the current 25 ‘red’ rated risks will be familiar to the Trust Board and its sub-committees, as these have been previously discussed (some very regularly) at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:
- High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- 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
- Risk to Trust Oncologists who are treating Cancer patients from East Kent, due to East Kent radiology reporting delays
- Inability to manage the Haematology workload effectively and in a timely manner due to Consultant vacancies
- 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
- The Health & Safety Executive (HSE) Improvement Notice for the Containment Level (CL) 3 laboratory (which was issued on 15/12/17, and for which the compliance date is 28/02/18)
- Unreliable data collection tool increasing number of missed referrals from A&E to Virtual Fracture Clinic
- Risk associated with failing to learn from incidents
- Specialist Medicine mortality review compliance

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

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

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

Guidance on likelihood / probability

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

Risk grading matrix

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

Trust Board meeting – February 2018

Maidstone and Tunbridge Wells NHS Trust

2-10	**Integrated Performance Report, January 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for January 2018 (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
- An Infection Prevention and Control 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

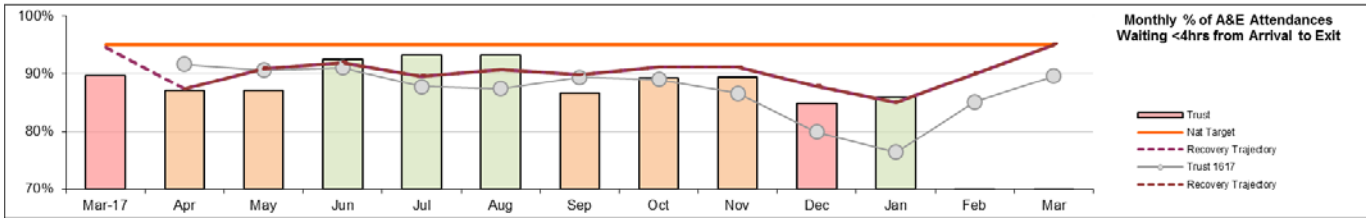
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; 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 January 2018

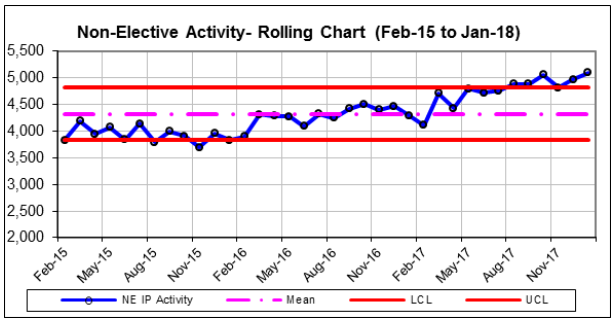
OPERATIONAL PERFORMANCE REPORT FOR JANUARY 2018

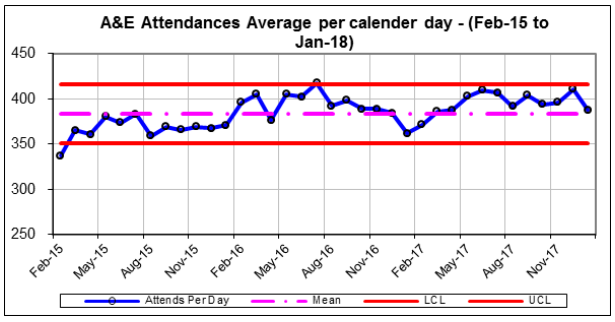
1. 4 hour emergency standard

Performance for the Trust achieved the expected trajectory in January, scoring 85.90% against a target of 85.00%. Jan-18's score is 5.5 percentage points better than Jan-17. The Trust is aiming to achieve 90% or more for A&E every month.

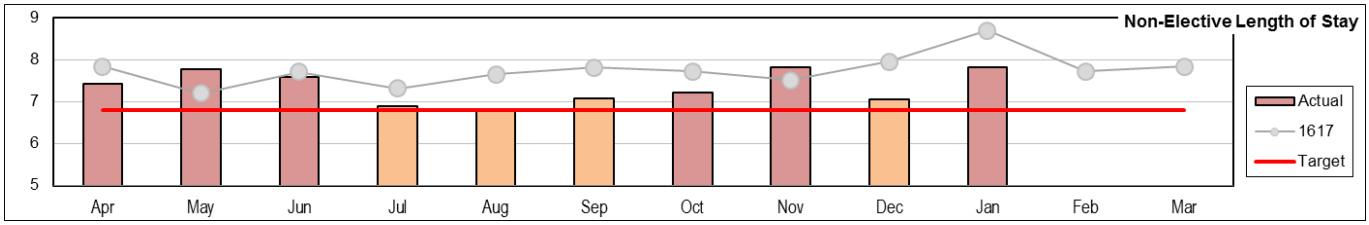


- A&E Attendances continue to increase. The sudden rapid growth seen in late 2015 and early 2016 has eased off, but 1718 YTD attendance is still 3.2% up on last year, and there was a significant and unusual increase in attendances between mid-November and early January that has no clear reason.
- Non-Elective Activity (excluding Maternity) remains considerably above plan 39.9% higher than plan for Jan at 4,450 discharges, and 20.7% higher than Jan last year. Some of this is driven by increased use of ambulatory / assessment wards, and increased capacity in CDU but the underlying driver is the increased demand through ED.





- Non-elective LoS was 7.83 days for January discharges. YTD, average non-zero NE LoS is 7.35 days, 0.34 days less than 1617.



- The average occupied bed days rose to a record 847 average through January

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.
- The Trust has commissioned an external company, 2020 Productivity, to support the overall delivery of the urgent care improvement

2. Delayed Transfers of Care

Percentage delayed of occupied bed-days bounced back from 3.72% in Dec to 4.27% in Jan. The number of bed days lost increased from 845 in Dec to 1,023 in Jan. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1 2 & 3 of the Home First initiative in full . 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. The Urgent Care Division have plans in place to test the frailty model at TWH during the week of 26-02-2018.

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
A : Awaiting Assessment	22	32	14	14	13	11	7	2	2	7	6	2	5
B : Awaiting Public Funding		4	3	1	3	3	3	2		2	1		1
C : Awaiting Further Non-Acute NHS Care	8	13	16	17	21	27	11	8	21	15	10	18	21
Di : Awaiting Residential Home	30	24	35	21	8	16	16	23	32	21	19	18	24
Dii : Awaiting Nursing Home	78	77	76	57	70	94	53	63	42	46	54	38	37
E : Awaiting Care Package	49	30	38	35	39	43	27	27	32	24	36	14	18
F : Awaiting Community Adaptations	9	10	13	6	8	7	15	8	5	10	12	4	12
G : Patient or Family Choice	9	19	28	6	10	8	10	13	14	28	38	13	11
H : Disputes		1	1	1	1	2		1			1		
I : Housing	3	5	4	3	3	5	6	8	2	2	1	2	3
Total	208	215	228	161	176	216	148	155	150	155	178	109	132
Trust Rate of Delayed Transfers of Care	**6.7%**	**7.1%**	**6.2%**	**5.6%**	**6.0%**	**6.1%**	**5.4%**	**4.5%**	**5.3%**	**5.4%**	**4.8%**	**3.7%**	**4.3%**

3. Cancer 62 Day First Definitive Treatment

62 day performance has recovered from the drops seen in October and November with the December performance at December to 74.3%. However the number of treatments are lower than normal which is a common occurrence every December.

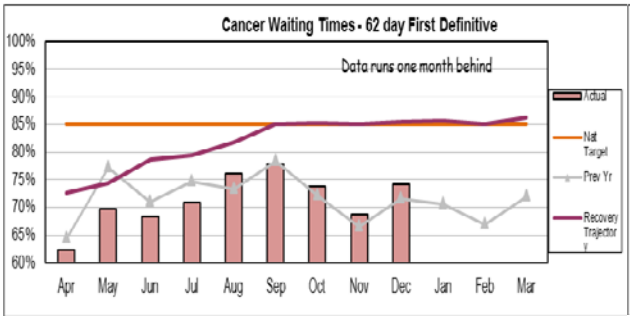
The delivery plan remains focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help reduce the backlog. The backlog at the end of December was 52, a 4 patient increase over the month. 28 of these were MTW patients - this number had been steadily reducing, but December was up 3.

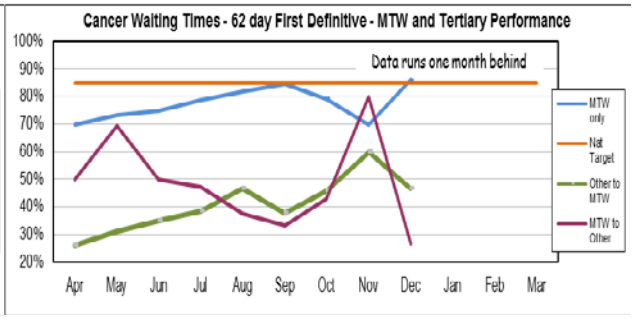
The key improvement initiative for the cancer services is the **daily huddle** where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same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

The Oncology PTL is taking place weekly to replicate the main PTL meeting in order to progress radiotherapy and chemotherapy treatments and oncology are calling in to the daily huddle as well

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.

A “critical-friend” review organised by NHSI has taken place, where all aspects of pathway management were looked at from referral to treatment for all cancer patients. Their report is awaited.





62 Day Performance - All			
Tumour	Total	Brch	%
Breast	14.5	2.5	82.8
Lung	6.0	2.5	58.3
Haemat.	1.5	0.0	100.0
Upper GI	13.0	2.5	80.8
Lower GI	12.5	2.5	80.0
Skin	0.0	0.0	######
Gynae	10.0	2.5	75.0
Urology	23.0	6.5	71.7
Head & Nk	3.5	2.5	28.6
Sarcoma	1.0	0.0	100.0
Other	0.5	0.5	0.0
Total	**85.5**	**22.0**	**74.3**

62 Day Performance - MTW			
Tumour	Total	Brch	%
Breast	14	2	85.7
Lung	2	0	100.0
Haemat.	1	0	100.0
Upper GI	9	0	100.0
Lower GI	10	1	90.0
Skin	0	0	######
Gynae	7	1	85.7
Urology	20	5	75.0
Head & Nk	0	0	######
Sarcoma	1	0	100.0
Other	0	0	######
Total	**64**	**9**	**85.9**

In December, Urology, Breast & GI have contributed the largest number of breaches overall.

MTW only patient performance for December is 85.9%, the highest this year.

4. Referral To Treatment – 18 weeks

January performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 83.6% which is a slight increase since last month. Our original trajectory required us to achieve 91.88% by the end of Jan 18.

The Trust has reported 12x 52wk breaches of the RTT standard in January (the breaches occurred over the months of November & December), all of which occurred in Orthopaedics. Learning has been identified and the directorate management team are being supported to ensure the patient tracking processes are robust in order to avoid further breaches.

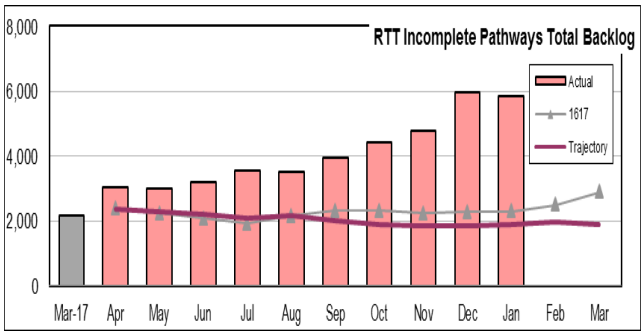
The RTT waiting list remains higher than plan and some of the increase is attributable to data quality issues which are being addressed and expected to be fully resolved by the end of March at the latest.

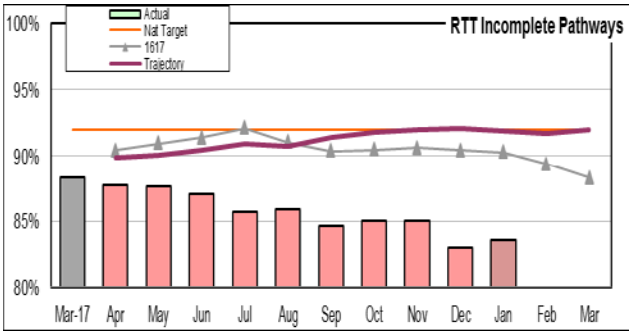
	Jan-18	Jan-18 Trajectory	Variance from trajectory
RTT Backlog Incomplete	5,825	1,900	3,939
RTT Waiting List	35,467	23,396	12,071
RTT Incomplete performance %	83.6%	91.9%	-8.3%

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

- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans
- Monitor weekly all Non-Admitted patients at 11wks or over without an OPA and all Admitted patients at 18wks or over without a TCI
- Ensure backlog patients are booked chronologically to avoid long waits/52 wk breaches
- Outsourcing to continue for Neurology in order to support Backlog reduction. Locum's being appointed in Endocrinology
- Additional funds have been released from NHSi of £250K to reduce backlog before end of March 18 – this will be focused on T&O and Gynaecology

- External validation team employed for 8 weeks to remove duplicate pathways that have been created post go live of Allscripts PAS
- Intense training on PTL management has been instigated and rolled out to each CAU which should be completed by end of March
- Increase clinic/theatre capacity/activity on weekends to improve income, activity and incomplete performance
- Continue weekly PTL/RTT performance monitoring to maintain overall performance
- Ensure robust management of Diagnostic waiting lists to ensure problems identified early to allow for solutions to be identified in a timely manner





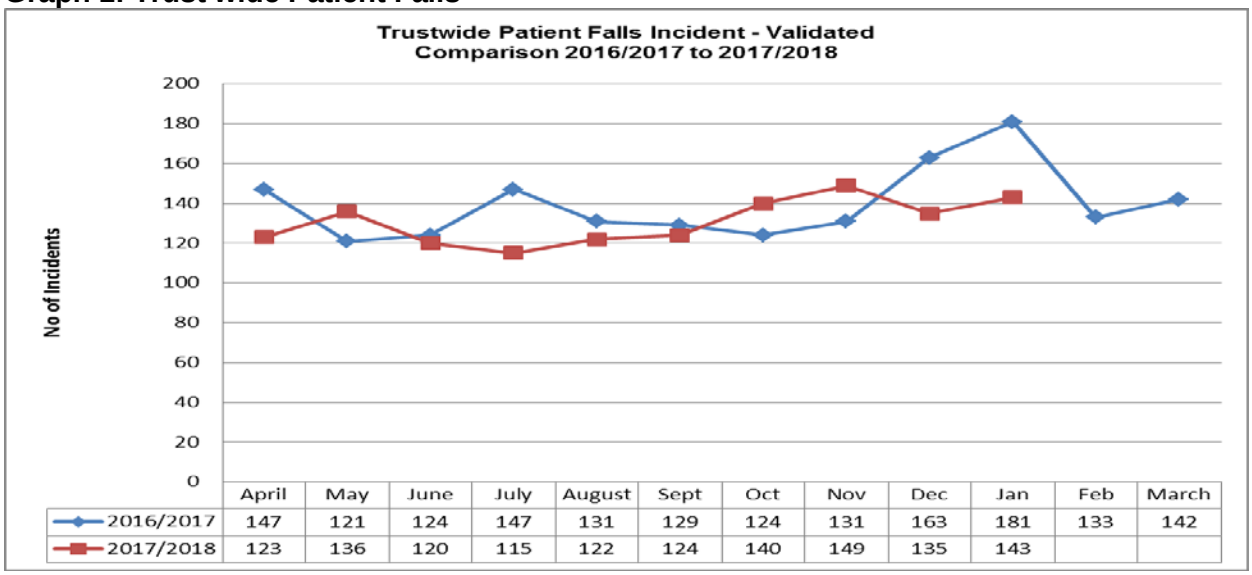
Quality and Safety March Trust Board (January data)

Patient Falls incidents

There were 143 falls reported for the month of January, this is an increase compared to 135 in December. This can be seen in graph 1, which provides a comparison year to date and to last year. The rate per 1000 bed days is currently 5.91 which is below our internal limit of 6.0. The breakdown of incidents by site is shown in graph 2, indicating a higher rate at Tunbridge Wells compared to Maidstone.

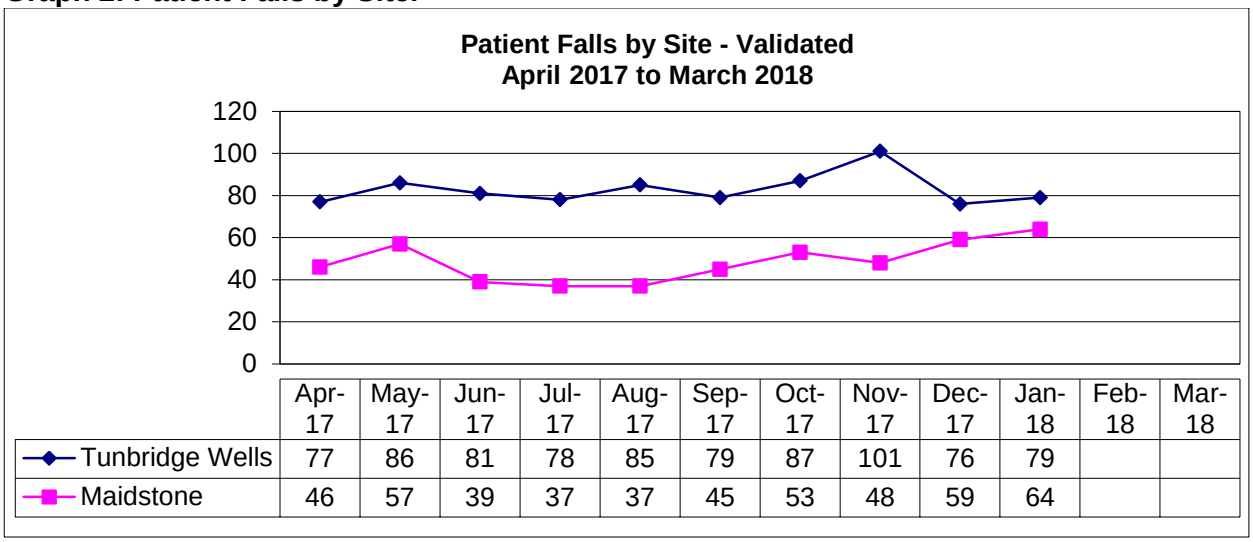
There have been 5 falls declared as Serious Incidents (SI) in January compared to 2 in December. The total number of falls SIs year to date is 31 compared to 30 this time last year.

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	149	135	143		

Graph 2: Patient Falls by Site.



	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	101	76	79		
Maidstone	46	57	39	37	37	45	53	48	59	64		

The national falls audit has been completed, and an action plan developed which is overseen by the Falls Group (chaired by Associate Director of Nursing Planned Care). Actions currently being implemented include:

- Implementation of assessment form within the Emergency Department for patients with dementia and/or delirium.
- Ensuring lying and standing blood pressure is recorded and that this becomes embedded in practice. The Falls Prevention Practitioner is working with the Professional Standards team to have this element incorporated into the existing falls prevention assessment.
- Visit has been undertaken to a neighbouring trust (SASH) that has seen sustained improvements in falls prevention to share ideas and processes.
- Plans being developed to refine and implement the Safety Huddle with an initial trail on two wards (one on each site) to ensure the frame work of the huddle is correct before wider implementation.

These actions are on track for implementation and completion by the end of April.

Pressure Ulcers:

The incidence of pressure injury is not giving cause for concern currently, and is demonstrating some improvement overall. The rate (per 1000 admissions) is 2.87 compared to 3.17 this time last year. The rate for the year to date is 2.19 compared to 2.78 last year. This is against an improvement threshold of 3.0.

Friends and Family test

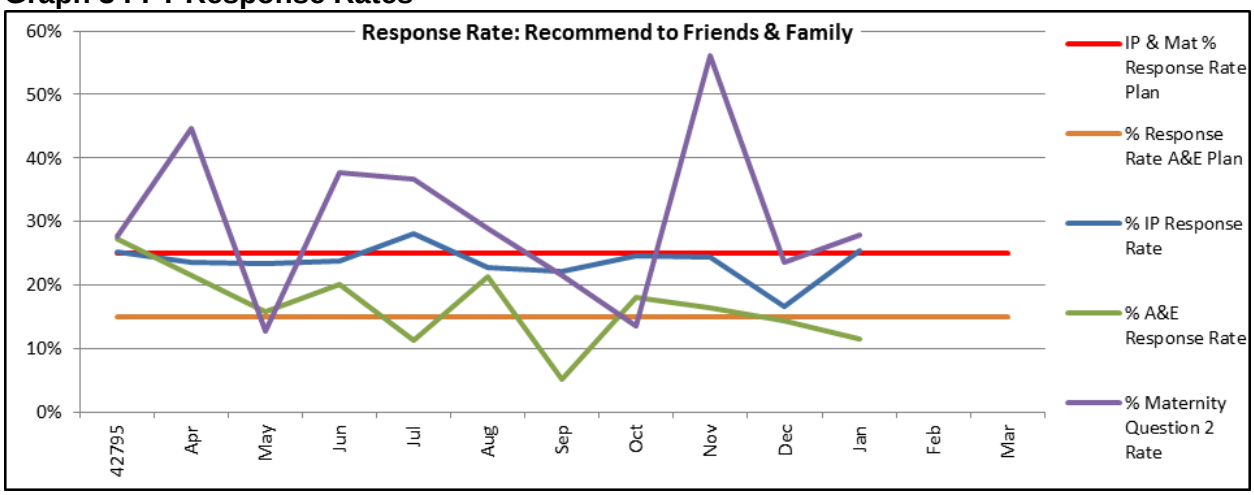
The response rates for January can be seen in graph 3, indicating some recovery in response rates compared to December for both inpatients and maternity. Accident & Emergency continue to show a drop in return rates.

Positive response rate can be seen in graph 4. This indicates a small increase in positive responses for all areas, with Accident & Emergency remaining slightly below target, and at target for maternity and inpatient areas.

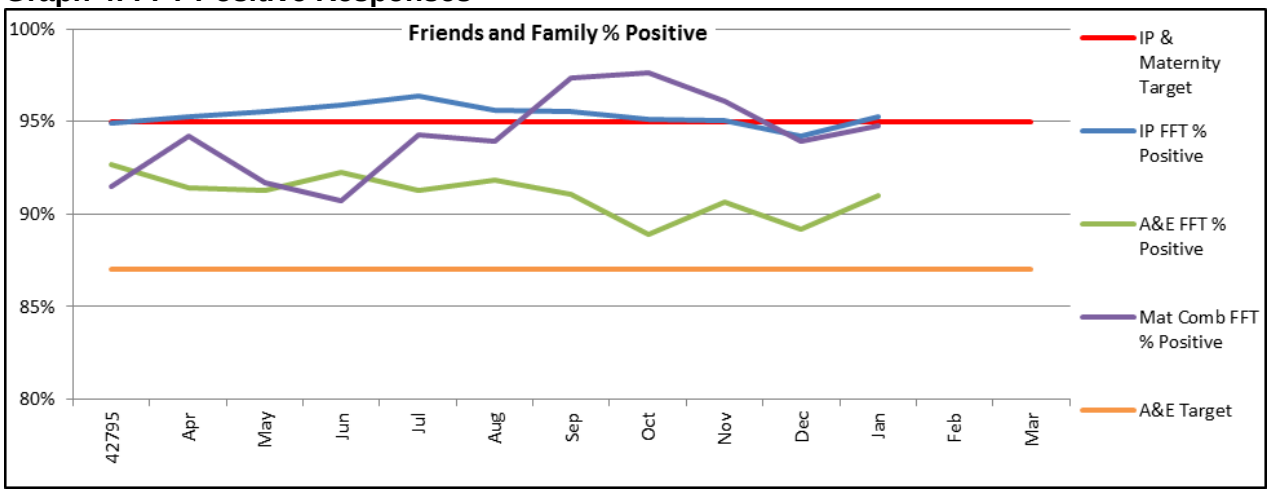
The FFT group continues to work with both IWGC and the directorates to ensure continued focus on administering the FFT and to enable teams to respond to any emerging themes.

We have a new account manager with IWGC, which will provide us with an opportunity to review the FFT group approach and consider new approaches to ensure continued and improved engagement with the process.

Graph 3 FFT Response Rates



Graph 4: FFT Positive Responses



Complaints

There were 48 new complaints reported for January which equates to a rate of 2.00 new complaints per 1,000 occupied bed days.

It was agreed at the last Board to provide some further information relating to the overall key themes and trends from complaints on a monthly basis, which is provided below.

The available data has been analysed by the date of the event being complained about, rather than when the complaint itself was received. It is hoped that this will give a truer picture of the current issues affecting our patients and service users. However, it should be noted that although the majority of complaints are raised within a month or two of the event occurring, there will be a degree of time delay. As a result, there will be less data available for the current and preceding month, than there will be for earlier months. The charts/graphs below will therefore be updated each month and may show variations (if compared retrospectively) for this reason.

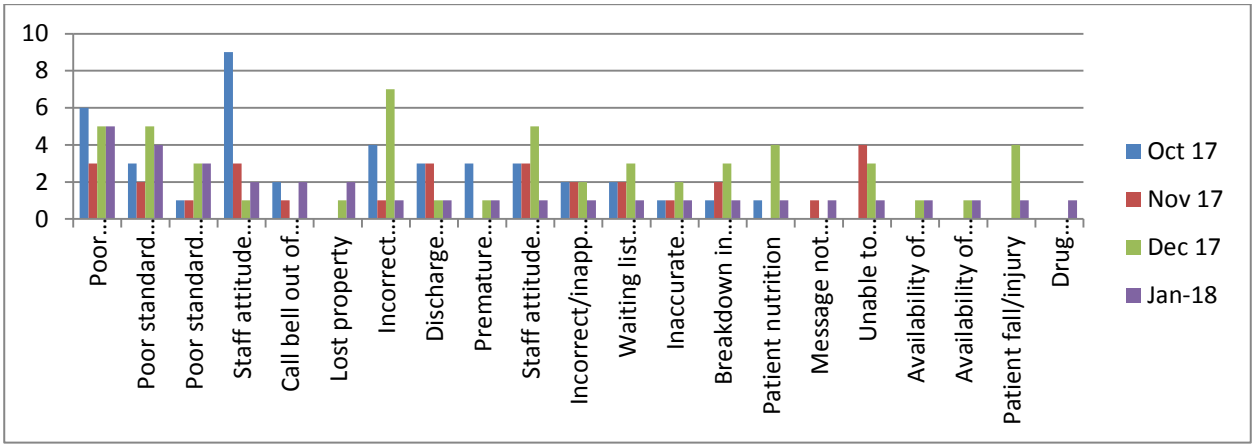
Table 1: Complaints by Sub-subject – most frequently raised in January 2018

	Oct 17*	Nov 17*	Dec 17*	Jan-18*
Poor communication with patient/relative	6	3	5	5
Poor standard of nursing care	3	2	5	4
Poor standard of medical care	1	1	3	3
Staff attitude (medical)	9	3	1	2
Call bell out of reach/not responded to	2	1	0	2
Lost property	0	0	1	2

*reflects the date of the event being complained about

The following graph (Graph 5) shows an expanded view of the themes of complaints about events that occurred in January 2018.

Graph 5: All themes/subjects raised in complaints made about events occurring January 2018.



It is clear that consistently, communication with patients/relatives remains the key theme within complaints. Between October and January, this has remained one of the top 2 most frequently raised subjects in new complaints.

Looking at emerging issues, there has been a rising trend of complaints about:

- Poor standards of nursing care
- Poor standards of medical care
- Patient nutrition
- Messages not responded to/calls not returned
- Unable to contact ward/department
- Availability of medical staff
- Availability of nursing staff
- Patient fall/injury
- Drug administration delays errors

All other areas show reducing trends, however, the most significant reduction has been around complaints relating to poor staff attitude (medical, including surgeons)

Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints. As of January 2018, communications have been provided with a summary of all upheld/partially upheld complaints, highlighting the underlying causes of the complaint and emphasising the learning that staff in all areas across the Trust can take from each one.

Infection Prevention and Control

MRSA – The arbitration for the post-48 hour MRSA bacteraemia in November 2017 has determined that the bacteraemia was unavoidable and has been attributed the case to a 'third party'. The trust was able to argue this successfully due to the high standard of care by the ward and comprehensive documentation of the case.

The Infection control team is assisting WKCCG in the investigation of a community acquired MRSA bacteraemia diagnosed in December 2017 which has now also been referred to arbitration. The MRSA screening programme is integral to preventing MRSA bacteraemia. The screening rate for January was 99.5% for elective screening. Due to data issues following the Allscripts implementation the data are still not sufficiently robust to report non-elective screening.

C. difficile - There were 2 cases of post-72 hour C. difficile infection in January against a monthly limit of two cases. The current rate of C. difficile infection is 10.5 per 100 000 obd for the year to date. The trust is currently on trajectory for the year with 23 cases seen.
Methicillin sensitive *Staphylococcus aureus* bacteraemia – 22 cases of hospital attributable MSSA bacteraemia have been seen year to date, 1 case 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. Community acquired blood stream infections continue to rise steeply, placing a significant burden on the acute services as the majority of these patients require admission

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.

Influenza - During January 2018 the Trust diagnosed 40 cases of Influenza (30 Flu B and 10 Flu A). Eight of these patients required ITU admission.

The A&E departments have received additional training on managing flu patients on admission and fit testing for masks is ongoing. All wards have stocks of masks and Trust wide communications have gone out to encourage staff to swab all patients with a suspicion of Influenza. Clinical staff are encouraged to test all patients with respiratory symptoms to determine the true burden of infection.

Financial commentary

- The Trust's deficit including STF was £1.6m in January which was £2.9m adverse to plan, due to, £1.3m STF underperformance in month due to non-delivery of the financial control target and A&E trajectory, £0.6m slippage against the original plan CIP phasing and £1m adverse variances against budget.

- The Trust's YTD deficit excluding STF is £14.9m which is £9.4m adverse to the plan.

- In January the Trust operated with an EBITDA surplus of £0.2m an improvement of £0.5m between months but £3.7m adverse to plan

- The Trusts deficit in January was in line with last month's forecast, Clinical Income underperformed against forecast by £0.3m, increase in bad debt provision relating to laundry services to Carillion (£0.2m) offset by one off benefits relating to Injury recovery income (£0.2m), Energy Accrual review (£0.1m) and reduction in Outsourcing costs (£0.2m)

- The key variances in the month are as follows:
  - Total income was £0.1m favourable in the month; Clinical Income excluding HCDs was £0.4m favourable in January. The key adverse variances in January were Elective & Day Cases (£1.2m), and Adult Critical Care Activity (£0.2m) offset by favourable variances within non elective (£1.6m), inclusion of £0.8m IR West Kent CCG CV and £0.4m Winter funding and A&E (£0.3m).The position included an adverse adjustment of £0.7m relating to the aligned incentive contract (£1.4m) positive YTD). STF was £1.3m adverse in January due to non-delivery of the financial target, other operating income was £0.4m favourable, £0.7m favourable relating to pass-through items (STP and PAS) offset by adverse variance against Private Patient Income (£0.4m).
  - Pay was £1.6m adverse in the month, total pay spend (excluding reserves) was £0.6m higher than December but in line with last month's forecast. Medical Staffing costs increased by £0.3m mainly due to the increase in Temporary staffing costs (£0.2m) mainly within Urgent care associated with staffing escalation areas. Nursing costs increased by £100k between months, the increase was a result of the enhanced bank rates and escalation costs although these costs were less than forecasted.
  - Non Pay was overspent by £1.4m in January this was mainly due to Pass through costs (£0.9m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.7m adverse (mainly due to unidentified CIP) .

- The CIP performance in January delivered efficiencies of £2.3m which was £0.6m adverse to the phasing of the original plan, £7.6m 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 £22.4m, £9.4m adverse to plan.

- The Trust held £8.3m of cash at the end of January which is higher than the plan (£7.8m). This was as a result of early receipt of part of the SLA income for M11. The Trust continues to proactively engage 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 Trust has received approval of all the phases for its Salix loan application of £744k for 2017/18 to support its energy infrastructure renewal and received £629k to date. The Trust has also received to date £535k out of £645k of capital financing for its GP A&E Streaming works. The Springs property sale completed on 22nd January with sale proceeds of £800k. The Trust is planning an underspend in depreciation to support the Income & Expenditure position and this will be matched by a corresponding reduction in the planned capital spend. The current FOT is £11.64m (before donations and asset sales).
- The Trust is forecasting a Year End deficit including STF of £14m, £7.3m adverse to plan. The Trusts forecast excluding STF is a deficit of £17.9m which is £13.4m adverse to plan.

Workforce Commentary

As at the end of January 2018, the Trust employed 5035.0 whole time equivalent substantive staff, a 10.3 WTE decrease from the previous month. Bank and agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (December) increased by 0.3% to 5.00%, 1.7% over target and higher than the same period last year. Directorates demonstrating the highest sickness rates include Clinical Governance (9.05%), Facilities (8.45%) and Children's Services (6.47%) and with rates having increased in two of the three areas since last month. At a divisional level, Planned Care has a lower combined sickness absence rate (4.01%) than Urgent Care (5.09%) or Women, Children and Sexual Health (6.14%). In contrast with the others, Urgent Care has demonstrated a reduction in sickness levels from last month. A modest movement from long-term to short-term absence has been recorded in December, an expected change due to increased seasonal illness. At a trust level, the breakdown in December is 45.87% short-term, 54.13% long term. It is evident there that while the increase in seasonal cold and influenza contributes to the overall rate rise, long-term absence is still having a significant impact. 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 increased marginally to 87.96%, and remains above the target percentage. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required. Directorates with lower overall compliance include Trauma and Orthopaedic (81.69%) and General Surgery (82.23%) with the latter having decreased slightly from the previous month.

Turnover has decreased since last month to 11.97%, higher than target with outliers in Estates (29.70%) and ICT (22.41%) (although both have reduced from last month). It should be noted that due to the 12 month rolling calculation, turnover figures typically move more slowly and incorporate historic data as well as the most recent month. 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 89.22%, an increase of 0.47% from the previous month.

Trust Performance Dashboard

Position as at: 31 January 2018

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)	4.16	8.3	11.3	10.5	-0.8	-	11.5	10.3	
1-02	Number of cases C.Difficile (Hospital)	1	2	25	23	-2	-	27	27	
1-03	Number of cases MRSA (Hospital)	0	0	1	0	-1	0	0	0	
1-04	Elective MRSA Screening	97.0%	99.5%	97.0%	99.5%	2.5%	1.5%	98.0%	99.5%	
1-05	% Non-Elective MRSA Screening	96.0%	No data	96.0%	No data			95.0%	No data	
1-06	**Rate of Hospital Pressure Ulcers	3.17	2.87	2.78	2.19	- 0.59	- 0.82	*3.01*	2.39	3.00
1-07	***Rate of Total Patient Falls	7.28	5.96	6.05	5.91	- 0.14	- 0.09	*6.00*	5.91	
1-08	***Rate of Total Patient Falls Maidstone	6.05	6.79	5.42	5.65	0.22			5.57	
1-09	***Rate of Total Patient Falls TWells	8.22	5.42	6.53	6.09	- 0.44			6.14	
1-10	Falls - SIs in month	8	5	30	31	1				
1-11	Number of Never Events	0	1	2	3	1	3	*0*	3	
1-12	Total No of SIs Open with MTW	33	76			43				
1-13	Number of New SIs in month	13	19	91	150	59	50			
1-14	***Serious Incidents rate	0.54	0.79	0.41	0.68	0.27	0.63	*0.0584 - 0.6978*	0.68	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	1.27	1.05	0.72	1.18	0.46	- 0.05	*0 - 1.23*	1.18	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment - month behind	95.7%	95.1%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.3%	97.5%	96.5%	97.3%	0.8%	2.3%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.34%	2.27%	3.24%	2.56%	-0.68%	-0.4%	*3.00%*	2.56%	
1-20	C-Section Rate (non-elective)	12.9%	9.8%	13.8%	13.6%	-0.23%	-1.4%	*15.0%*	13.6%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0260	1.0492	0.0	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		106.0	106.0	-	6.0	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.7%	1.5%	1.3%	1.2%	-0.1%				
2-04	****Readmissions <30 days: Emergency	12.3%	11.9%	11.8%	12.6%	0.8%	-1.0%	*13.6%*	12.6%	14.1%
2-05	****Readmissions <30 days: All	10.7%	11.6%	10.9%	12.0%	1.1%	-2.7%	*14.7%*	12.0%	14.7%
2-06	Average LOS Elective	3.88	2.96	3.28	3.25	- 0.03	0.05	*3.20*	3.25	
2-07	Average LOS Non-Elective	8.69	7.83	7.63	7.35	- 0.28	0.55	*6.80*	7.35	
2-22	NE Discharges - Percent zero LoS	31.6%	38.0%	30.9%	36.6%	5.7%			36.6%	
2-08	******FollowUp : New Ratio	1.82	1.66	1.80	1.71	- 0.09	0.19	*1.52*	1.71	
2-09	Day Case Rates	88.7%	87.5%	85.5%	86.2%	0.7%	6.2%	80.0%	86.2%	82.2%
2-10	Primary Referrals	9,442	11,117	97,393	97,053	-0.3%	-1.9%	119,266	116,184	
2-11	Cons to Cons Referrals	5,134	4,302	51,357	43,913	-14.5%	-9.4%	58,644	52,569	
2-12	First OP Activity (adjusted for uncashed)	16,653	17,003	166,115	159,821	-3.8%	-4.2%	201,705	191,325	
2-13	Subsequent OP Activity (adjusted for uncashed)	31,328	25,962	310,152	274,076	-11.6%	-12.7%	383,906	328,100	
2-14	Elective IP Activity	445	467	6,479	5,613	-13.4%	-21.2%	8,303	6,719	
2-15	Elective DC Activity	3,460	3,280	37,494	34,790	-7.2%	-5.6%	43,602	41,648	
2-16	**Non-Elective Activity	4,292	5,102	43,324	48,313	11.5%	25.3%	46,435	57,628	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	12,947	14,609	138,968	143,441	3.2%	2.1%	168,161	172,033	
2-18	Oncology Fractions	6,013	5,331	60,007	55,514	-7.5%	-12.2%	75,273	66,617	
2-19	No of Births (Mothers Delivered)	514	528	5,029	5,036	0.1%	1.1%	5,977	6,043	
2-20	% Mothers initiating breastfeeding	80.8%	81.7%	81.3%	81.5%	0.2%	3.5%	78.0%	81.5%	
2-21	% Stillbirths Rate	0.4%	0.19%	0.38%	0.31%	*-0.1%*	*-0.2%*	*0.47%*	0.31%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	12	21	9	21	0	21	
3-02	*****Rate of New Complaints	1.12	2.00	1.69	1.84	0.2	0.53	*1.318-3.92*	1.84	
3-03	% complaints responded to within target	60.0%	61.8%	74.3%	61.3%	-13.0%	-13.7%	75.0%	61.3%	
3-04	****Staff Friends & Family (FFT) % rec care	76.6%	66.7%	76.6%	66.7%	-9.9%	-12.3%	79.0%	66.7%	
3-05	*****IP Friends & Family (FFT) % Positive	95.6%	95.3%	95.5%	95.4%	-0.1%	0.4%	95.0%	95.4%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	88.9%	91.0%	90.2%	90.9%	0.8%	3.9%	87.0%	90.9%	85.5%
3-07	Maternity Combined FFT % Positive	94.8%	94.8%	93.8%	94.4%	0.5%	-0.6%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	83.6%	84.1%	82.8%	84.4%	1.6%			84.4%	

* 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

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Qtr to Date Prev Yr	Year/Qtr 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	76.4%	85.90%	87.0%	88.9%	1.9%	-0.6%	90.1%	90.1%	83.0%
4-02	Emergency A&E >12hr to Admission	0	6	0	6	6	6	*0*	6	
4-03	Ambulance Handover Delays >30mins	New	570	New	3,819					
4-04	Ambulance Handover Delays >60mins	New	81	New	509					
4-05	RTT Incomplete Admitted Backlog	866	2,834	866	2,834	1,968	1,569	1,259	1,259	
4-06	RTT Incomplete Non-Admitted Backlog	434	3,005	434	3,005	2,571	2,370	631	631	
4-07	RTT Incomplete Pathway	90.3%	83.6%	90.3%	83.6%	-6.7%	-7.5%	92%	92.0%	
4-08	RTT 52 Week Waiters	-	6	-	27	27	27	-	27	
4-09	RTT Incomplete Total Backlog	2,295	5,839	2,295	5,839	3,544	3,939	1,890	1,890	
4-10	% Diagnostics Tests WTimes <6wks	99.62%	99.3%	99.7%	99.3%	-0.4%	0.3%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	5	5	2	5	3	- 4	9	9	
4-12	*Cancer two week wait	95.3%	84.8%	92.8%	87.1%	-5.7%	-5.9%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	94.2%	75.7%	89.1%	81.8%	-7.3%	-11.2%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	97.0%	97.7%	96.7%	97.4%	0.8%	1.4%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	71.6%	74.3%	72.0%	72.2%	0.2%	-7.5%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	76.5%	85.9%	76.5%	77.6%	1.1%		85.0%		
4-17	*Cancer 104 Day wait Accountable	10.0	4.5	79.5	58.0	-21.5	58.0	*0*	58.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	78	99	78	99	21				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	63	90	63	90	27				
4-20	Delayed Transfers of Care	6.7%	4.3%	6.7%	5.1%	-1.6%	1.6%	3.5%	4.9%	
4-21	% TIA with high risk treated <24hrs	84.2%	72.2%	82.7%	70.7%	-12.0%	10.7%	60%	70.7%	
4-22	*******% spending 90% time on Stroke Ward	86.3%	77.2%	87.6%	89.6%	2.1%	9.6%	80%	89.6%	
4-23	*******Stroke:% to Stroke Unit <4hrs	42.9%	60.0%	51.4%	59.8%	8.4%	-0.2%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	62.0%	70.9%	56.9%	65.2%	8.3%	17.2%	48.0%	65.2%	
4-25	*******Stroke:% assessed by Cons <24hrs	68.0%	79.2%	66.1%	80.5%	14.4%	0.5%	80.0%	80.5%	
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	5	6	24	18	24	*0*	24	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

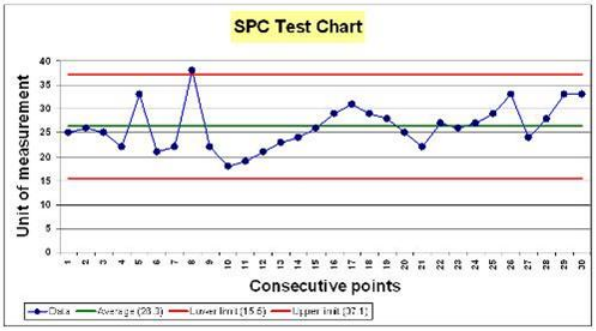
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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	35,130	36,038	355,537	362,623	2.0%	0.1%	436,716	433,933	
5-02	EBITDA	818	199	10,831	13,034	20.3%	-55.3%	38,055	15,300	
5-03	Surplus (Deficit) against B/E Duty	258	(1,622)	(14,125)	(11,013)			6,673	(13,989)	
5-04	CIP Savings	2,715	2,302	18,047	18,022	-0.1%	-30.2%	31,721	22,357	
5-05	Cash Balance	2,676	8,315	2,676	8,315			1,000	1,000	
5-06	Capital Expenditure	669	457	3,341	4,158			*16,948*	11,473	
5-07	Establishment WTE	5,605.4	5,609.0	5,605.4	5,609.0	0.1%	0.0%	5,609.0	5,609.0	
5-08	Contracted WTE	5,165.0	5,035.0	5,165.0	5,035.0	-2.5%	-1.5%	5,110.1	5,110.1	
5-09	Vacancies WTE	440.4	574.0	440.4	574.0	30.3%	15.0%	498.9	498.9	
5-11	Vacancy Rate (%)	7.9%	10.2%	7.9%	10.2%	2.4%	1.3%	8.9%	8.9%	
5-12	Substantive Staff Used	4,962.0	4,876.7	4,962.0	4,876.7	-1.7%	-4.6%	5,110.1	5,110.1	
5-13	Bank Staff Used	294.8	544.9	294.8	544.9	84.9%	62.7%	335	335.0	
5-14	Agency Staff Used	189.0	187.8	189.0	187.8	-0.6%	14.6%	164.0	164.0	
5-15	Overtime Used	36.5	45.9	36.5	45.9	25.6%				
5-16	Worked WTE	5,482.3	5,655.3	5,482.3	5,655.3		0.8%	5,609.0	5,609.0	
5-17	Nurse Agency Spend	(522)	(868)	(6,996)	(6,498)	-7.1%				
5-18	Medical Locum & Agency Spend	(1,086)	(1,545)	(12,432)	(12,792)	2.9%				
5-19	Temp costs & overtime as % of total pay bill	14.8%	18.7%	15.6%	15.9%	0.2%				
5-20	Staff Turnover Rate	10.5%	12.0%		11.8%	1.5%	1.3%	*10.5%*	11.8%	11.05%
5-21	Sickness Absence	4.6%	5.0%		3.8%	0.4%	0.5%	*3.3%*	3.8%	4.3%
5-22	Statutory and Mandatory Training	90.8%	88.0%		88.0%	-2.8%	3.0%	85.0%	88.0%	
5-23	Appraisal Completeness	88.2%	89.2%		89.2%	1.0%	-0.8%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	98.4%	97.7%	98.9%	98.2%	-0.7%		93.5%	98.2%	
5-25	****Staff FFT % recommended work	52.5%	61%	52.5%	61%	8.1%	-1.4%	62.0%	61%	
5-26	***Staff Friends & Family -Number Responses	619	33	619	33	-586				
5-27	*****IP Resp Rate Recmd to Friends & Family	27.2%	25.3%	22.9%	23.5%	0.7%	-1.5%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	9.1%	11.4%	14.3%	15.5%	1.2%	0.5%	15.0%	15.5%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	51.6%	28.0%	25.7%	30.0%	4.3%	5.0%	25.0%	30.0%	24.0%

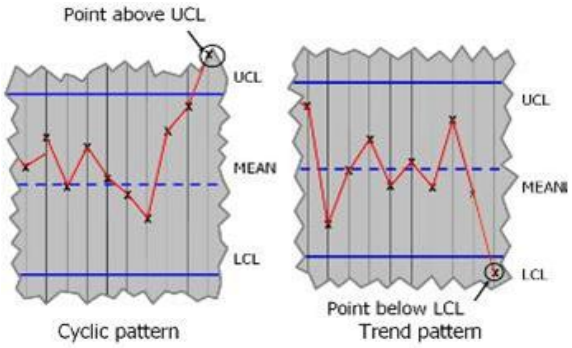
Explanation of Statistical Process Control (SPC) Charts

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

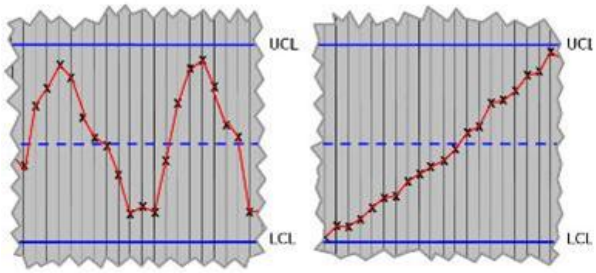


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

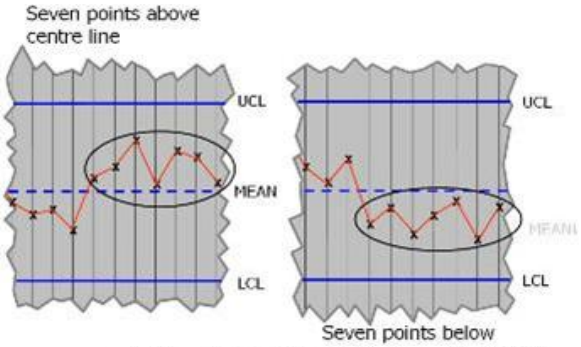


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

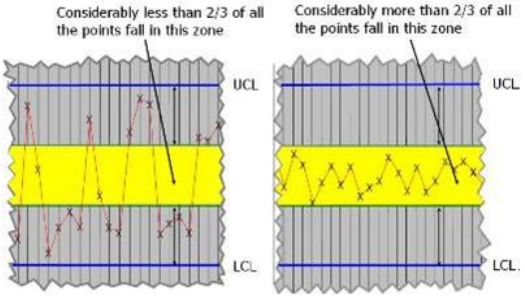


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

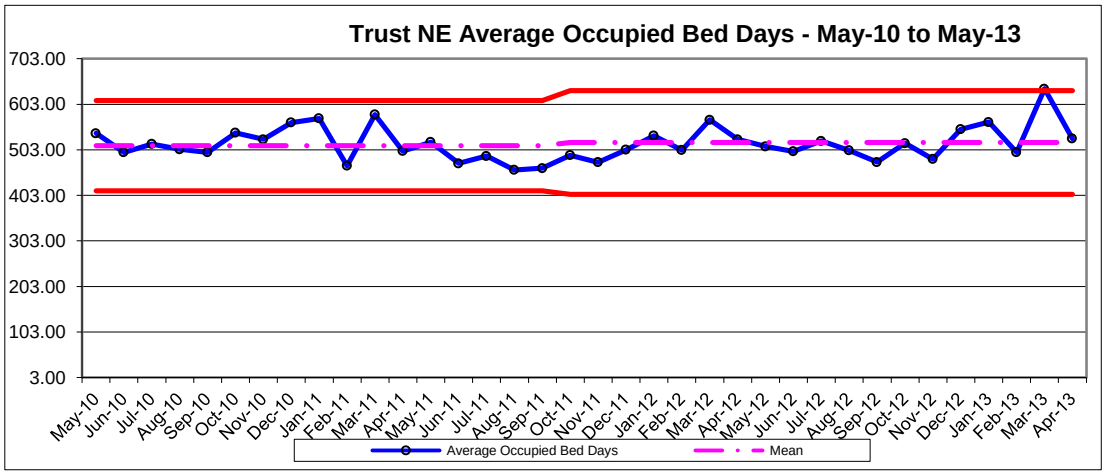


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

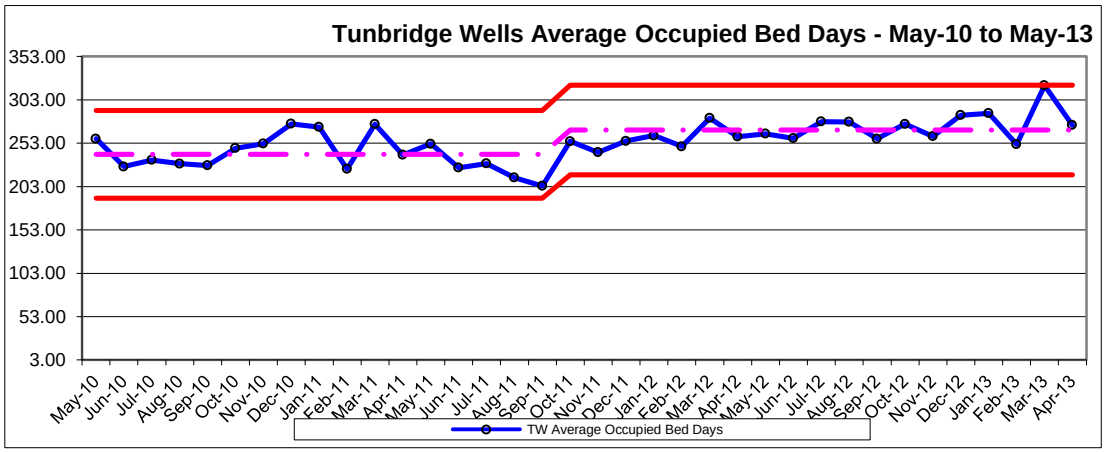


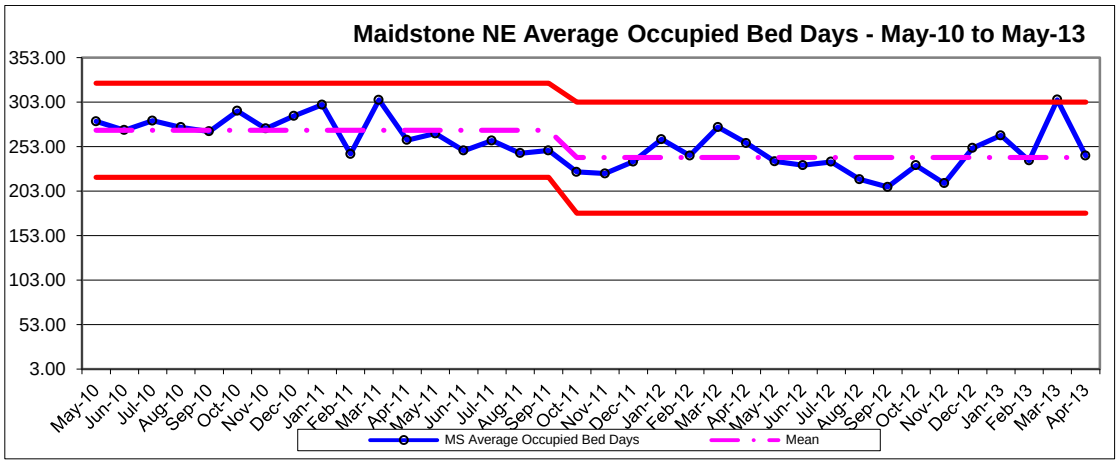
Changes to Control Lines

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



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

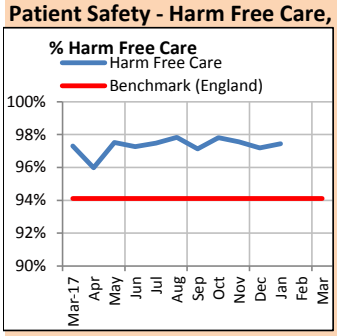


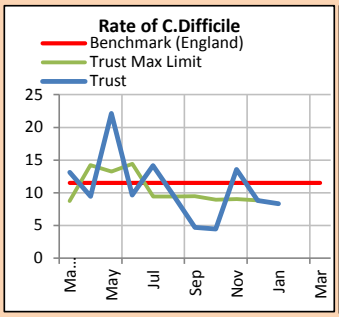


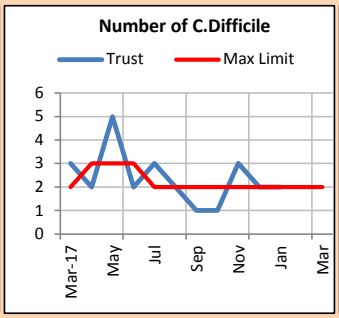
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

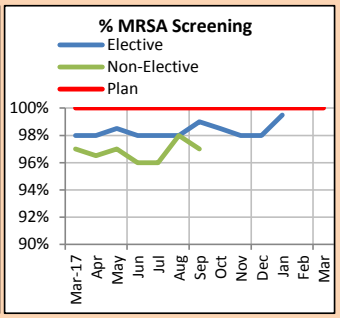
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

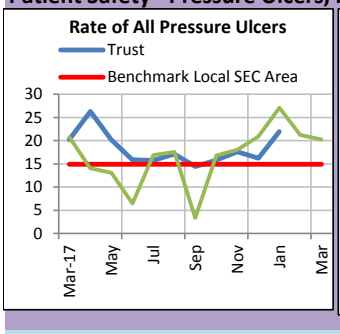


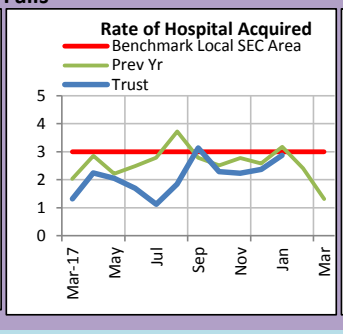


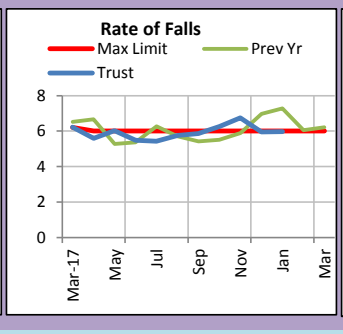


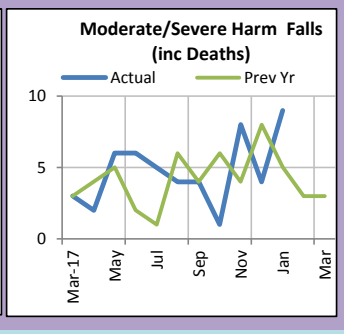


Patient Safety - Pressure Ulcers, Falls

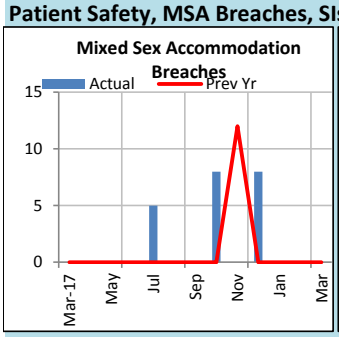


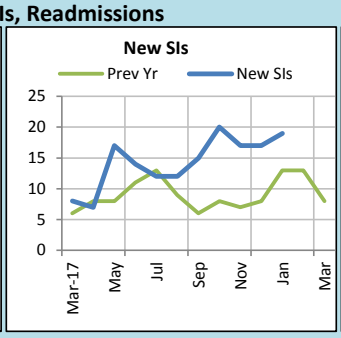


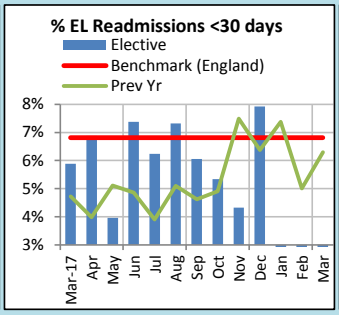


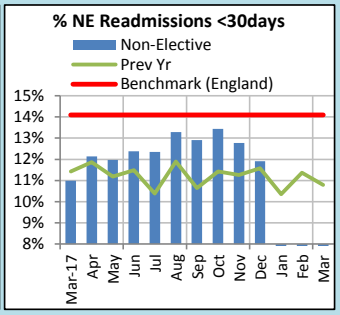


Patient Safety, MSA Breaches, SIs, Readmissions

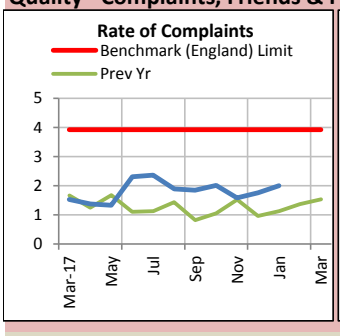


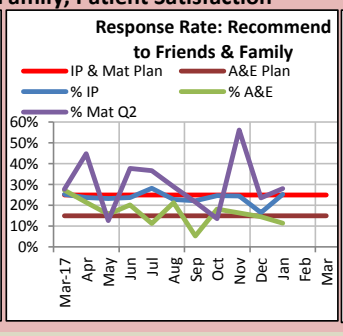


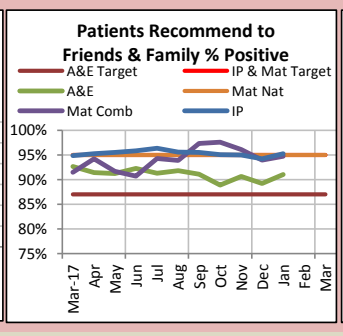


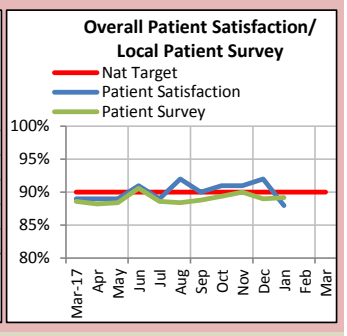


Quality - Complaints, Friends & Family, Patient Satisfaction

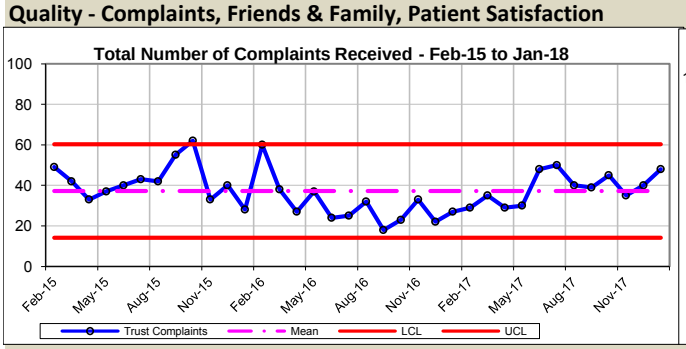


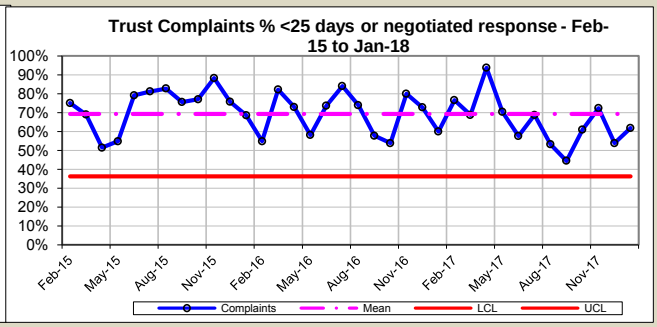




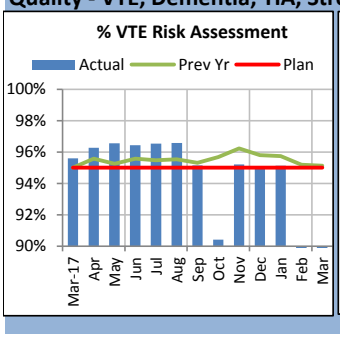


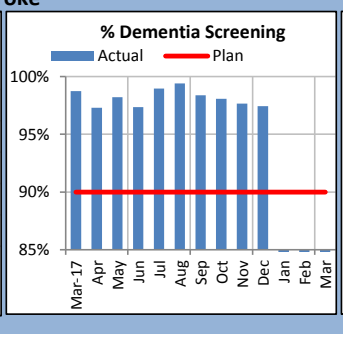
Quality - Complaints, Friends & Family, Patient Satisfaction

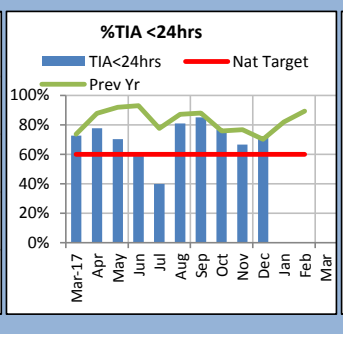


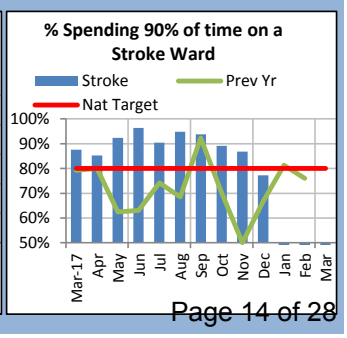


Quality - VTE, Dementia, TIA, Stroke

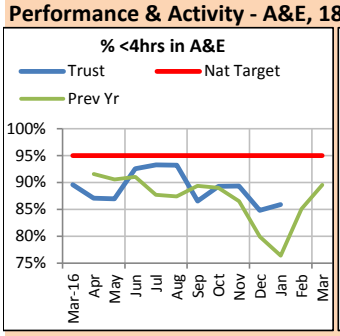


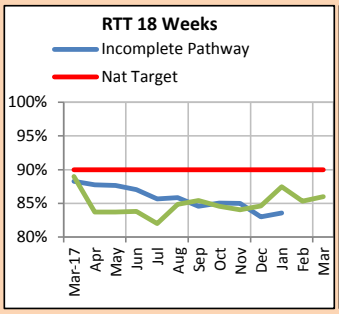


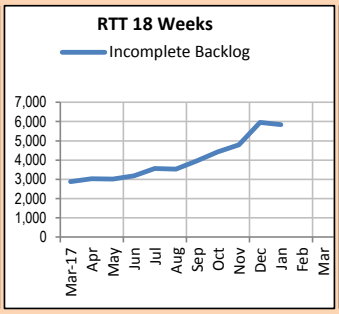


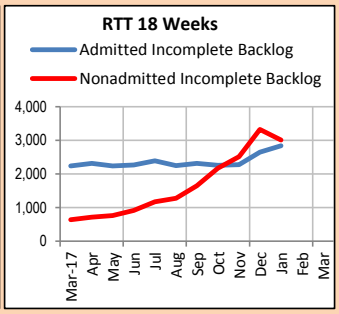


Performance & Activity - A&E, 18 Weeks

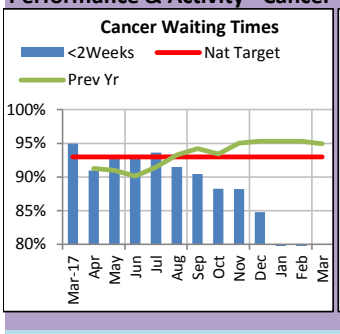


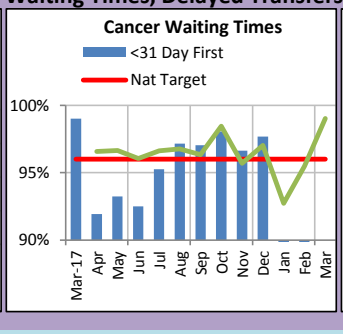


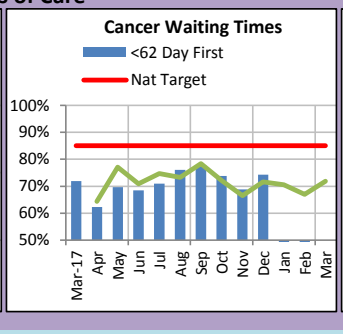


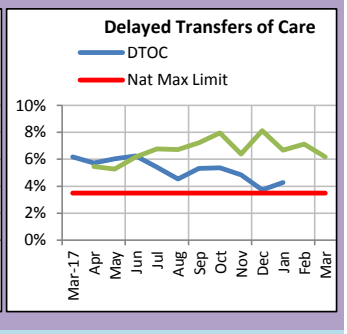


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

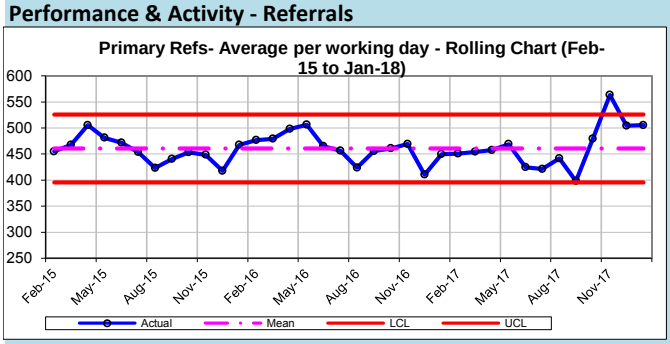


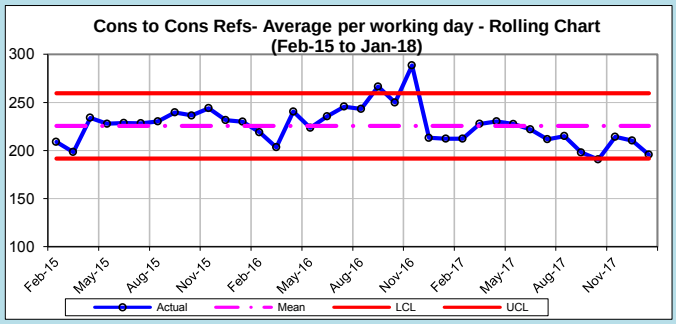




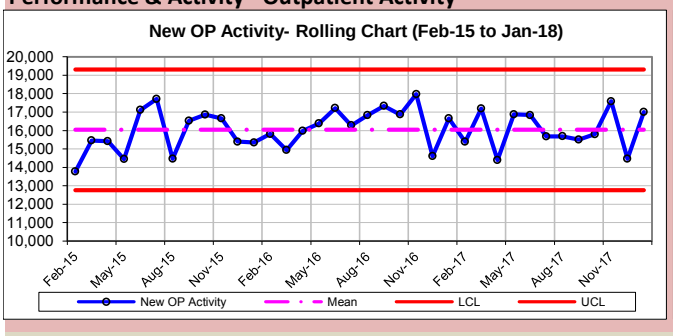


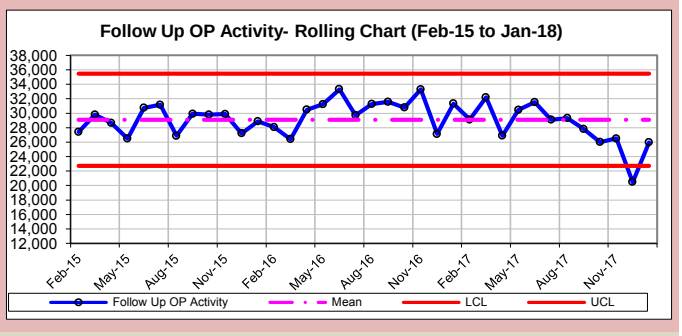
Performance & Activity - Referrals



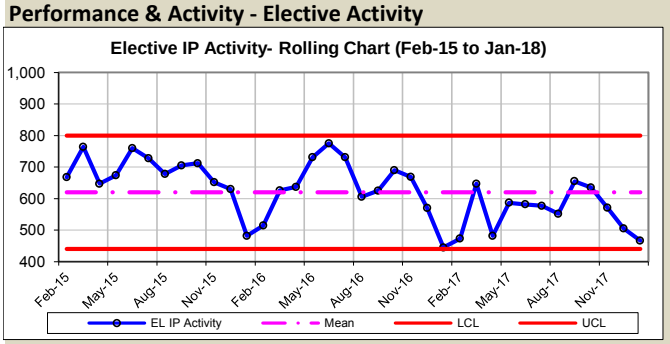


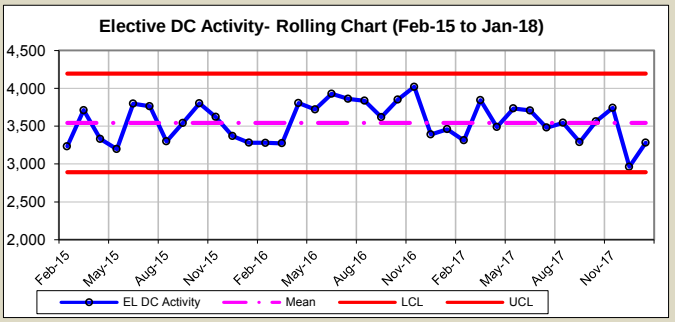
Performance & Activity - Outpatient Activity



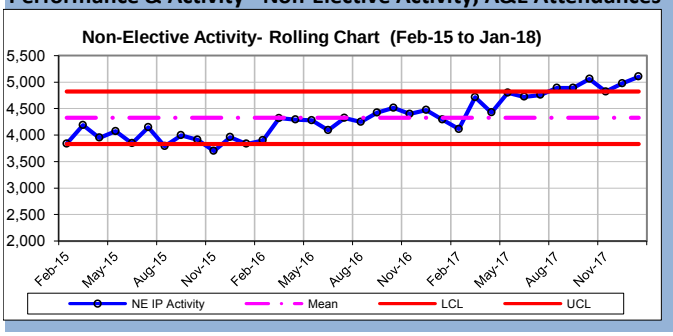


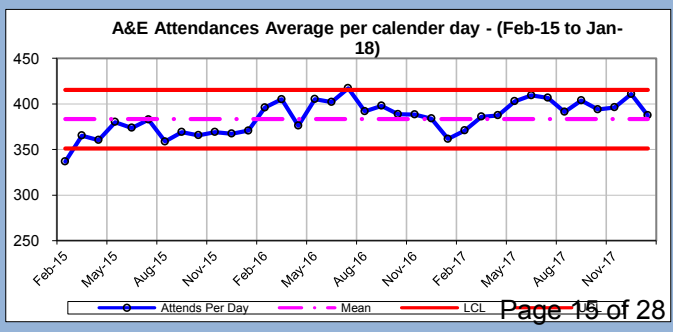
Performance & Activity - Elective Activity



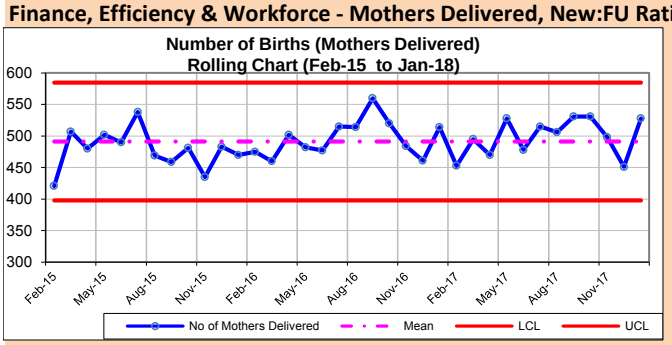


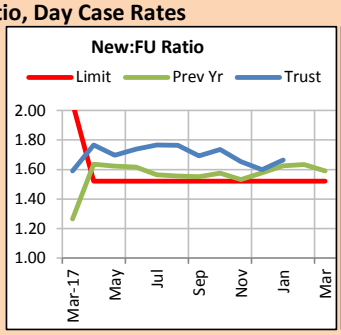
Performance & Activity - Non-Elective Activity, A&E Attendances

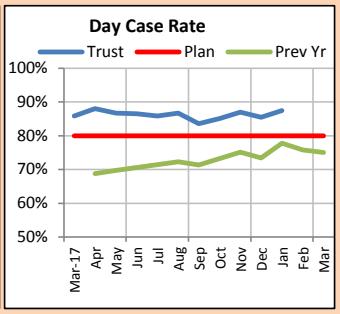




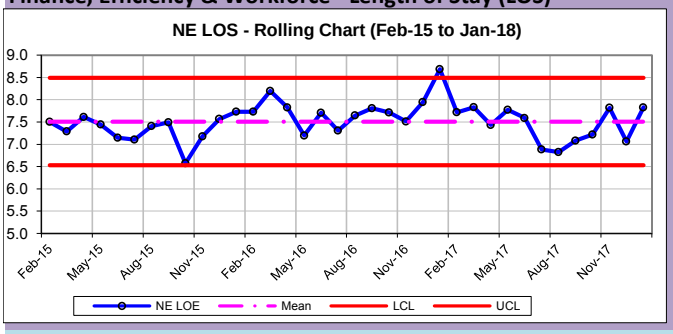
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

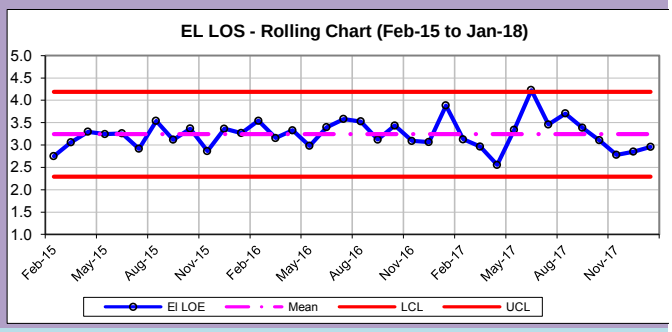




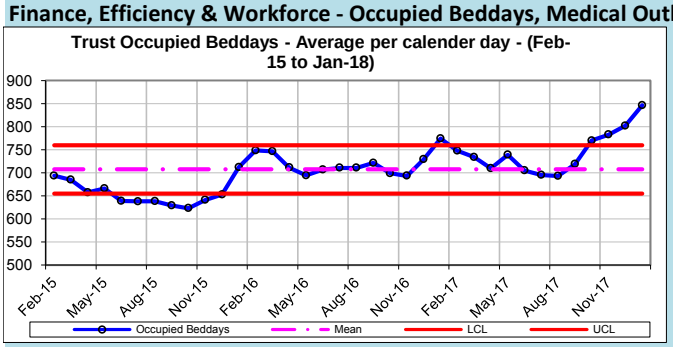


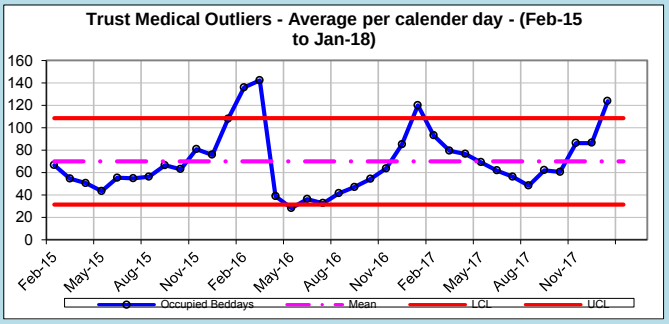
Finance, Efficiency & Workforce - Length of Stay (LOS)



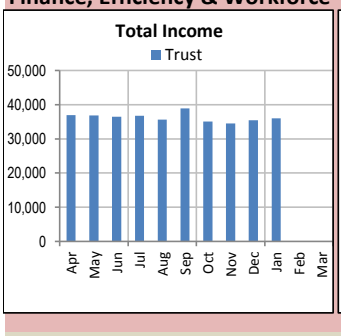


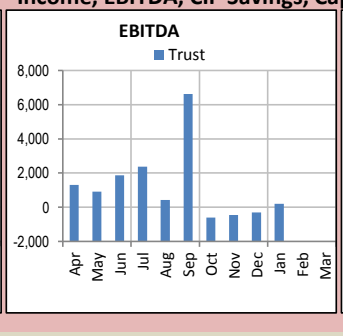
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

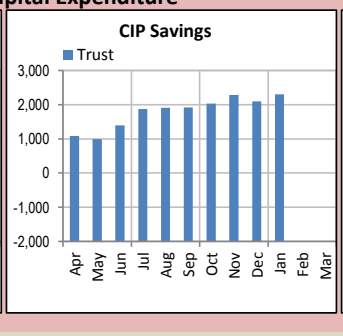


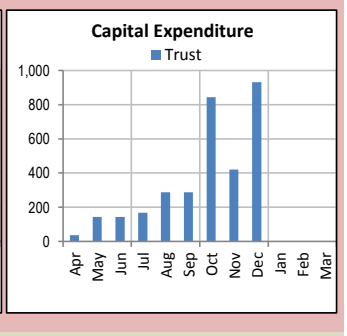


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

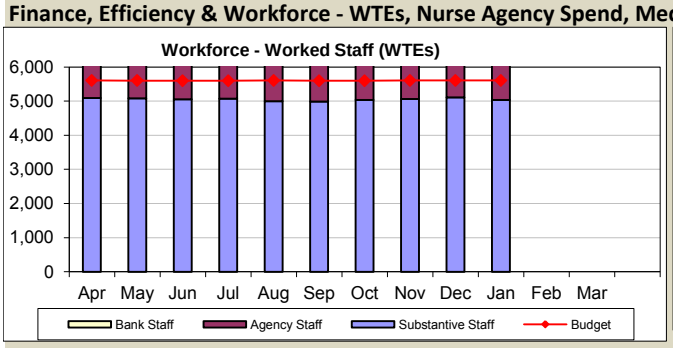


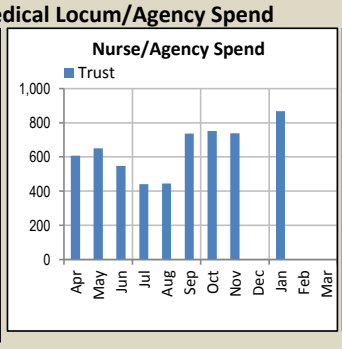


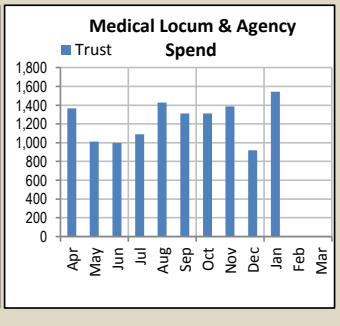




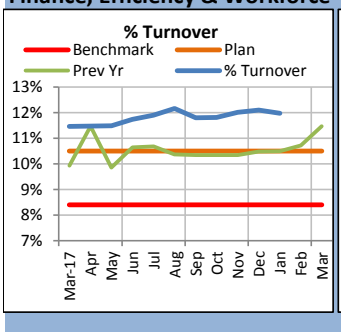
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

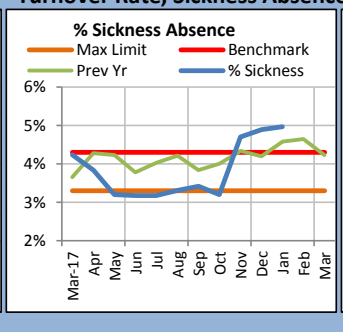


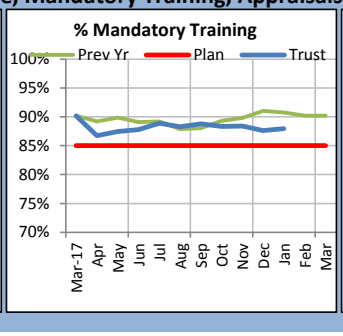


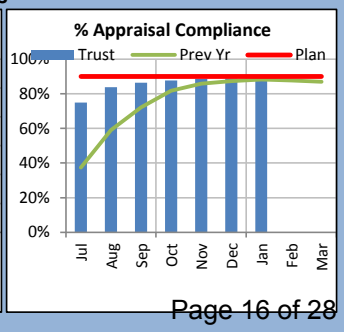


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 10
2017/18

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for January 2017

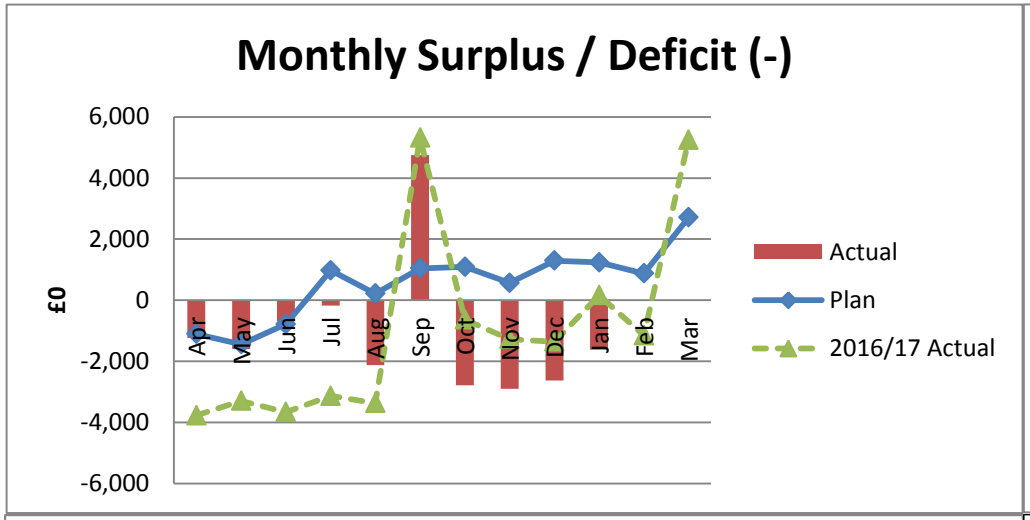
1.Executive Summary

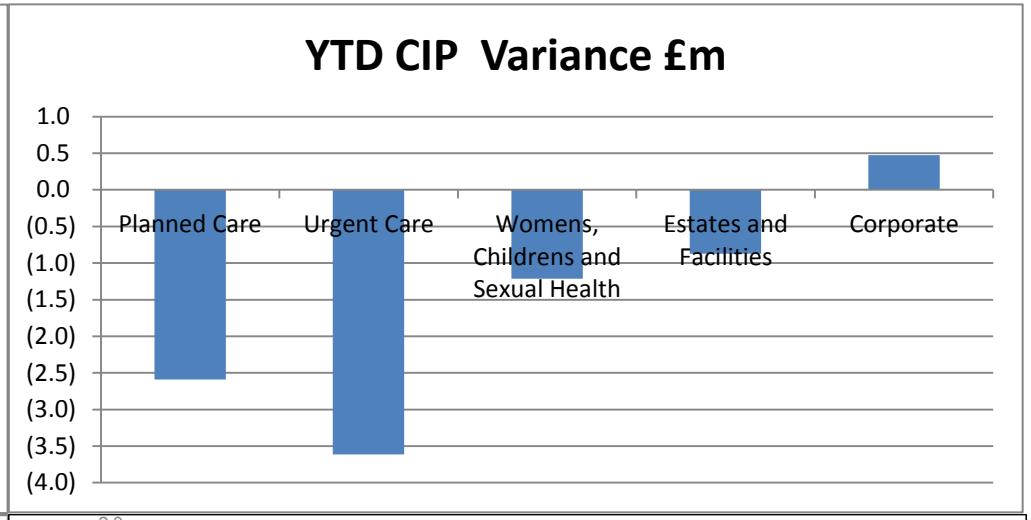
1a. Executive Summary January 2017

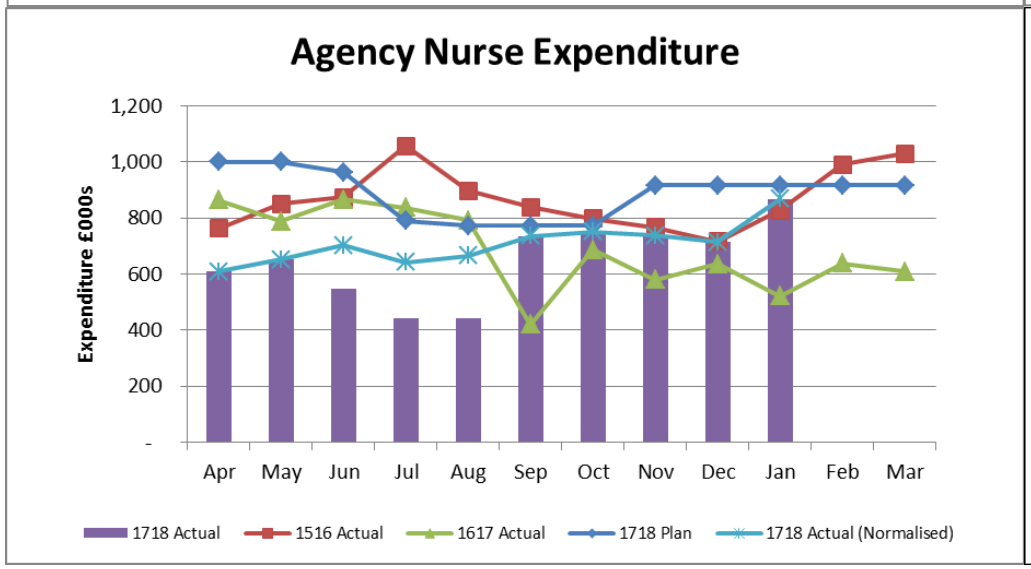
Key Variances £m

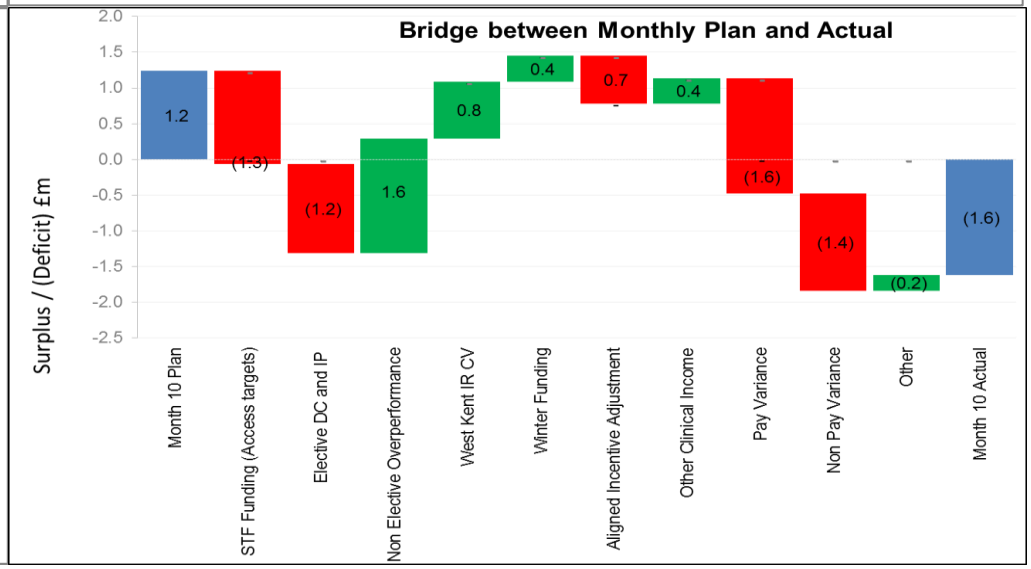
	January	YTD		Headlines
Total Surplus (+) / Deficit (-)	(2.9)	(14.1)	Adverse	The Trusts deficit including STF was £1.6m in January which was £2.9m adverse to plan, £1.3m STF slippage relating to non delivery of financial performance for January, £0.6m slippage against CIP and £1m overspent against budget.
Clinical Income	0.4	(0.0)	Adverse	Clinical Income excluding HCDs was £0.4m favourable in January. The key adverse variances in January were Elective & Day Cases (£1.2m), and Adult Critical Care Activity (£0.2m) offset by favourable variances within non elective (£1.6m), inclusion of £0.8m IR West Kent CCG CV and £0.4m Winter funding and A&E (£0.3m).The position included an adverse adjustment of £0.7m relating to the aligned incentive contract (£1.4m) positive YTD).
Elective IP and DC	(1.2)	(8.2)	Adverse	Elective and Day Case activity is adverse to plan in month by £1.2m in month and £8.1m year to date.
Sustainability and Transformation Fund	(1.3)	(4.7)	Adverse	The Trust did not deliver its financial performance and A&E trajectory in Jnauary therefore was not eligible for STF income.
Other Operating Income	0.4	4.3	Favourable	Other Operating Income £0.4m favourable in the month, £0.7m relating to pass through costs associated with STP (£0.6m) and PAS AllScripts (£0.1m) , £0.2m favourable relating to Injuy Cost Recovery income due to a full reconcillation to the Compensation Recovery Unit (CRU) database) partly offset by adverse variances relating to Private Patient Income (£0.4m) .
Pay	(1.6)	(4.7)	Adverse	Pay was £1.6m adverse in the month, total pay spend (excluding reserves) was £0.6m higher than December but in line with last month's forecast. Medical Staffing costs increased by £0.3m mainly due to the increase in Temporary staffing costs (£0.2m) mainly within Urgent care associated with staffing escalation areas. Nursing costs increased by £100k between months, the increase was a result of the enhanced bank rates and escalation costs although these cosrs were less than forecasted
Non Pay	(1.4)	(11.9)	Adverse	Non Pay was overspent by £1.4m in January this was mainly due to Pass through costs (£0.9m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.7m adverse (mainly due to unidentified CIP) .
Other Finance Costs	1.1	(1.7)	Favourable	Other Finance Costs £1.1m favourable in January. £0.7m favourable associated with a YTD PDC adjustment which is consistent with the month 9 forecast.The underspend relating to impairments (£0.3m) is offset by a technical adjustment
CIP / FRP	(0.6)	(7.8)	Adverse	The Trust achieved £2.3m savings in January which was £0.3m higher than December however this was £0.6m adverse to plan. The Trust has delivered £18m savings YTD and is £7.8m adverse to plan.

1b. Executive Summary KPI's January 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure January 2017/18

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	28.5	28.1	0.4	282.2	282.3	(0.0)	334.9	339.7	(4.8)
	High Cost Drugs	3.6	3.7	(0.1)	35.8	34.9	0.9	47.8	42.2	5.6
	Total Clinical Income	**32.0**	**31.8**	**0.2**	**318.0**	**317.2**	**0.9**	**382.6**	**381.9**	**0.8**
	STF	0.0	1.3	(1.3)	3.9	8.6	(4.7)	3.9	11.2	(7.3)
	Other Operating Income	4.0	3.7	0.4	40.7	36.4	4.3	47.4	43.7	3.7
	Total Revenue	36.0	36.8	(0.7)	362.6	362.1	0.5	433.9	436.7	(2.8)
Expenditure										
	Substantive	(17.9)	(17.9)	(0.0)	(179.0)	(179.7)	0.7	(214.7)	(215.3)	0.6
	Bank	(1.3)	(0.5)	(0.9)	(11.1)	(5.3)	(5.9)	(13.2)	(6.3)	(6.9)
	Locum	(1.5)	(0.8)	(0.7)	(12.8)	(8.6)	(4.2)	(15.2)	(10.2)	(4.9)
	Agency	(1.1)	(1.1)	(0.0)	(8.3)	(11.1)	2.7	(10.0)	(13.3)	3.2
	Pay Reserves	(0.2)	(0.2)	0.0	(0.5)	(2.4)	1.9	(1.0)	(2.9)	1.9
	Total Pay	(22.2)	(20.6)	(1.6)	(211.7)	(207.0)	(4.7)	(254.1)	(248.0)	(6.1)
	Drugs & Medical Gases	(4.5)	(4.2)	(0.2)	(44.1)	(42.5)	(1.6)	(52.9)	(50.9)	(2.0)
	Blood	(0.2)	(0.2)	0.0	(2.0)	(2.1)	0.0	(2.4)	(2.5)	0.0
	Supplies & Services - Clinical	(2.6)	(1.9)	(0.7)	(25.8)	(19.9)	(5.9)	(31.0)	(23.7)	(7.3)
	Supplies & Services - General	(0.4)	(0.4)	(0.0)	(4.7)	(4.2)	(0.4)	(5.5)	(5.1)	(0.5)
	Services from Other NHS Bodies	(0.7)	(0.6)	(0.1)	(7.6)	(6.3)	(1.3)	(9.1)	(7.6)	(1.5)
	Purchase of Healthcare from Non-NHS	(0.2)	(0.6)	0.3	(3.6)	(6.8)	3.2	(4.4)	(7.9)	3.6
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(17.2)	(17.2)	(0.0)	(20.6)	(20.6)	(0.0)
	Establishment	(0.3)	(0.3)	0.0	(2.9)	(3.1)	0.3	(3.4)	(3.7)	0.3
	Premises	(1.8)	(1.8)	(0.0)	(18.5)	(18.0)	(0.5)	(22.4)	(21.5)	(0.9)
	Transport	(0.2)	(0.1)	(0.0)	(1.2)	(1.2)	(0.0)	(1.5)	(1.4)	(0.1)
	Other Non-Pay Costs	(1.1)	(0.4)	(0.7)	(10.4)	(4.1)	(6.3)	(11.3)	(4.9)	(6.4)
	Non-Pay Reserves	(0.0)	(0.0)	(0.0)	0.1	(0.8)	0.8	(0.0)	(0.9)	0.9
	Total Non Pay	(13.7)	(12.3)	(1.4)	(137.9)	(126.0)	(11.9)	(164.6)	(150.7)	(13.9)
	Total Expenditure	(35.8)	(32.9)	(3.0)	(349.6)	(333.0)	(16.6)	(418.6)	(398.7)	(20.0)
EBITDA	**EBITDA**	0.2	3.9	(3.7)	13.0	29.1	(16.1)	15.3	38.1	(22.8)
		0.0	*0.0*	*0.0*	*3.6%*	*8.0%*	*-3304.8%*	*3.5%*	*8.7%*	*817.4%*
Other Finance Costs										
	Depreciation	(1.2)	(1.3)	0.1	(11.3)	(12.2)	0.9	(13.8)	(14.8)	1.0
	Interest	(0.1)	(0.1)	(0.0)	(1.0)	(1.1)	0.0	(1.2)	(1.3)	0.1
	Dividend	0.5	(0.1)	0.7	(0.6)	(1.2)	0.7	(0.7)	(1.5)	0.8
	PFI and Impairments	(1.1)	(1.5)	0.3	(15.5)	(12.1)	(3.3)	(18.3)	(14.9)	(3.5)
	Total Finance Costs	(1.9)	(3.0)	1.1	(28.4)	(26.7)	(1.7)	(34.0)	(32.4)	(1.6)
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(1.7)	0.9	(2.6)	(15.4)	2.5	(17.8)	(18.7)	5.7	(24.4)
Technical Adjustments	**Technical Adjustments**	0.0	0.3	(0.3)	4.3	0.6	3.7	4.7	1.0	3.7
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(1.6)	1.2	(2.9)	(11.0)	3.1	(14.1)	(14.0)	6.7	(20.7)
	Surplus/ Deficit (-) to B/E Duty Excl STF	(1.6)	(0.1)	(1.6)	(14.9)	(5.5)	(9.4)	(17.9)	(4.5)	(13.4)

Commentary

The Trusts deficit including STF was £1.6m in January which was £2.9m adverse to plan, £1.3m STF slippage relating to non delivery of financial performance for January, £0.6m slippage against CIP and £1m overspent against budget.

The Trust's normalised pre STF run rate in January was a deficit of £2m which was £1.3m lower than December and £0.2m less than the year to date monthly average. The main normalised adjustments in January related to: Implementation of IR rules (£0.7m), PDC adjustment (£0.6m), Winter funding £0.4m and Enhanced bank holiday payments (£0.3m), these adjustments were in line with the month 9 forecast.

The Trusts deficit in January was in line with last months forecast, Income overperformance of £0.1m offset overspends within pay (£0.1m), a full review is incorporated in slide 3d.

Clinical Income excluding HCDs was £0.4m favourable in January. The key adverse variances in January were Elective & Day Cases (£1.2m), and Adult Critical Care Activity (£0.2m) offset by favourable variances within non elective (£1.6m), inclusion of £0.8m IR West Kent CCG CV and £0.4m Winter funding and A&E (£0.3m).The position included an adverse adjustment of £0.7m relating to the aligned incentive contract (£1.4m) positive YTD).

STF income £1.3m adverse in January, the Trust did not deliver the financial performance or A&E trajectory in January.

Other Operating Income £0.4m favourable in the month, £0.7m relating to pass through costs associated with STP (£0.6m) and PAS AllScripts (£0.1m) , £0.2m favourable relating to Injury Cost Recovery income due to a full reconciliation to the Compensation Recovery Unit (CRU) database) partly offset by adverse variances relating to Private Patient Income (£0.4m) .

Pay was £1.6m adverse in the month, total pay spend (excluding reserves) was £0.6m higher than December but in line with last month's forecast. Medical Staffing costs increased by £0.3m mainly due to the increase in Temporary staffing costs (£0.2m) mainly within Urgent care associated with staffing escalation areas. Nursing costs increased by £100k between months, the increase was a result of the enhanced bank rates and escalation costs although these costs were less than forecasted.

Non Pay was overspent by £1.4m in January this was mainly due to Pass through costs (£0.9m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.7m adverse (mainly due to unidentified CIP) .

Other Finance Costs £1.1m favourable in January. £0.7m favourable associated with a YTD PDC adjustment which is consistent with the month 9 forecast. The underspend relating to impairments (£0.3m) is offset by a technical adjustment.

The Trust is forecasting a Year End deficit including STF of £14m, £7.3m adverse to plan. The Trusts forecast excluding STF is a deficit of £17.9m which is £13.4m adverse to plan.

5. Expenditure and WTE Analysis

5a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Change between Months
Revenue	Clinical Income	26.9	26.4	28.7	31.9	31.8	32.3	32.1	31.2	32.6	31.3	31.2	31.7	32.0	0.3
	STF	(0.0)	0.0	0.8	0.4	0.4	0.6	0.3	0.0	2.2	0.0	0.0	0.0	0.0	0.0
	High Cost Drugs	3.7	3.3	3.6	(0.1)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.5	3.9	7.6	4.7	4.6	3.5	4.3	4.5	4.1	3.8	3.4	3.8	4.0	0.2
	Total Revenue	**35.1**	**33.5**	**40.7**	**37.0**	**36.8**	**36.5**	**36.7**	**35.7**	**38.9**	**35.0**	**34.5**	**35.5**	**36.0**	**0.6**
Expenditure	Substantive	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(18.1)	(17.8)	(17.7)	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(0.1)
	Bank	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	(0.9)	(1.1)	(0.9)	(1.3)	(1.3)	(1.1)	(1.3)	(1.3)	(0.0)
	Locum	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	(1.0)	(1.1)	(1.4)	(1.3)	(1.3)	(1.4)	(1.3)	(1.5)	(0.2)
	Agency	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	(0.8)	(0.5)	(0.6)	(1.0)	(0.8)	(0.9)	(0.8)	(1.1)	(0.3)
	Pay Reserves	0.0	0.0	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Total Pay	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	(21.1)	(20.8)	(20.8)	(20.0)	(21.6)	(21.6)	(21.6)	(22.2)	(0.6)
Non-Pay	Drugs & Medical Gases	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(4.6)	(4.2)	(4.8)	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(0.2)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(2.7)	(2.7)	(2.7)	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(0.1)
	Supplies & Services - General	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	0.0
	Services from Other NHS Bodies	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	0.2
	Purchase of Healthcare from Non-NHS	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	(0.3)	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	0.2
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(1.7)	(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)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.0
	Premises	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(1.6)	(1.7)	(1.9)	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	0.3
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.0)
	Other Non-Pay Costs	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	(0.7)	(1.4)	(1.6)	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(0.0)
	Non-Pay Reserves	0.0	0.0	1.3	(0.1)	(0.1)	(0.1)	0.2	0.0	0.3	(0.0)	(0.0)	(0.0)	(0.0)	0.0
	Total Non Pay	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(13.5)	(13.6)	(14.4)	(11.7)	(14.1)	(13.4)	(14.2)	(13.7)	0.5
	Total Expenditure	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(34.6)	(34.3)	(35.2)	(31.6)	(35.7)	(35.0)	(35.8)	(35.8)	(0.1)
EBITDA	EBITDA	0.8	0.3	7.0	1.3	0.9	1.9	2.4	0.4	7.3	(0.6)	(0.5)	(0.3)	0.2	0.5
		2%	*1%*	*17%*	*4%*	*2%*	*5%*	*6%*	*1%*	*19%*	*-2%*	*-1%*	*-1%*	*1%*	
Other Finance Costs	Depreciation	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(0.1)
	Interest	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	0.7	0.1	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	0.7
	PFI and Impairments	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	4.0
	Total Other Finance Costs	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.6)**	**(2.6)**	**(2.2)**	**(2.5)**	**(6.4)**	**(1.9)**	**4.5**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	0.1	(42.4)	4.6	(1.3)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	5.0
Technical Adjustments	Technical Adjustments	0.1	40.3	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	0.0	(4.0)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	0.3	(2.0)	4.5	(1.2)	(1.6)	(0.7)	(0.2)	(2.1)	4.8	(2.8)	(2.9)	(2.6)	(1.6)	1.0
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	0.3	(2.0)	3.7	(1.6)	(2.0)	(1.3)	(0.4)	(2.1)	2.5	(2.8)	(2.9)	(2.6)	(1.6)	1.0

Maidstone and Tunbridge Wells NHS Trust

4. Cost Improvement Programme

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer	0.2	0.2	0.0
Critical Care	0.2	0.2	0.0
Diagnostics	0.1	0.2	(0.1)
Head and Neck	0.1	0.1	(0.0)
Surgery	0.1	0.2	(0.1)
T&O	0.4	0.4	0.1
Patient Admin	0.0	0.0	0.0
Private Patient Unit	0.0	0.0	(0.0)
Planned Care	**1.2**	**1.3**	**(0.1)**
Urgent Care	**0.6**	**0.8**	**(0.2)**
Womens, Childrens and Sexual Health	**0.1**	**0.4**	**(0.2)**
Estates and Facilities	**0.1**	**0.3**	**(0.2)**
Corporate	**0.3**	**0.2**	**0.1**
Total	**2.3**	**3.0**	**(0.6)**

Comment
The Trust achieved £2.3m savings in January which was £0.3m higher than last month however this was £0.6m adverse to plan. The plan includes £2m unidentified savings phased from July.

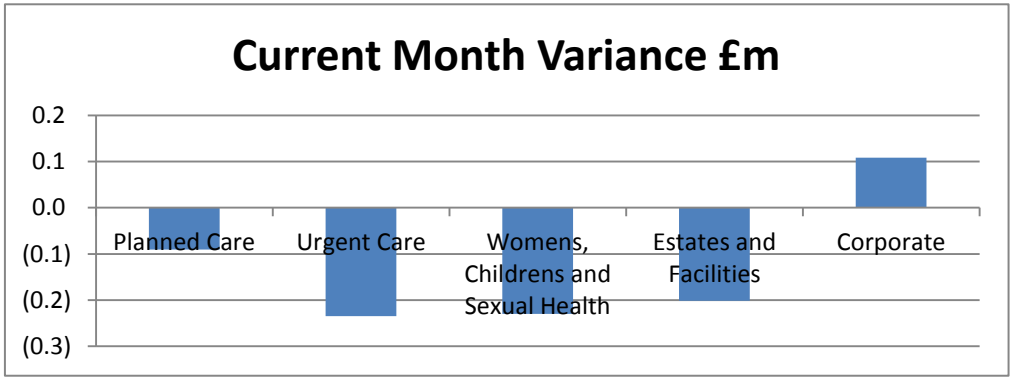
The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in January were £1.6m below plan.

Planned Care: £0.1m adverse compared to original CIP plan and £0.4m to the 'live' plan. The main directorates adverse to plan (Live) are Critical Care Directorate were £102k adverse in January, £60k due to unidentified CIP, £20k adverse due to unidentified Procurement savings and £20k adverse relating to Endoscopy Bowel screening sessions. Diagnostics are £128k adverse in January, £96k due to unidentified CIP, £40k due to unidentified procurement savings and £10k due to slippage associated with reduction in outsourcing costs.

Urgent Care: £0.2m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.8m adverse in the month which is mainly due to £0.45m unidentified savings , slippage in closing 1ward (£0.1m), slippage in deep dive savings plan (£0.15m) and slippage in identifying procurement savings (£0.1m).

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

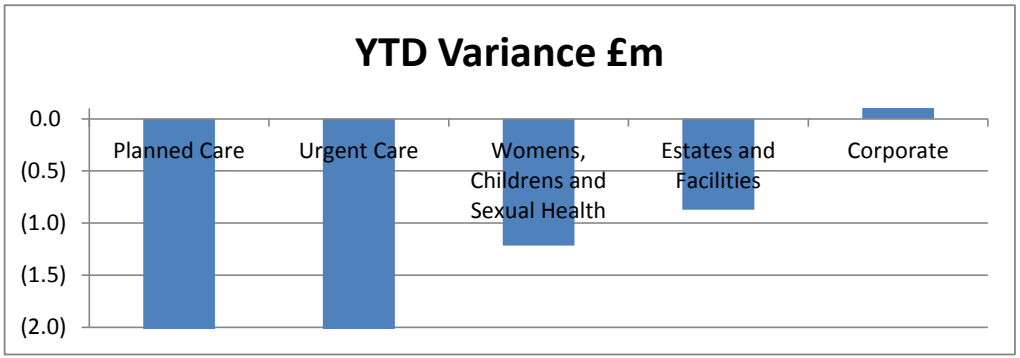
Estates and Facilities: £0.2m adverse to the original and £0.3m adverse to 'live' plan. The main slippage relates to EPC energy business case (£70k per month) , Laundry contract (£30k) and bus service contract review (£20k).



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer	1.4	1.6	(0.2)
Critical Care	1.1	1.8	(0.6)
Diagnostics	0.8	1.8	(1.0)
Head and Neck	0.7	0.8	(0.1)
Surgery	0.8	1.4	(0.6)
T&O	4.3	4.4	(0.1)
Patient Admin	0.1	0.1	0.0
Private Patient Unit	0.1	0.1	(0.0)
Planned Care	**9.4**	**11.9**	**(2.6)**
Urgent Care	**3.6**	**7.3**	**(3.6)**
Womens, Childrens and Sexual Health	**1.7**	**2.9**	**(1.2)**
Estates and Facilities	**1.4**	**2.2**	**(0.9)**
Corporate	**2.0**	**1.5**	**0.5**
Total	**18.0**	**25.8**	**(7.8)**



Comment

The Trust has achieved £18m savings YTD which is £7.8m 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 £13.3m below plan.

Planned Care: £2.6m adverse compared to original CIP planned phasing, £4.4m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£1,172k adverse) which is due to £675k unidentified, procurement 10% savings target (£450k) and £20k slippage relating to outsourcing reduction. Surgery Directorate (£879k) adverse which is due to unidentified savings (£600k), deep dive review (£120k) and medical pay savings (£95k) relating to job planning and WLI savings.

Urgent Care: £3.6m adverse compared to the original plan, when compared to the 'live' plan the directorate are £5.8m adverse YTD. This is due to £3.2m unidentified savings, delay in closing wards (£1.4m), slippage in procurement savings (£0.55m) and slippage in deep dive savings target (£0.6m).

Womens, Childrens and Sexual Health: £1.2m adverse compared to the original plan, when compared to the 'live' plan the directorate are £1.4m adverse YTD. The YTD adverse variance (£1.4m) is due to unidentified savings.

Estates and Facilities: £0.5m adverse compared to the original plan, when compared to the 'live' plan the directorate are £1.9m adverse YTD. This is due to £0.43m Energy Savings, £0.18m Bus Service contract, £0.1m delay in sale of Springs, £0.15m Laundry contract savings and £0.15m Rental income from East Kent.

Corporate: Corporate directorates are £0.5m favourable to the original plan and are £0.3m 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.

Change

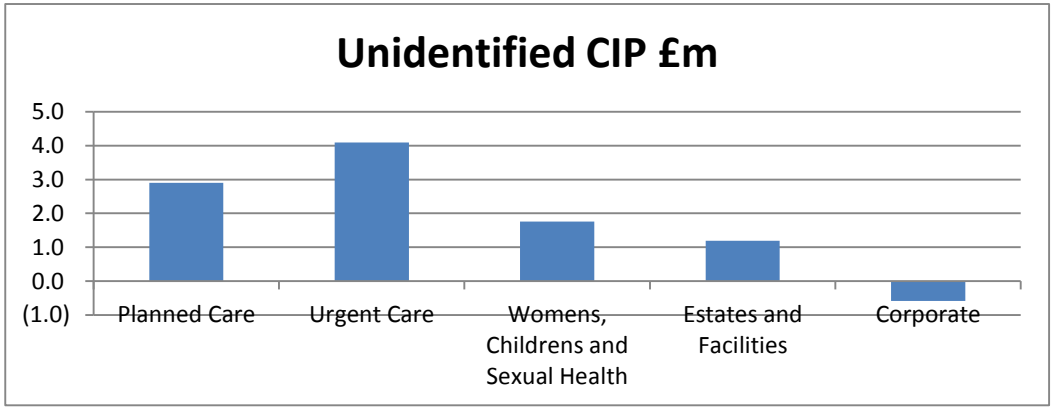
Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	*Unidentified (Risk Adjusted)*	*Plan*	*% Unidentified*
	£m	£m	£m	
Cancer	1.8	0.6	2.4	24%
Critical Care	1.5	0.6	2.2	29%
Diagnostics	1.0	0.9	1.8	47%
Head and Neck	0.9	0.1	1.0	8%
Surgery	1.0	0.8	1.8	43%
T&O	5.1	(0.0)	5.1	-1%
Patient Admin	0.1	(0.0)	0.1	-6%
Private Patient Unit	0.1	0.0	0.2	22%
Planned Care	**11.7**	**2.9**	**14.6**	**20%**
Urgent Care	**4.8**	**4.1**	**8.9**	**46%**
Womens, Childrens and Sexual Health	**1.9**	**1.8**	**3.7**	**48%**
Estates and Facilities	**1.6**	**1.2**	**2.8**	**43%**
Corporate	**2.5**	**(0.6)**	**1.9**	**-31%**
Total	**22.4**	**9.4**	**31.7**	**30%**

Savings as per 8th December



The Trust has a £31.7m CIP plan for 2017/18 and has identified £22.6m (non risk adjusted) , £9.1m unidentified. The current forecasted risk adjusted identified savings is £22.4m, a shortfall of £9.4m.

Planned Care Division have identified £11.8m savings which is risk adjusted to deliver £11.7m. The division has £2.9m risk adjusted shortfall (20%).

Urgent Care Division have identified £4.8m savings which is risk adjusted to deliver £4.8m. The division has £4.1m risk adjusted shortfall (46%).

W&CH Division have identified £1.9m savings which is risk adjusted to deliver £1.9m. The division has £1.8m risk adjusted shortfall (48%).

Estates and Facilities Division have identified £1.6m savings which forecasted to fully deliver. The division has a risk adjusted shortfall of £1.2m (43%). The forecast assumes the asset sale (£1m benefit to I&E) will not materialise in 2017/18.

5. Balance Sheet and Cash Flow

5a. Balance Sheet

January 2017

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

	January			December	Full year	
£m's	Reported	Plan	Variance	Reported	Plan	Forecast
Property, Plant and Equipment (Fixed Assets)	269.8	275.9	(6.2)	270.1	282.1	282.9
Intangibles	2.4	2.8	(0.4)	2.5	2.1	2.5
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	(0.0)	1.2	1.2	2.0
Total Non-Current Assets	**273.4**	**279.9**	**(6.5)**	**273.9**	**285.4**	**287.4**
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	7.7	8.3	(0.6)	7.7	8.3	7.9
Receivables (Debtors) - NHS	24.5	48.1	(23.6)	38.7	21.0	28.6
Receivables (Debtors) - Non-NHS	15.3	9.5	5.8	13.9	9.5	11.2
Cash	8.3	7.8	0.5	7.9	1.0	1.0
Assets Held For Sale	0.0	0.0	0.0	0.8	0.0	0.0
Total Current Assets	**55.8**	**73.7**	**(17.9)**	**68.9**	**39.7**	**48.7**
Current Liabilities	0.0	0.0	0.0	0.0	0.0	0.0
Payables (Creditors) - NHS	(8.2)	(6.8)	(1.4)	(7.2)	0.0	(4.5)
Payables (Creditors) - Non-NHS	(36.1)	(30.2)	(5.9)	(40.8)	(14.5)	(39.2)
Deferred Income	(14.1)	(18.1)	4.0	(27.2)	(3.5)	(7.1)
Capital & Working Capital Loan	(2.3)	(2.2)	(0.1)	(2.3)	(19.1)	(19.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.5)	(5.5)
Provisions for Liabilities and Charges	(1.8)	(1.3)	(0.6)	(1.8)	(1.3)	(2.0)
Total Current Liabilities	**(67.5)**	**(63.6)**	**(3.9)**	**(84.3)**	**(43.9)**	**(77.6)**
Net Current Assets	(11.7)	10.1	(21.8)	(15.4)	(4.2)	(28.9)
Finance Lease - Non- Current	(193.6)	(194.3)	0.6	(194.1)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(11.7)	(15.2)	3.6	(11.7)	(26.3)	(10.8)
Working Capital Facility	(36.3)	(29.0)	(7.2)	(31.3)	0.0	(27.0)
Provisions for Liabilities and Charges- Long term	(1.1)	(0.5)	(0.6)	(1.1)	(0.4)	(1.0)
Total Assets Employed	**19.0**	**51.0**	**(32.0)**	**20.4**	**61.8**	**27.1**
Financed By:						
Capital & Reserves						
Public dividend capital	205.3	206.8	(1.5)	205.0	208.6	207.3
Revaluation reserve	30.3	30.3	(0.0)	30.3	36.2	39.5
Retained Earnings Reserve	(216.6)	(186.1)	(30.4)	(214.9)	(182.9)	(219.7)
Total Capital & Reserves	**19.0**	**51.0**	**(32.0)**	**20.4**	**61.8**	**27.1**

Commentary:

Non-Current Assets -
The value of PPE after depreciation is £0.5m less than the December reported position. The total additional purchase of assets have been offset by the depreciation charge for the period.

Current Assets -
Inventory is relatively similar to the December reported position.
NHS Receivables have reduced by £14.2m compared to the December reported position reflecting a similar reduction in deferred income. It is also below the plan value by £23.6m. Of the £24.5m reported balance, £11.5m relates to invoiced debt. The remaining £13.0m relates to uninvoiced accrued income comprising partially completed spells. Due to the financial situation of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debts.
Non NHS Receivables have increased by £1.4m compared with the December reported position, and is above plan by £5.8m. Included within this balance is trade invoiced debt of £3.3m.
The Springs sale completed in January 2018.

Current Liabilities -
NHS payables have increased from the December reported position by £1.0m. Non-NHS trade payables have decreased since December by £6.5m. This was helped by the working capital loan received in January.

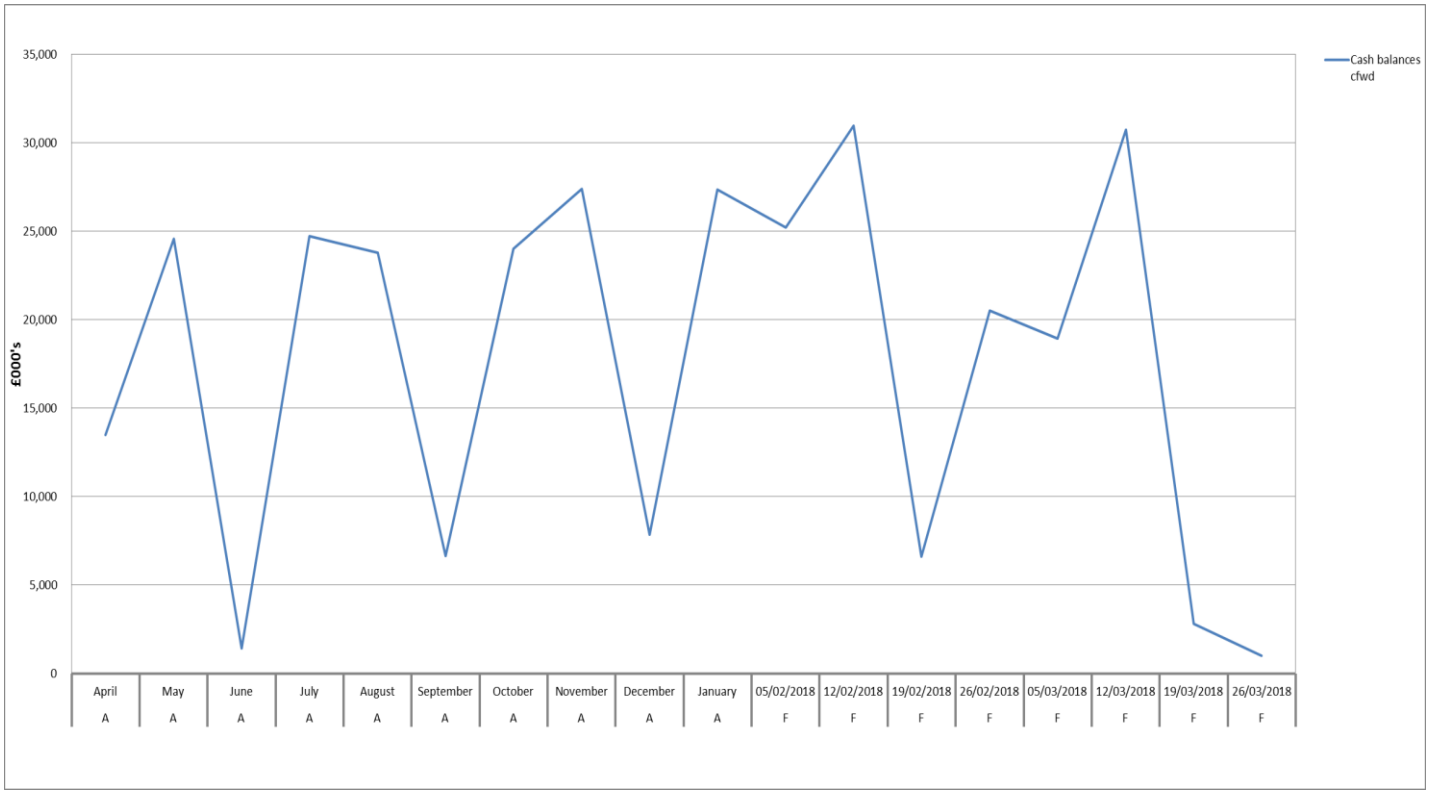
Of the £42.5m creditor balances, £21.2m relates to actual invoices, £21.3m relates to uninvoiced accruals. The accruals include expected values for tax, NI, Superannuation and PDC payments.
£14.1m is deferred income primarily relating to advance SLA payments from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA.

Long term Liabilities-
The PFI liability reduces each year as the Unitary Charge includes financing repayments. The £5.0m increase in working capital facility represents the working capital loan approved recently by DH.

Capital and Reserves- The increase in Public Dividend Capital reflects the £315k received from DH to support the funding of the A&E GP streaming project.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April.
For 17/18 the Trust received £5.0m cash support in January 2018.

During the year to date, the Trust has managed its liquidity even though the actual position has been an Income & Expenditure deficit through a combination of:

-Sustained pressure on partner CCG and local Trusts to reduce the burden of intra-NHS debt. The Trust tends to be a net provider of services to other local Trusts and is therefore exposed to their cash pressures as trade creditors tend to be preferred in payment.

-Effectively "borrowing" temporarily in the early part of the year from capital resource as the Trust's programme is back-ended in timing, and has been reduced.

6. Capital

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	2,466	8,573	6,107	8,873	5,034	3,839
ICT	1,040	1,510	470	1,664	1,807	-143
Equipment	650	3,910	3,260	5,909	4,131	1,778
PFI Lifecycle (IFRIC 12)	268	268	0	502	502	0
Donated Assets	0	350	350	450	167	283
Total	**4,425**	**14,611**	**10,186**	**17,398**	**11,640**	**5,758**
Less donated assets	0	-350	-350	-450	-167	-283
Asset Sales (net book value)	-1,741	0	1,741	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**2,684**	**14,261**	**11,577**	**15,221**	**9,746**	**5,475**

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. Linac 1 at Maidstone has been installed and is now in clinical use.
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 May 2018. The Trust has been awarded £645k for GP A&E Streaming works, as additional PDC, and has received £535k funding to date.

The Trust disposed of the Hillcroft property for £1.04m gross receipts generating a small profit on sale of c.£20k. The Springs property sale was completed on 22nd January with sale proceeds of £800k. 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 and the Trust has received £629k to date.

The Trust is already planning an underspend in depreciation to support the Income & Expenditure position but this needs to be matched by a corresponding reduction in the planned capital spend. 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 £11.64m (before donations and asset sales) reflecting the forecast underspend in depreciation.

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-11	Emergency Care Improvement Programme (ECIP): report of acute site visit to Maidstone & Tunbridge Wells hospitals, January 2018	Chief Operating Officer

The report of the Emergency Care Improvement Programme's (ECIP's) acute site visit to the Maidstone and Tunbridge Wells Hospitals on 17th and 18th January 2018 is enclosed.

A read across from the recommendations to the projects within the Best Flow workstream of the Best Care programme is underway, but all the recommendations will be included in an action plan (although some of these are already in progress).

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 21/02/18

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

Emergency Care Improvement Programme
Safer, faster, better care for patients

NHS Improvement

Miles Scott
Chief Executive Officer
Maidstone and Tunbridge Wells NHS Trust

14 February 2018

By email

Dear Miles

Re: Acute site visit to the Maidstone and Tunbridge Wells hospitals, Wednesday 17th and Thursday 18th January 2018

Thank you for accommodating the Emergency Care Improvement Programme (ECIP) to undertake a gap analysis of your urgent and emergency care pathways on Wednesday 17th and Thursday 18th January 2018. The gap analysis was against the Good practice guide: Focus on improving patient flow (July 2017), a copy of which is available here. The review and analysis was led by Professor Matthew Cooke, ECIP regional clinical director (London region). We would like to take this opportunity to formally thank those involved in both setting up the site visit and in meeting with us for sharing their time, being open and being prepared to engage in constructive discussions.

This report expands on the initial verbal feedback provided at the end of our visit. The report offers specific recommendations for you to consider to achieve and sustain a step improvement in flow across the urgent and emergency care pathway. A summary of all the recommendations is provided in a table in the appendices.

As your ECIP lead, I will continue to act as the main point of contact for accessing any further ECIP support agreed. We hope that this report is useful and welcome feedback on both the process and the report itself.

Yours sincerely

Spencer Humphrys
Improvement Manager
Emergency Care Improvement Programme (ECIP)

Mobile: 07841 533933
E-Mail: spencer.humphrys@nhs.net

Cc:
Professor Matthew Cooke, Clinical Director, ECIP (London region)
Pete Gordon, Senior Improvement Manager, ECIP (Midlands and East region)
Heather Cooper, Senior Improvement Manager, ECIP (South region)
Dr Andrew Rochford, Clinical associate, ECIP
NHS Improvement regional team
NHS England regional team

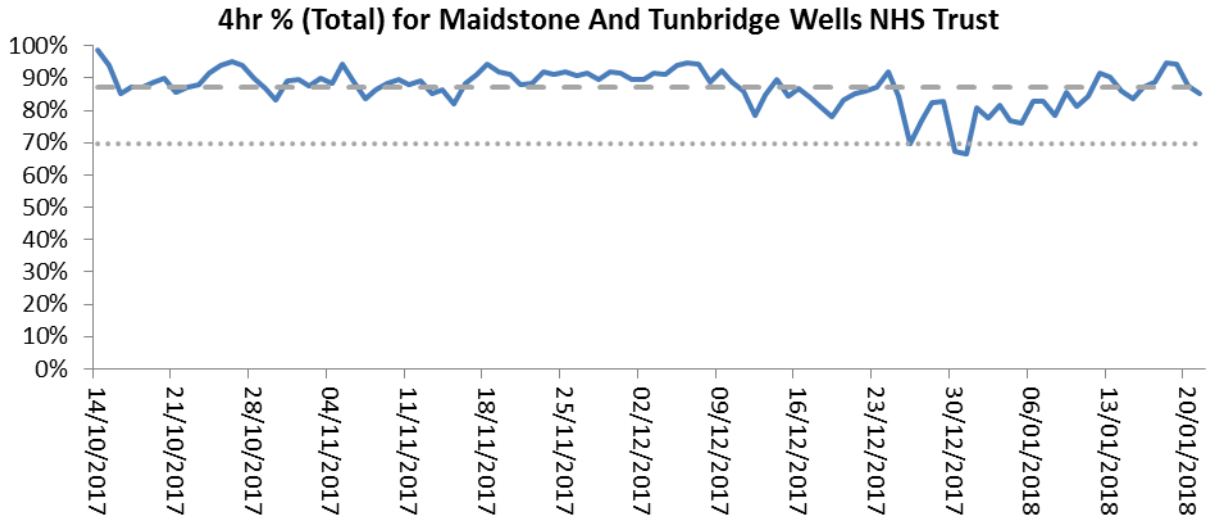
Overview

This acute site review focussed on your urgent and emergency care pathways, with the review and this feedback based on the Good practice guide: Focus on improving patient flow (July 2017). This report is based on our observations, staff feedback, trust data and a gap analysis against current evidence-based best practice. The report builds on the verbal feedback provided at the end of the visit and aims to provide practical recommendations to support sustained improvement in patient flow.

The estate on both sites was in very good condition, and there was consistent evidence of infrastructure changes and upgrades to improve patient flow and quality. The processes and informal networks seemed better on the Maidstone site, with several excellent areas and pathways.

The Maidstone and Tunbridge Wells NHS Trust (MTW) has seen a slight increase in emergency department (ED) attendances over the past year. A 0.9% fall in attendances at the Maidstone site has slightly offset the 2.3% rise at the Tunbridge site. Since October 2017, trust performance against the ED four hour standard has shown periods of both positive and negative statistical change, in recent weeks returning to the period average around 87.03% (see figure 1 below).

Figure 1: Weekly performance against the four hour quality standard



It is well documented that poor patient flow does not simply impact patient experience. Research into poor patient flow has established increasing links with adverse patient outcomes including:

- For patients who are seen and discharged from A&E, the longer they have waited to be seen, the higher the chance they will die during the following 7 days (Guttmann *et al.,* 2013).
- The longer a patient spends in the emergency department the longer their associated inpatient stay in the hospital (Liew *et al.,* 2003).
- Ten days spent in hospital leads to the equivalent of an additional 10 years ageing in the muscles of people aged over 80 (Giles *et al,* 2004).
- Delays in transfer from ED to higher dependency units increase mortality and length of stay (Chalfin *et al,* 2007).
- Once a hospital has over 90% bed occupancy it reaches a tipping point in its resilience (Forster *et al,* 2003).
- Non-clinical bed moves between wards affect patient safety and increase length of stay (Webster *et al,* 2016).

In this report, we have kept the number of recommendations to a minimum where practical. We recognise that MTW has already undertaken significant changes, most recently with the support of the consultancy company 2020. We would encourage you to incorporate the new recommendations in this report into existing action plans and streams of work. We believe that increased focus on the key actions will support more sustainable improvement.

It is our overarching assessment that the trust knows what it needs to do and there is good organisational self-awareness, at all levels, of where the challenges are. There are many areas of good practice in place, particularly on the Maidstone site, but there is a lack of consistency across the trust. The trust needs to focus its resources on addressing these issues and empowering teams locally to create and deliver solutions to these problems. To support this, the trust will need to develop its internal reporting mechanisms and metrics so that variation is easily identifiable.

Commentary and key recommendations

The report sets out the key internal process recommendations that, if implemented robustly, would support increased resilience across your urgent and emergency care pathways. More importantly, these recommendations would improve patient experience and mitigate the potential harm associated with poor patient flow.

The following recommendations are taken from the recommendations within the body of this document. These are the top recommendations we suggest the Trust and system work on to improve the performance against the four hour standard. For ease, we have summarised all recommendations at the end of the document in appendix 1.

1. We recommend that an acute frailty service is established at the Tunbridge Wells site, drawing on the good practice and processes embedded on the Maidstone site. This new service should be integrated with the various admission avoidance teams, services and pathways.
2. We recommend that the Tunbridge Wells AEC team continue to run rapid cycle PDSA tests to maximise patient attendance and throughput. This should include testing different approaches to patient identification.
3. We recommend that a full assessment of your homefirst service is undertaken, including a demand and capacity analysis, to understand strengths and opportunities to deliver a full discharge to assess service.
4. We recommend that the Trust uses a process to identify constraints to patient flow, supported by effective governance arrangements to act on and remove the constraints at ward, trust and system level.
5. We recommend that the Trust implements the SAFER patient flow bundle across all inpatient wards (excluding maternity and paediatrics) to improve flow.

1. Mental health

Mental health services and access are good during the day time but out of hours there is a poor response. We were told that this regularly results in patients waiting in CDU overnight. New section 136 plans will mean more patients coming to the hospital but without change this is likely to lead to poor patient experience and increased delays for this category of patient.

Recommendation

1. We recommend that ECIP support a system wide assessment against good practice in the management of mental health patients.

2. Ambulance handovers

The rapid assessment process (RAP) for managing ambulance handovers is good at both sites and the designated space is excellent. The consistency of senior medical input and cohorting patients after RAP represents good practice. Despite this good practice, there is large day to day variation in long handover delays (see figures 2 and 3 below), this is probably attributable to exit block from the ED. We were told that despite the daily differences in ambulance arrivals at both sites, the staffing allocation is the same between the two hospitals.

Figure 2: Daily count of ambulance handover delays between 30 and 60 minutes

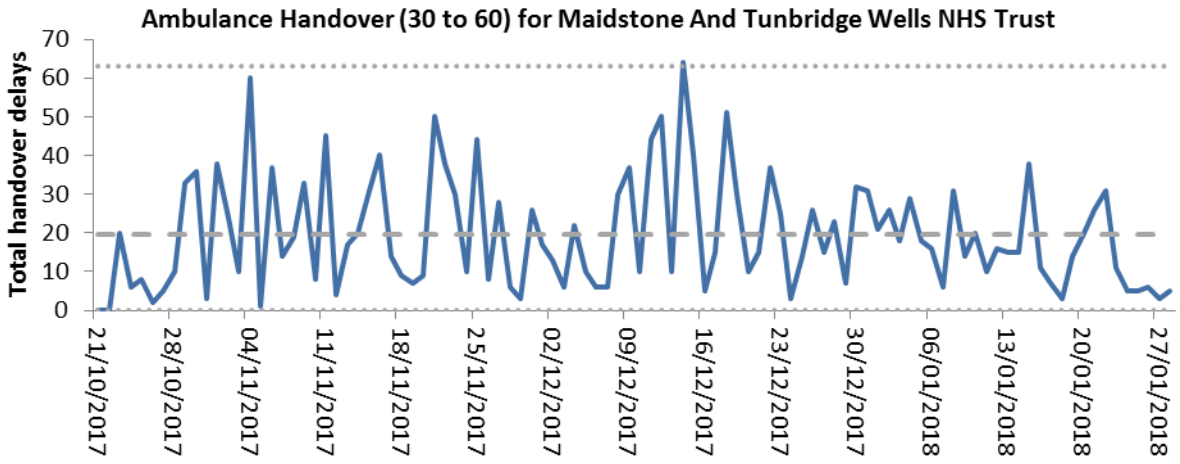
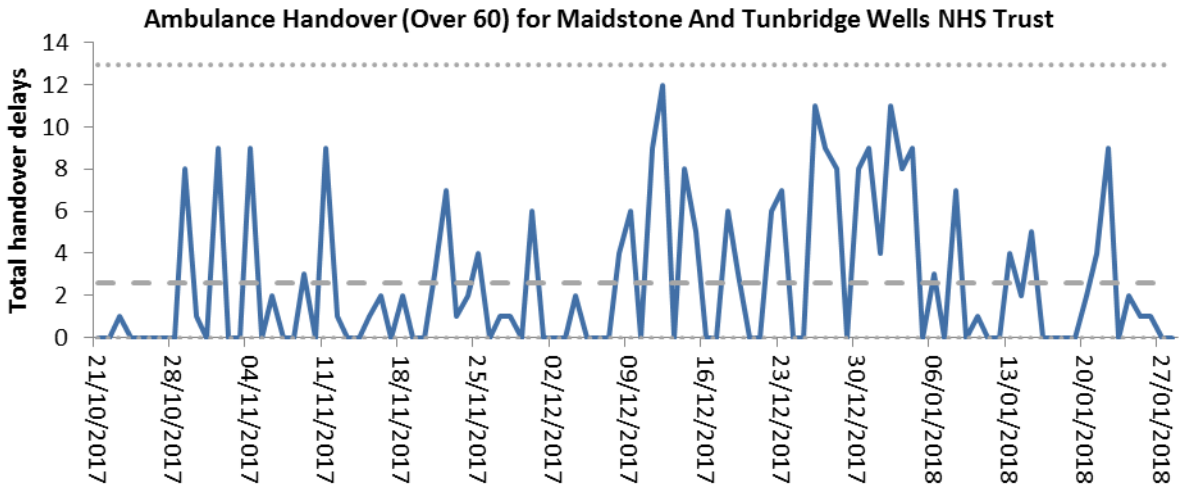


Figure 3: Daily count of ambulance handover delays of 60 minutes or greater



We were told that patients are assessed for fitness to sit in the designated 'red chairs' on both sites, however, this process is more consistent and has more impact at the Maidstone site. This partly due having more chairs at the Maidstone site. Best practice is that clinically stable patients referred to an ED by a GP should go directly to an assessment service; we were told that currently this does not happen consistently on either site.

Recommendations

1. We recommend that the Trust and South East Coast Ambulance service rapidly test processes to convey patients directly to other areas in the ED (e.g. minors, GP assessment, ambulatory emergency care) to reduce avoidable pressure on the RAP service.
2. We recommend that an emergency conveyance audit is undertaken (based on the 6As methodology) at the Tunbridge Wells site to assess the potential for non-conveyance or alternative conveyance routes.

3. Primary care streaming

Since the GP service has recently transferred to the trust, the service is in a state of development but the plans are in alignment with best practice. The plans which were discussed with us to implement NHS pathways to aid streaming and align ED advice with the system is excellent. We were told that currently only one patient per hour is allowed to be streamed to the out of hours (OOH) provider. In practice, this pathway is rarely used due to the difficult and time consuming process required.

Recommendations

1. We recommend that the trust tests clear criteria to maximise patient streaming to primary care services and the OOH provider. There should not be restrictions put on the volume of referrals.

4. Emergency department

Both departments operate well, with around 60% of patients seeing a senior decision maker within the first hour. Both sites have similar internal processes but the Maidstone site has improved flow. We were told that the Maidstone site has a lower general acuity of patient, which is supported by a lower conversion rate of attendance to admission (Maidstone: 25%; Tunbridge: 30%). Despite the relatively small difference in percentage, as the Tunbridge Wells site has higher daily attendances, including roughly double the volume of ambulance arrivals, this equates to an admission difference of 19 patients a day (Maidstone: 30; Tunbridge: 49). The admitted performance on both sites is markedly different, with performance (between February and October 2017) at the Maidstone site consistently outperforming the Tunbridge site (Maidstone: 86%; Tunbridge: 52%). Low admitted performance is an indicator of ED crowding and safety risks. Exit block in the Tunbridge site is impacted by many elements, with ward and assessment unit processes and opportunities described later in this report. An important difference we noted, regardless of the formal processes, is that the informal networks and relationships at Maidstone seem stronger and inpatient medical teams take a more active role in supporting the ED.

The consultant establishment is low for two EDs but the cover provided by the ED consultant team is excellent. We were told most GP expected patients are routed through the ED at the Tunbridge Wells site and around 20 per day are processed through the Maidstone ED. At the Tunbridge Wells site, this was highlighted as a key constraint in maintaining flow through the minors area when downstream capacity was not available.

Both sites are actively using a fit to sit approach and the naming of these chairs as 'red chairs' is a good concept. Maidstone has more 'red chairs' and seems to use them more frequently and effectively. We were told that the use of these chairs was essential in reducing the ED bed occupancy at the Maidstone site.

We were told that patients can stay on trolleys for prolonged periods in the ED and other areas. This seems more common and more of a risk at the Tunbridge Wells site. The clinical risks of this (e.g. pressure ulcers) is mitigated by improved mattresses but the narrow trolley width does not allow a patient to be moved or rolled. Overall, we felt that this represents poor patient experience. The safety rounds highlight patients in the ED who have spent over 4 hours on a trolley but we were told that there are often no beds available for these patients when highlighted. The Trust should look at developing systems to report and resolve any episodes of a prolonged period on a trolley wherever it occurs.

The ED safety checklist is not utilised but the staff have developed good quality rounds that cover the relevant areas of the ED checklist. The disadvantages are that documentation is departmental rather than patient level and the rounds are two hourly rather than one hourly. We recommend the Trust considers if the current safety rounds could be adapted to match the best practice of the ED safety checklist.

The ED team are keen to explore the use of non-medical practitioners, including paramedics. We were informed that there have been some challenges to bringing in non-medical practitioners and using them to their full competencies due to challenges from the therapeutics committee. There is no reason why a paramedic cannot have the same scope of practice inside a hospital as they do when working in the community.

Recommendations

1. We recommend that the Tunbridge Wells site rapidly tests different models to increase the availability of 'red chairs'. This could be delivered by converting two cubicles, one for assessment and one for seating, as the total cubicle capacity in the Tunbridge Wells site is high compared to the attendances.
2. We recommend that an emergency admission (6As) audit is undertaken at the Tunbridge Wells site to understand scope for alternative pathways to admission.

5. Clinical decision units (CDU)

There is a CDU at each site co-located with the ED which is open 24 hours each day. At the time of the site visit, neither CDU met the criteria to be considered equivalent to an inpatient ward. As such, patients placed in these areas should not have been taken off the four hour clock. This was raised to the executive team and within the same week the executive approved investment on both sites to rectify the issues. We have revisited the Maidstone site and seen the current building works and plans for developing an excellent and wholly compliant CDU.

Both CDUs offer seated capacity only, with those patients needing to stay on trolleys for observation or prolonged treatment being admitted to alternative locations. However, on the Tunbridge Wells site we did not observe the capacity or processes to allow these patients to be quickly moved out of the ED. The Maidstone CDU redevelopment will provide a seated area and a separate space for reclining chairs / trolleys for patient assessment and treatment.

All patients requiring admission to CDU are approved by a senior ED medic. As the current model does not have a dedicated ED medical presence, the management of patients being referred in to the

area stays with the referring medic. In practice, this will mean that patients' results will not be acted upon as soon as available resulting in prolonged stays in the unit.

On both sites we were told that appropriate patients would not normally be streamed directly to CDU (e.g. intoxicated low risk head injury) as "this would cause breeches". This suggests that the CDU is not consistently seen as a value adding clinical area and that potentially the CDUs are not large enough for the current level of demand. However, the redeveloped Maidstone CDU will offer more capacity than is currently available which may resolve this issue at that site.

Recommendations

1. We recommend reviewing the medical oversight of the CDUs to ensure that patients are admitted to the unit with appropriate plans and results are acted upon as soon as they are available. Best practice states that CDUs should be supervised and led by a named consultant (where practical).
2. We recommend that the Ambulatory Emergency Care team and the ED team at the Tunbridge Wells site review current criteria and use of the CDU. This should ensure that the CDU criteria is balanced and co-ordinated with that of the AEC to avoid unnecessary duplication, ensure there is appropriate capacity where needed and that flow processes are not cumbersome.

6. Ambulatory emergency care (AEC)

There are AEC units on both sites, although the Tunbridge Wells unit is in its infancy. In Maidstone, the AEC is more established and has good processes for flow from the ED and the ED clinical team rate the service highly. This is reflected in a slightly higher than national average zero day length of stay percentage (see figure 4 below). The service receives patients by actively pulling and by referrals from the ED. The AEC team use the ED ICT system (Symphony) to review current ED patients to maximise the pull process. The team loosely use the Ambscore to help identify patients from the ED, however, the remit of patients accepted is far broader and clinical judgement is applied frequently. The unit also accepts patients referred by specialties to facilitate early discharge for further treatment (e.g. blood transfusion, drains etc).

The Tunbridge Wells AEC had been in operation for 5 weeks on the date of the visit and as such was still developing the pathways, links, processes and relationships. In contrast to the Maidstone site, the zero day length of stay percentage is lower than the national average, and 9.3% lower than the Maidstone site (see figure 5 below). The Tunbridge Wells AEC places a heavy focus on the use of the Ambscore, however, research has shown that this process can miss up to 50% of appropriate patients. There is a dedicated room for assessments and procedures but this is frequently used as an escalation space for inpatient management. This results in poor flow and lower utilisation of AEC during times of peak pressure. We were told by the senior team that the general AEC area is no longer used as an escalation space for inpatients and that the unit can now physically only accept trolleys. However, the ward team told us that the unit was still being used as an escalation space overnight, most recently two days before our visit. From our observation, there did not seem to be a team that 'owned' the AEC and was responsible for driving improvements or pulling patients from the ED. This was echoed by the ED team who felt that there was little benefit in referring patients to the AEC as they were infrequently accepted and the pathway difficult. On the AMU, there is an 'ambulatory' room for elective procedures and an AEC for emergency care, which are not co-located. This is duplicating effort and resource and reducing the impact of both services. Ambulatory emergency care should be seen as a philosophy rather than a specific location, and it should provide

services for patients requiring same day emergency treatment and care for those returning on a semi-planned basis for further treatments.

Figure 4: Zero day length of stay percentage on the Maidstone site (2017 average = 39.9%)

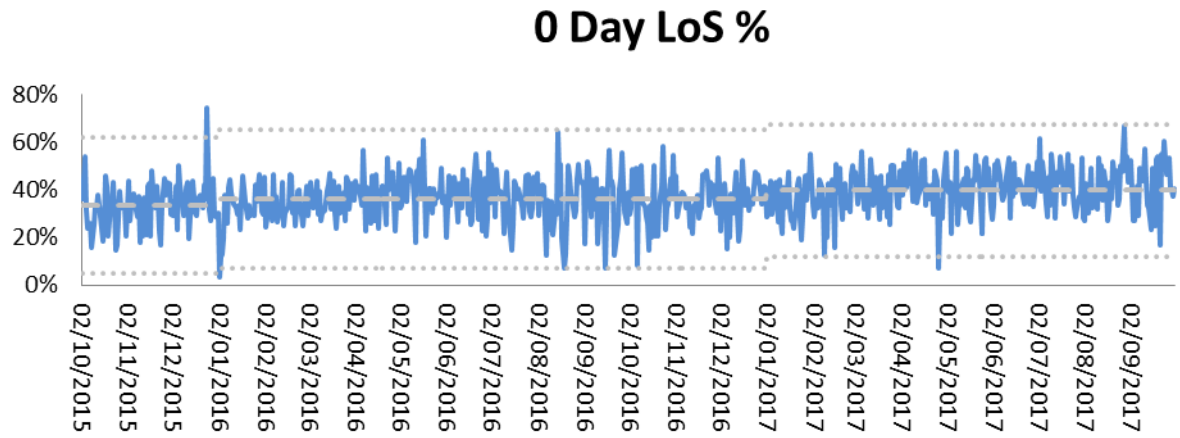
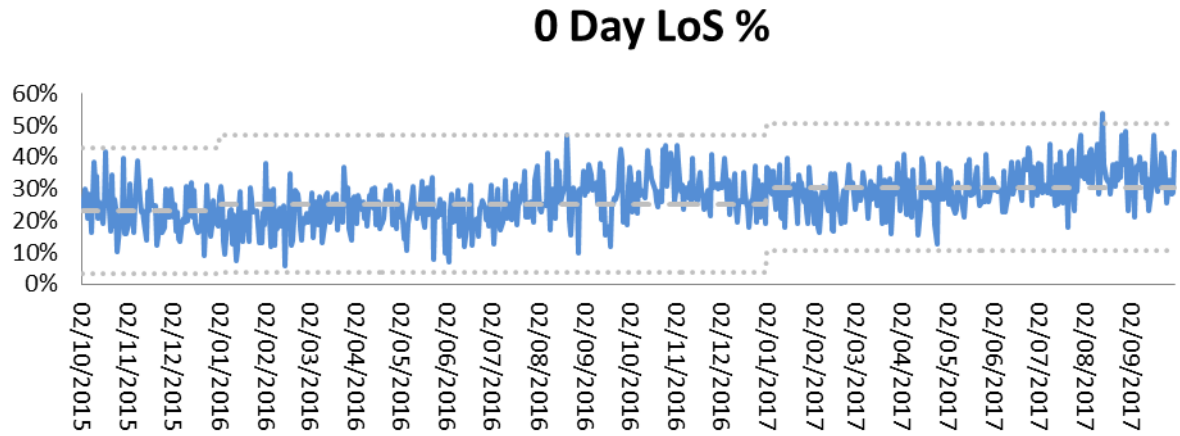


Figure 5: Zero day length of stay percentage on the Tunbridge Wells site (2017 average = 30.6%)



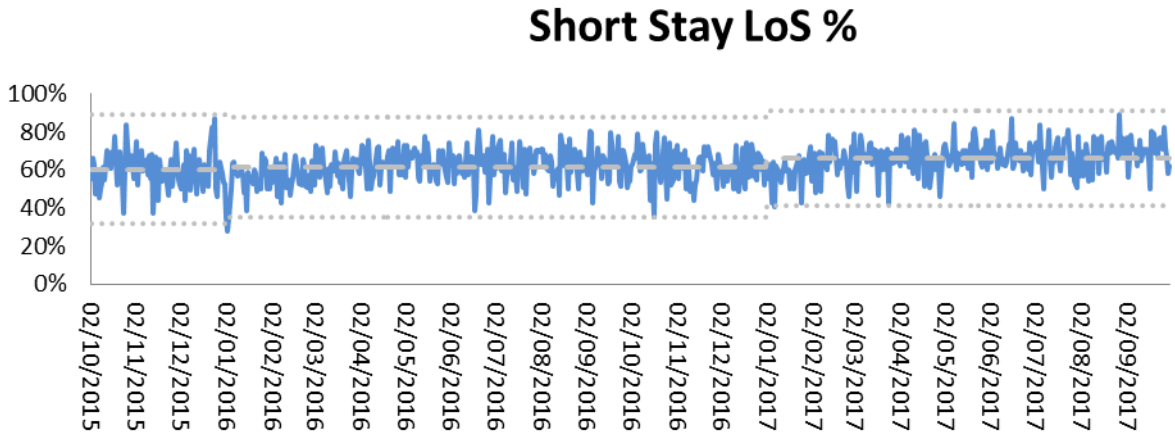
Recommendations

1. We recommend that the Ambulatory Emergency Care service and Acute Medical Unit at the Tunbridge Wells site test different approaches to ensure all clinically stable GP referred patients are able to be accepted directly in to the medical area and not via the ED.
2. We recommend that the trust undertakes an AEC opportunity case note audit at the Tunbridge Wells site. This audit should include members of the AEC and ED teams to review ED attendances and identify themes and opportunities for AEC service development.
3. We recommend that the Tunbridge Wells AEC team continue to run rapid cycle PDSA tests to maximise patient attendance and throughput. This should include testing different approaches to patient identification, including:
    a. Expanding the current selection criteria to that of an exclusion based process to maximise opportunities.
    b. Undertaking regular board rounds in the ED with ED staff to identify and pull appropriate patients.
    c. Having access to the ED ICT system to identify patients.
    d. Allowing automatic referral from the ED for appropriate patients.

7. Acute medical units (AMUs) and other assessment services

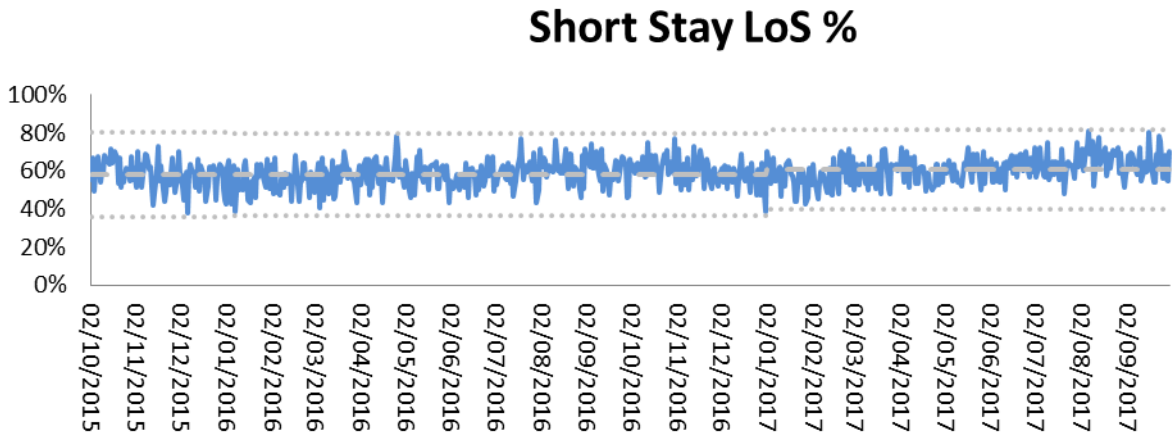
Maidstone

Figure 6: short stay length of stay percentage on the Maidstone site (2017 average = 66.3%)



The percentage of short stay admissions at Maidstone is in line with the national average (see figure 6 above). There are 8 trolley spaces dedicated for patient assessment, including the direct reception of medically expected GP referred patients. Despite this allocation, the area is frequently used for admitted patients resulting in approximately 20 clinically stable GP referred patients being processed through the ED each day. There is good consultant cover, although probably not sustainable, and good support from other physicians on the acute take. Delays occur most commonly when newly admitted patients are admitted directly to inpatient wards requiring the post take ward round to visit many areas. There is strong medical and nursing leadership and good MDT working, although there is little in-reach to the AMU from other acute medical specialties. The unit maintains good flow and a low average length of stay, supported by early start times and quick and effective ward rounds. Improvements could be made in expanding the current use of clinical criteria for discharge and undertaking actions in real time on the ward round (e.g. TTOs).

Figure 7: short stay length of stay percentage on the Tunbridge Wells site (2017 average = 60.7%)



The percentage of short stay admissions on the Tunbridge Wells site is in lower than the national average, and 5.6% lower than the Maidstone site (see figure 6 above). The AMU at Tunbridge Wells is not currently functioning as an AMU. Medical cover is provided predominantly during weekday core

hours, with the juniors starting around 09.30 which is late for an AMU. The model and medical approach adopted is more aligned to a traditional medical ward than an assessment and short stay unit. Staff reported good MDT involvement and the involvement of physician assistants is a good development which has helped the unit deliver its objectives.

The surgical assessment unit (SAU) had similar challenges. The original set up in September 2016 was based on sound principles and good clinical practice, including nurse led triage, a waiting room, assessment trollies and short stay beds. The washing and toileting facilities are sufficient for a short stay and assessment unit but not for long staying patients. We found little evidence of senior clinical input or leadership on the ward. This was compounded by a traditional model of assessment (nurse then junior doctor then registrar and then consultant) which is duplicating effort, wasting resources and slowing patient flow. The frequency and duration of medical outliers on the SAU is a key driver of a lessened function, for example, on the day of the review one medical patient had been on the ward for 3 weeks.

Recommendations

1. We recommend that high volume surgical specialties (e.g. Orthopaedics, general surgery) test different approaches to ensure all clinically stable GP referred patients are able to be accepted directly in to the specialty assessment area (SAU) and not via the ED.
2. We recommend that the trust, with the clinical support of ECIP, review the medical model and flow through the AMU at Tunbridge Wells. An objective should be to deliver seven day consultant input.
3. We recommend that the AMU on the Tunbridge unit tests an early morning board round, with MDT huddles planned around midday and mid-afternoon to drive actions and flow through the unit.

8. Specialties

We heard that some processes are notorious for their delay; for example, we were told that it is common to wait a week for an inpatient echocardiogram. The delays and lack of confidence on flow critical actions happening at the planned time (e.g. transport arriving, TTO's being completed etc.) have resulted in staff not willing to proactively pull patients to the ward early in the day. Although the delays highlighted were outside of the ward's control, we were also told that the batching of medical processes after ward rounds (e.g. writing electronic discharge notices or TTOs) caused avoidable delays.

We saw little evidence of simple rules being used to standardise ward processes to minimize variation (e.g. ward / board round checklists, the SAFER patient flow bundle or Red2Green days). Consequently, there is non-value adding variation between wards in the delivery of key processes such as board and ward rounds (including start times, attendance and outcomes), the use of clinical criteria for discharge and escalation of issues. Equally, there is non-value adding variation in the delivery of senior medical input to and leadership of the wards. Staff told us that the key block to daily senior review was consultant vacancies, particularly in relation to weekend consultant cover, although this is clearly an objective.

Many staff were complimentary about the discharge lounge on the Maidstone site, but stated that flow and use would be improved if they were able to stay open later. Staff were less sure of the impact and helpfulness of the Tunbridge Wells discharge lounge. This seems to be made worse by a more difficult and less responsive process to discharge patients home with transport.

The Tunbridge Wells site has relatively unique challenges with the volume of single patient rooms. One element which was flagged to us was the delay in cleaning rooms and the impact this had on patient flow, with some wards flagging that it could take a considerable time from one patient leaving the room to the room being available to accept the next patient. Furthermore, there is considerable delay in timely discharge for patients requiring hospital transport with an inefficient partial booking system. This challenge, in particular is already recognised by the trust's executive team.

Recommendations

1. We recommend that the Trust rolls out a process to identify constraints to patient flow, supported by effective governance arrangements to act on and remove the constraints at ward, trust and system level.
2. We recommend that the Trust implements the SAFER patient flow bundle across all inpatient wards (excluding maternity and paediatrics) to improve flow. As part of this, we recommend that the trust uses 'know how you're doing' boards in all ward and assessment areas to ensure visibility of key performance metrics

9. Frailty

There is an acute frailty service on the Maidstone site which provides good care and manages the expectations of patients and their carers to a high standard. We were told that the frailty team pull 5-6 patients out of the ED each day and use a well structured twice daily board round to drive flow. During our visit, we observed an excellent culture of a flat hierarchy, full MDT engagement open to challenge from peers and a strong focus on getting frail older patients home as the standard destination. The frailty team are currently using the Bournemouth criteria which is not the nationally recommended criteria. The suggested criteria is the Rockwood clinical frailty scale. The unit is open core hours on weekdays so a proportion of frail older patients will not be receiving this excellent level of care. The unit currently does not have a direct line to accept calls or referrals from community based health care professionals.

There is currently no acute frailty service at the Tunbridge Wells site which is a key opportunity. We were told of the plans to create space on ward 2 to create an acute frailty service later in the year, however, there is work that needs to be done prior to the infrastructure works to build and develop the culture and processes. At the moment there is no in-reach from the older persons team to the ED or AMU due to the workload elsewhere (i.e. clinics, managing the fractured neck of femur patients). This means that frail older patients are being admitted, some unnecessarily, and not receiving the input from the right specialty in an appropriate time. This is likely to result in avoidable deconditioning and a system driven increase in care needs, morbidity and potentially mortality.

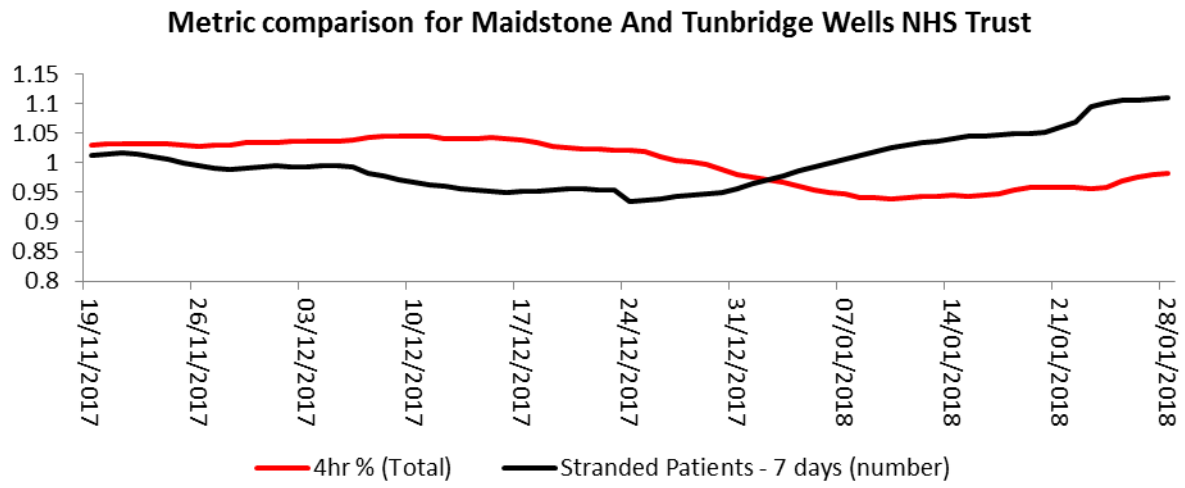
Recommendations

1. We recommend that an acute frailty service is established at the Tunbridge Wells site, drawing on the good practice and processes embedded on the Maidstone site. This new service should be integrated with the various admission avoidance teams, services and pathways.
2. We recommend that an emergency admission audit (6As) of older patients is undertaken to understand the current gaps in service and to identify themes and opportunities for the design of the new acute frailty service.
3. We recommend that the use of the Rockwood Clinical Frailty Scale is standardised across the sites, as per national guidance. This will align the work of the trust to primary care and the ambulance service.

4. We recommend that the frailty team in Maidstone run some small PDSA tests of holding a direct access phone for community health professionals (e.g. GPs, ambulance service) to avoid ED attendances (either by deflection or accepting direct admissions).
5. Given the consultant vacancies, we recommend that that the non-inpatient workload (i.e. clinics) at the Tunbridge Wells site is reviewed to assess if there is any scope to convert outpatient work to inpatient acute frailty care.

10. Admission, discharge and transfer

Figure 8: A comparison of the four hour standard performance against the number of stranded patients in the hospital. This shows a relationship of an increasing number of stranded patients to a decreasing four hour standard performance (note: on the vertical axis, 1 equals the average over the period)



We heard mixed stories about the local homefirst process. Staff were unable to clearly articulate what the system vision and principles are for the homefirst service but many nursing staff found the service invaluable and supportive. Conversely, the key medical staff we spoke to were concerned that they weren't seeing relevant outcome metrics for their patients (i.e. long term care needs, readmission rates etc.). The systems and capacity are not yet in place for therapy assessments to be undertaken in the community and we heard that the system is still operating an assess to discharge service. In practice, this means that assessments are still undertaken in the acute setting which could be performed in the community after discharge. Undertaking these assessments in the home environment as soon as the patient is medically safe for discharge has been shown to provide more accurate assessments, lower placements to care homes and lower long term health and social care needs. The system is still some distance from being able to discharge patients when they no longer benefit from acute hospital care, however, it is worth noting that, as a system, you are closer to a full discharge to assess model than many other ECIP systems.

We were told that the front door therapy and admission avoidance teams operate effectively, but there is duplication of work and overlap of roles which is an inefficient use of capacity. The front door therapy team have capacity to see only those patients whose admission can be immediately avoided (i.e. excluding any medically unwell patients). This is a missed opportunity for early identification of pre-admission function, setting of functional goals and discharge plans for patients needing a short inpatient stay. Although the TADs service and HIT team are professionally integrated, there is still a degree of silo working and duplication between the two teams. We were told that inpatient therapy teams are not integrated yet and cross cover is not consistently provided. An impact of this is that

some basic assessments remain aligned to professions which is slowing flow on the wards. We heard on almost all wards that availability of therapists is a key constraint to flow. The staffing establishment appeared to be low, however, as the teams and processes are not integrated, capacity could possibly be released by improving working processes in addition to assessing recruitment need.

The current discharge process is sequential in manner (e.g. certain processes are only 'allowed' to start (by rules or capacity) once the patient is medically fit for discharge) rather than processes starting early and running in parallel. The system has taken a positive step in testing trusted assessments on a small scale to improve this. There is considerable scope for improvement and impact in this area, particularly in relation to the homefirst model.

Recommendations

1. We recommend that a full assessment of your homefirst service is undertaken, including a demand and capacity analysis, to understand strengths and opportunities to deliver a full discharge to assess service.
2. We recommend that a length of stay review and a multi-agency discharge event (MADE) is undertaken at the Tunbridge Wells site. This will help understand the operational opportunities in moving toward a full discharge to assess model and help unblock the site.
3. We recommend testing front loaded therapy and community assessments (i.e. increasing input to the emergency department and assessment units) to reduce work later in the journey and speed up discharge processes.
4. We recommend testing more simple therapy and discharge paperwork, started in the emergency department or assessment unit, which flows with the patient during their journey through the hospital

Conclusion

The focus of this review was to undertake a gap analysis of the current processes and practices at the Maidstone and Tunbridge Wells hospitals against the recommendations in the patient flow guidance (referenced earlier). We have set out above the key observations from our visit and review of your services.

We hope that this report contains practical advice and guidance to help support the trust to improve both performance and patient experience and care along its urgent and emergency care pathways.

We would be happy to clarify or expand on any of the recommendations detailed within this report.

Appendix 1: Summary of recommendations

Key recommendations	• We recommend that an acute frailty service is established at the Tunbridge Wells site, drawing on the good practice and processes embedded on the Maidstone site. This new service should be integrated with the various admission avoidance teams, services and pathways. • We recommend that the Tunbridge Wells AEC team continue to run rapid cycle PDSA tests to maximise patient attendance and throughput. This should include testing different approaches to patient identification. • We recommend that a full assessment of your homefirst service is undertaken, including a demand and capacity analysis, to understand strengths and opportunities to deliver a full discharge to assess service. • We recommend that the Trust uses a process to identify constraints to patient flow, supported by effective governance arrangements to act on and remove the constraints at ward, trust and system level. • We recommend that the Trust implements the SAFER patient flow bundle across all inpatient wards (excluding maternity and paediatrics) to improve flow.
Mental health	• We recommend that ECIP support a system wide assessment against good practice in the management of mental health patients.
Ambulance handovers	• We recommend that the Trust and South East Coast Ambulance service rapidly test processes to convey patients directly to other areas in the ED (e.g. minors, GP assessment, ambulatory emergency care) to reduce avoidable pressure on the RAP service. • We recommend that an emergency conveyance audit is undertaken (based on the 6As methodology) at the Tunbridge Wells site to assess the potential for non-conveyance or alternative conveyance routes.
Primary care streaming	• We recommend that the trust tests clear criteria to maximise patient streaming to primary care services and the OOH provider. There should not be restrictions put on the volume of referrals. •
Emergency department	• We recommend that the Tunbridge Wells site rapidly tests different models to increase the availability of 'red chairs'. This could be delivered by converting two cubicles, one for assessment and one for seating, as the total cubicle capacity in the Tunbridge Wells site is high compared to the attendances. • We recommend that an emergency admission (6As) audit is undertaken at the Tunbridge Wells site to understand scope for alternative pathways to admission. •
Ambulatory emergency care	• We recommend that the Ambulatory Emergency Care service and Acute Medical Unit at the Tunbridge Wells site test different approaches to ensure all clinically stable GP referred patients are able to be accepted directly in to the medical area and not via the ED. • We recommend that the trust undertakes an AEC opportunity case note audit at the Tunbridge Wells site. This audit should include members of the AEC and ED teams to review ED attendances and identify themes and opportunities for AEC service development. • We recommend that the Tunbridge Wells AEC team continue to run rapid cycle PDSA tests to maximise patient attendance and throughput. This should include testing different approaches to patient identification,

	including: • Expanding the current selection criteria to that of an exclusion based process to maximise opportunities. • Undertaking regular board rounds in the ED with ED staff to identify and pull appropriate patients. • Having access to the ED ICT system to identify patients. • Allowing automatic referral from the ED for appropriate patients.
Clinical decision units	• We recommend reviewing the medical oversight of the CDUs to ensure that patients are admitted to the unit with appropriate plans and results are acted upon as soon as they are available. Best practice states that CDUs should be supervised and led by a named consultant (where practical). • We recommend that the Ambulatory Emergency Care team and the ED team at the Tunbridge Wells site review current criteria and use of the CDU. This should ensure that the CDU criteria is balanced and co-ordinated with that of the AEC to avoid unnecessary duplication, ensure there is appropriate capacity where needed and that flow processes are not cumbersome.
Acute medical units and other assessment services	• We recommend that high volume surgical specialties (e.g. Orthopaedics, general surgery) test different approaches to ensure all clinically stable GP referred patients are able to be accepted directly in to the specialty assessment area (SAU) and not via the ED. • We recommend that the trust, with the clinical support of ECIP, review the medical model and flow through the AMU at Tunbridge Wells. An objective should be to deliver seven day consultant input. • We recommend that the AMU on the Tunbridge unit tests an early morning board round, with MDT huddles planned around midday and mid-afternoon to drive actions and flow through the unit.
Specialties	• We recommend that the Trust rolls out a process to identify constraints to patient flow, supported by effective governance arrangements to act on and remove the constraints at ward, trust and system level. • We recommend that the Trust implements the SAFER patient flow bundle across all inpatient wards (excluding maternity and paediatrics) to improve flow. As part of this, we recommend that the trust uses 'know how you're doing' boards in all ward and assessment areas to ensure visibility of key performance metrics
Frailty	• We recommend that an acute frailty service is established at the Tunbridge Wells site, drawing on the good practice and processes embedded on the Maidstone site. This new service should be integrated with the various admission avoidance teams, services and pathways. • We recommend that an emergency admission audit (6As) of older patients is undertaken to understand the current gaps in service and to identify themes and opportunities for the design of the new acute frailty service. • We recommend that the use of the Rockwood Clinical Frailty Scale is standardised across the sites, as per national guidance. This will align the work of the trust to primary care and the ambulance service. • We recommend that the frailty team in Maidstone run some small PDSA tests of holding a direct access phone for community health professionals (e.g. GPs, ambulance service) to avoid ED attendances (either by deflection or accepting direct admissions). • Given the consultant vacancies, we recommend that that the non-

	inpatient workload (i.e. clinics) at the Tunbridge Wells site is reviewed to assess if there is any scope to convert outpatient work to inpatient acute frailty care.
Admission, discharge and transfer	• We recommend that a full assessment of your homefirst service is undertaken, including a demand and capacity analysis, to understand strengths and opportunities to deliver a full discharge to assess service. • We recommend that a length of stay review and a multi-agency discharge event (MADE) is undertaken at the Tunbridge Wells site. This will help understand the operational opportunities in moving toward a full discharge to assess model and help unblock the site. • We recommend testing front loaded therapy and community assessments (i.e. increasing input to the emergency department and assessment units) to reduce work later in the journey and speed up discharge processes. • We recommend testing more simple therapy and discharge paperwork, started in the emergency department or assessment unit, which flows with the patient during their journey through the hospital

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-12 The approach to managing patients experiencing a long waiting time: interim report on recovery plan — Chief Operating Officer

Background

In March 2016, NHS England published their report 'External Clinical Review Handbook' which sets out the processes to be followed by Trusts to review 18 week Referral to Treatment (RTT) pathways (see Appendix 1). These reviews aim to provide assurance to patients, patient groups, commissioners and the public 'as to whether any patients have been harmed as a result of incidents *(delays),* as well as to avoid future harm to patients.' MTW is in the process of undertaking such a review and the time line is outlined below.

The table below outlines the timeline and actions being put into place during Q4 2017/18. The findings from this review and subsequent actions will be presented to the Quality Committee.

Action	By When	Progress
A list of patients treated (admitted and non-admitted RTT) in October to be provided by Information team.	November 2017	Completed
Clinical Audit will request case notes in batches over this 2 month review period, numbers ordered at each request will to take account of the workload on medical records and storage of case notes within the specialty offices.	January 2018	Completed
Case note review will be carried out by individual consultants over a 2 month period to assess level of risk of harm. As part of this, reviewing consultants will be provided with information on the episode of care to be assessed.	February and March 2018	In progress
A draft report will be made available to Medical Director, Head of Delivery Development and Director of Operations (Planned Care) for review and action planning.	May 2018	

Alongside this review, work will continue in all specialities within the Trust to ensure waiting times and RTT backlogs are reduced to improve overall performance taking into account the recent request from NHS England to reduce non-urgent elective activity in January to respond to winter pressures. In addition further refinement of the validation of waiting lists will continue in light of the new PAS system introduced in Q3 of 2017/18.

Which Committees have reviewed the information prior to Board submission?
-

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

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-14	Staffing (planned and actual ward staffing for January 2018; and 6-monthly review of Ward and non-Ward areas)	Chief Nurse

1. Planned and actual ward staffing for January 2018

Below and enclosed (Appendix A) are details of the planned v actual nursing staffing as uploaded to UNIFY for January 2018. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Wards of note this month include:

Cornwallis: low CSW fill rate. This was due, in part, to an inability to fill from Bank. However support from other wards (either RN or CSW) provided. Falls have increased this month with 8 compared to 2 last month (threshold of 3).

John Day: RN:CSW ratio shift. An accepted risk to ensure sufficient staff available to provide fundamental aspects of care. No change in nurse sensitive indicators noted in month.

Chaucer: High fill rate due to escalation of frailty assessment unit overnight. Falls are 3 above threshold.

Maidstone UMAU: Escalated overnight, falls reduced this month, with 4 compared to 6 last month (threshold of 4).

Ward 22/ASU: Low RN fill rate, due to an inability to fill from Bank/Agency. Falls rate has improved with 9 compared to 16 last month (threshold 7).

MAU (TW): Escalated at night. Falls improved this month with 6 incidents compared to 15 last month.

Ward 10: 15 nights of enhanced care requirements to cover a cohort of patients ranging between 1 and 3 patients.

Whatman: Falls rate significantly improved this month with 3 compared to 20 last month (threshold 6)

Ward 20: RN shifts unfilled due to inability to fill from Bank/Agency. Falls rate increased this month with 9 compared to 6 last month (threshold 7)

Overall RAG ratings (as detail later in this report) are based on quality indicators (namely incidence of falls and pressure injury in month) and professional judgement. Consideration is being given to refine this approach with a more objective framework. Progress on the reintroduction of the Quality, Effectiveness & Safety Trigger Tool (QuEST), as referred to last month, is on track. The core templates are now available and discussions will be had with the Ward Managers and Matrons over the next couple of weeks, with the intention of having the first round of data by the end of March.

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 latest update on the NHSI database at November indicated a national average range of 7.5 – 8.5.
The overall CHPPD for Maidstone is 7.4, and for Tunbridge Wells it is 8.4; giving an overall for the Trust of 8.

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

	Moderate Impact: 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

2. 6-monthly review of Ward and non-Ward areas)

The attached documents (Appendices B and C) provide information on the ward staffing establishment review undertaken in November 2017. The review was undertaken in line with National Quality Board guidelines and NICE recommendations.

The reviews were undertaken by the Deputy Chief Nurse, and included the relevant Ward Manager, Matron, Finance Manager and Associate Director of Nursing. Carter Model Hospital data including Care Hours Per Patient Day were considered along with nurse sensitive indicators, FFT results and professional judgement.

The table in Appendix B details the ward budgeted establishment, number in post, vacancy, nurse sensitive indicators and commentary on individual ward establishments. Appendix C provides some further context and detail in relation to the methodology of the review.

A number of changes have been recommended which have been included in the relevant directorate business plans. The key changes are:

- Medical Wards (Chaucer, Whatman, 21)
- Increase of 1wte Band 6 per ward by decreasing Band 5 by 1.5wte
- Whatman - increase CSW included in business planning brought to review meeting for professional oversight.
- CCU: increase of 3wte Band 5 to meet increased capacity demand, as part of business planning cycle
- Future/planned changes
- Cornwallis (Surgical) on Foster Clarke; establishment agreed as part of decant/refurbishment plan. Move had not been completed at time of review.
- Ward 2; Frailty Unit being developed. Skill mix & establishment being considered as part of approval & implementation plan.

The key risks remain overall vacancy and the challenges in recruiting experienced registered nurses. The wards are able to provide safe care when staffing levels are at agreed levels.

Which Committees have reviewed the information prior to Board submission?
-

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

Appendix A

January '18		Day		Night			Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	97.4%	87.9%	97.6%	95.2%	7.1	47.4%	100.0%	3	0			141,716	132,329	(9,387)
MAIDSTONE	Cornwallis (on Foster)	100.8%	88.7%	99.2%	88.7%	6.6	62.5%	97.5%	8	0	↓	Falls above threshold of 3 in month.	119,539	72,057	(47,482)
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	71.0%	98.4%	N/A	9.5	88.9%	100.0%	1	0		CSW x 3 moved to support other areas. Acceptable risk, based on acuity, as unit is colocated on Culpepper.	104,994	106,475	1,481
MAIDSTONE	Culpepper	98.4%	95.2%	100.0%	100.0%	6.4	109.7%	94.1%	1	0					
MAIDSTONE	John Day	85.1%	122.6%	100.6%	100.0%	6.4	65.6%	90.5%	4	1		RN:CSW ratio shift due to unfilled RN shifts.	153,396	127,486	(25,910)
MAIDSTONE	Intensive Treatment Unit (ITU)	90.3%	N/A	90.7%	N/A	35.9	100.0%	100.0%	0	0		10 shifts not required due to reduced acuity and dependency. Staff moved where appropriate.	177,798	174,246	(3,552)
MAIDSTONE	Pye Oliver	94.9%	94.1%	100.0%	94.6%	5.6	26.9%	92.9%	9	0		Falls above threshold of 5 in month.	113,611	100,557	(13,054)
MAIDSTONE	Chaucer	95.4%	112.9%	174.2%	103.2%	6.8	18.3%	97.9%	7	0	↔	Escalated into Frailty Assessment bay throughout month.	128,611	112,063	(16,548)
MAIDSTONE	Lord North	94.8%	85.5%	95.7%	93.5%	7.3	0.0%	0.0%	3	0		CSW x 3 shifts unfilled.	102,977	101,914	(1,063)
MAIDSTONE	Mercer	109.7%	92.7%	95.7%	106.5%	6.1	161.1%	89.7%	5	0		FFT return reflects late submission from previous month.	102,103	101,227	(876)
MAIDSTONE	Edith Cavell	99.1%	107.1%	98.9%	151.6%	6.0	75.0%	91.7%	5	0		Side room pt., requiring enhanced care for 20 nights.	71,897	82,226	10,329
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	92.5%	93.0%	130.1%	183.9%	8.9	14.4%	93.7%	4	0	↑	Escalated throughout month.	127,019	104,359	(22,660)
TWH	Stroke/W22	88.7%	98.7%	98.7%	94.6%	11.4	400.0%	87.5%	9	0	↔	11 bank shifts unfilled. Falls above threashold of 7 in month FFT returns reflect late submissions from previous month.	147,941	163,074	15,133
TWH	Coronary Care Unit (CCU)	95.1%	83.9%	89.2%	N/A	10.5	72.4%	90.5%	3	0		CSW x 6 moved to other wards, 4 unfilled. 5 RN night shifts uncovered and 4 moved to support other areas at night.	72,620	61,501	(11,119)
TWH	Gynaecology/ Ward 33	90.9%	100.0%	98.4%	93.6%	6.4	7.5%	87.5%	1	0			72,484	74,602	2,118
TWH	Intensive Treatment Unit (ITU)	108.9%	96.8%	111.3%	87.1%	13.0	0.0%	-	1	0		Escalated dependency for 18 nights.	198,524	192,154	(6,370)
TWH	Medical Assessment Unit	89.2%	90.3%	115.5%	102.2%	7.1	0.0%	0.0%	6	3	↑	Escalated overnight throughout month. RN fill rate during the day due to unavailability of temporary staff. Priority given to cover at night.	190,067	162,759	(27,308)
TWH	SAU	93.5%	100.0%	100.0%	100.0%	3.7	0.0%	0.0%	2	0			59,808	54,119	(5,689)
TWH	Ward 32	93.5%	100.0%	100.0%	110.5%	6.6	11.6%	100.0%	5	1			132,756	122,788	(9,968)
TWH	Ward 10	90.1%	94.4%	79.8%	156.5%	8.3	45.0%	100.0%	2	0		RN:CSW ratio shift at night due to 15 nights of enhanced care needs.	123,271	112,453	(10,818)
TWH	Ward 11	94.5%	106.5%	95.2%	109.7%	6.6	1.1%	100.0%	4	0			118,304	110,018	(8,286)
TWH	Ward 12	87.0%	104.0%	97.8%	98.4%	6.4	19.7%	100.0%	4	2		23 RN shifts unfilled due to unavailability of temporary staff	122,680	122,915	235
TWH	Ward 20	89.2%	103.2%	96.8%	104.8%	5.6	61.1%	90.9%	9	0	↓	8 RN shifts unfilled due to unavailability of temporary staff. Falls above threshold of 7 in month.	114,240	106,507	(7,733)
TWH	Ward 21	101.6%	109.7%	98.7%	145.2%	6.9	29.5%	100.0%	3	2		11 nights of increased dependency. Additional CSWs utilised to support the delivery of fundamental nursing care.	135,987	133,012	(2,975)
TWH	Ward 2	74.5%	94.8%	92.5%	107.3%	6.0	67.9%	91.7%	17	0	↓	RN fill rate due to unavailability of temporary staffing Falls above threshold of 7 in month.	149,047	124,028	(25,019)
TWH	Ward 30	93.8%	83.9%	100.0%	94.6%	5.9	0.0%	0.0%	5	2		8 CSW shifts unfilled due to unavailability of temporary staffing.	116,957	108,041	(8,916)
TWH	Ward 31	89.8%	89.1%	96.8%	89.2%	6.5	0.0%	0.0%	4	2		shifts unfilled due to unavailability of temporary staffing. Support provided by matron and CNSs. Falls below threshold of 6	134,941	129,736	(5,205)
Crowborough	Birth Centre	87.1%	77.4%	90.3%	96.8%				0	0		Low fill rate covered by on-call and community midwives.	75,119	85,997	10,878
TWH	Ante-Natal	93.5%	100.0%	96.8%	83.9%	7.8	28.0%	94.8%	0	0		RM fill rate on delivery suite due to unavailability of staff. Maternity unit functions as a 'floor', with midwives following women through pathway of care. All women in established labour received 1:1 midwifery care.	657,308	615,173	(42,135)
TWH	Delivery Suite	96.1%	93.5%	88.5%	80.6%	10.5			0	0					
TWH	Post-Natal	97.3%	90.3%	93.5%	69.9%	5.9			0	0					
TWH	Gynae Triage	95.2%	96.8%	98.4%	80.6%				0	0			11,771	11,974	203
TWH	Hedgehog	106.5%	48.4%	109.0%	132.3%	8.1	32.7%	96.9%	0	0		Reduced unregistered fill rate during the day an accepted risk to ensure cover for additional capacity at night. 8 x 24/7 RMN cover required.	182,949	185,654	2,705
MAIDSTONE	Birth Centre	100.0%	93.5%	100.0%	100.0%				0	0			66,109	63,527	(2,582)
TWH	Neonatal Unit	104.3%	106.5%	102.7%	90.3%	14.4			0	0			169,958	167,377	(2,581)
MAIDSTONE	MSSU	110.8%	81.3%	118.2%	N/A		17.6%	99.3%	3	0		Escalation beds open on 3 nights.	48,108	40,769	(7,339)
MAIDSTONE	Peale	114.0%	77.1%	101.6%	96.8%	7.5	7.7%	100.0%	0	0			70,440	70,239	(201)
TWH	SSSU	100.0%	100.0%	100.0%	100.0%				4	0			209,942	66,724	(143,218)
MAIDSTONE	Whatman	91.3%	98.2%	100.0%	101.6%	5.3	85.7%	75.0%	3	3	↑	Falls rate improved.	96,373	90,070	(6,303)
MAIDSTONE	A&E	113.7%	90.3%	109.2%	100.0%		5.1%	92.3%	1	0		Additional RNs to support increased attendance/demand.	223,950	205,143	(18,807)
TWH	A&E	101.6%	93.5%	104.2%	98.4%		17.5%	90.7%	4	0			361,979	311,866	(50,113)
												Total Establishment Wards	**5,407,293**	**4,907,159**	**(500,134)**
												Additional Capacity beds	40,900	39,307	(1,593)
												Other associated nursing costs	1,907,386	3,056,561	-145,721
												Total	7,355,579	8,003,027	(647,448)

RAG Key
Under fill
Over fill

Jan/Feb 2018 Review undertaken Nov/Dec 2017, using Q3 data

Appendix B

Staffing Review by ward						Ratios		Nurse Sensitive Indicators (Q3)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	Ward Manager s'visory days/wk (in budget)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
Maidstone	AMU	48.41	46.59	1.82	4	70/30	1;4	0	15	0	1	18%/95%	Vacancy in CSW cohort. RN cohort over establishment by 1, due maternity leave cover. Falls limit set at 4 per month, 3 over for Q3 however has been consistently at or below limit in preceding two quarters. Shift in banding for CSWs, within budget. Considered role of Nursing Associate going forward (potentially from within Band 5 est)	No change to budgeted establishment
	Chaucer	28.11	26.3	1.8	5	60/40	1:6, 1:6, 1:7	1	13	1	0	26%/93%	RN to Pt ratio reflects need for rapid turn-over. This covers 14 in-patient beds, 11 assessment beds and treatment suite of 6 chairs/trollies. In-patient ratio would be 1:7, with Assessment beds at 1:6. Vacancy is based on budget. However there is an increase in both Band 6s and Band 2/3. RN vacancy would be 6.5wte within the Band 5 cohort.	No change to establishment Shift within Band 6 cohort achieved within budget.
	Culpepper/CCU	33.55	28.44	5.11	4	70/30	1:6 Culp, 1:3 CCU	0	2	1	0	80%/90%	RN:CSW ratio reflects CCU dependency. CCU and med combined (6 CCU beds, 13 medical. No changes in establishment previously. Establishment consistent with case mix unless escalation into Cath Lab recovery.	No change to budgeted establishment
	Cornwallis (on Foster Clark from Dec'17) data for 19 beds	23.84	22.92	0.86	3	65/35	1;6	0	5	0	3 (from earlier in year; none this Qtr)	50%/91%	Establishment safe for 19 beds. WM supervisory time reduced compared to peers based on smaller number of beds. Budgeted establishment for 28 beds during relocation to Foster Clark acceptable. Risk is related to recruitment and reliance on temporary staffing.	No change to establishment increase from 19 to 28 beds approved as part of the relocation plan.
	Cornwallis on F/C @ 28 beds	38.27	22.92	15.35	3	60/40	1;7	Data not available at time of review						
	Edith Cavell	25.32	20.52	4.8	4	60/40	1;7	4	14	1	0	80%/70%	Staff satisfactory when at establishment. Potential need for increased therapy support for ortho rehab.	No change to budgeted establishment
	John Day	43.33	32.63	10.7	4	70/30	1:5, 1:5, 1:6	2	11	12	2	85%/88%	The ward had a reduction in RNs in 2016 at night, there has been an increase in medication errors at night. This may be due to work done around more robust reporting of incidents. The ward is piloting a CSW to work as a 'flow coordinator' - to reduce the time spent by the WM dealing with day to day general queries. This is allowing the WM to focus on other safety & quality issues. There has been a sustained improvement in the number of falls since the last review in May 2017.	No change to budgeted establishment
	Lord North	30.59	27.68	2.91	3	80/20	1:4, 1:4, 1:6	0	5	2	0	30%/100%	High ratio of RNs to cover chemo regimes, and ward attenders. RN:CSW ratio reflects chemo requirements. Team cover KOC triage bleep and provide outreach to ICU etc. to cover chemo administration	No change to budgeted establishment
	Mercer	36.54	32.22	4.32	4	55/45	1:6, 1:6, 1:8	3	21	1	1	50%/95%	Falls limit for quarter is 18. Increased incidence in Nov., cause identified and rectified. At or below threshold generally. Ward has a stable workforce. RN:CSW ratio acceptable for specialty.	No change to budgeted establishment
	MSSU	14.9	12.43	2.47	1	70/30	1:6, 1:6, 1:9	0	0	0	1	20%/94%	Increased activity noted, particularly in relation to additional surgical capacity to allow wider use of in-patient surgical beds. Need to consider a Band 2 'twilight' shift to support late discharges as part of directorate business planning process.	No change to budgeted establishment
	Peale	16.64	18.02	0	3	80/20	1:4. 1:4, 1:6	1	2	0	0	38%/95%	Ward over-established on Band 5s following review in October'16. This is partly off-set by holding vacancy in Band 2 est. Support provided to other wards when required. High RN:Pt ratio reflects high proportion of single rooms.	No change to budgeted establishment
	Pye Oliver	38.07	29.31	8.76	4	50/50	1:7, 1:7, 1:9	4	24	1	1	40%/95%	RN:CSW ratio reflects the client group (gastro) who need help with basic care needs and risk of wandering. Recent turnover in Band 5s has impacted on some quality indicators.	No change to budgeted establishment
	Stroke	37.78	23.6	14.18	4	65/35	1:5, 1:5, 1:7	1	10	1	1	30%/100%	RN:PT ratio assumes Thrombolysis nurse in numbers. When this role is off the ward ratios increase to 1:6 and 1:9. Uplift in CSW by introduction of long days supported.	No change to budgeted establishment
	Whatman	31.7	22.7	9	5	50/50	1:9, 1:9. 1:9	4	31	3	1	90%/84%	MFFD ward. WM supervisory time reflects review of all MFFD patients on site, and covering complex discharge meetings. Falls reflect one peak in Q3. Additional CSW in place as part of directorate business planning - approach supported. Band 6 being increased by conversion of 1.5wte band 5.	Change to CSW & Band 6 cohort supported. Budget review as part of directorate business planning.
Tunbridge Wells	AMU	53.08	45.38	7.7	3	70/30	1;4	0	37	2	2	50%/91%	Staff satisfactory when at establishment. Falls above threshold this quarter, however now returning to at or below threshold. Unit works well when ambulatory care beds are not escalated to.	No change to budgeted establishment
	CCU	20.84	11.7	9.14	2	70/30	1;3	0	3	0	0	90%/90%	Established for 5 beds plus 3 recovery rooms. Escalated consistently. Considering increase of Band 5 cohort by 3wte to ensure nurse to patient ratios remain safe for higher dependency cardiac patients. This is being considered as part of the directorate business planning.	Change to Band 5 establishment supported as part of directorate review.
	SAU	20.73	19.08	1.65	3	70/30	1:4, 1:4, 1:4	1	1	1	1	0	Capacity is 9 bed + 3 assessment bays. Takes GP and A&E referrals. Covers surgical assessment clinic.	No change to budgeted establishment
	SSSU	25.5	15.5	10	3	60/40	1:6, 1:6, 1:12	0	10	1	2	0	RN:Pt ratio based on 24 patients. Unit is frequently escalated including to recovery. . Good medical consultant & physio cover for medical outliers. No support for catering, this has been resoled for the winter.	No change to budgeted establishment
	2	44.07	35.07	9	4	45/55	1:8, 1:8, 1:10	2	17	1	3	70%/80%	RN:CSW ratio is outside of accepted practice. A number of changes have been made since last review. The ward establishment is currently under review with a view to establish a Frailty Unit. This will be reviewed as part of the QIA process.	No change currently, as plans in progress to establish Frailty Unit.
	10	40.17	31.97	8.2	4	65/35	1:5, 1:7, 1:7	0	7	0	1	23%/93%	Ward takes all traumatic head injury so need for enhanced care at night is high.	No change to budgeted establishment
	11	39.56	33.56	6	4	65/35	1:5, 1:6, 1:7	0	11	1	1	26%/96%	Safe if at establishment. Ward has been running above establishment so recommendation to return to previous agreed levels as not change in quality indicators noted. No case for increase currently.	No change to budgeted establishment
	12	42.92	31.5	11.42	4	60/40	1:6, 1:6, 1:10	1	26	0	0	16%/92%	Falls have been subject to intensive review with no specific nursing trends identified. Plan to convert 1.5wte Band 5 to 6.	No change to budgeted establishment
	20	32.64	25.64	7	5	50/50	1:10, 1:10, 1:10	0	36	1	5	66%/88%	RN/PT ratio reflect MFFD case mix. However initiatives such as 'Home First' have impacted on number of 'suitable' patients for ward. 2/3rd of patients have dementia. Dementia Key Worker in establishment (additional to staffing m-f). Discharge coordinator specific to ward. Therapy support minimal, recommend directorate consider how a therapy role might be incorporated into ward establishment.	No change to budgeted establishment. Review at end of Q4.
	21	43.28	34.28	9	4	70/30	1:5, 1:6, 1:6	4	16	0	1	50%/95%	Increase in need for NIV support. Therefore considering increasing Band 6 by 2wte from existing Band 5 vacancy (9wte band 5 vacant: 1.5wte = 1wte Band 6).	No change to budgeted establishment
	22	52.58	38.08	14.5	4	60/40	1:5, 1:5, 1:6	0	29	0	4 (KSAF)	90%/93%	Staffing satisfactory if at establishment. Challenge of supporting stroke assessor bleep.	No change to budgeted establishment
	30	38.92	26.23	12.69	5	60/40	1:5, 1:7, 1:7	3	33	3	2	5%/80%	WM supervisory for 5 days to manage elective flow. No ward clerk for 2 days per week. Complaints identifying a trend for call bell response at night. Directorate exploring potential to increase CSW at night.	No change to budgeted establishment
	31	46.5	30.7	15.8	5	60/40	1:5, 1:7, 1:7	5	18	2	0	5%/100%	Vacancy is main risk. Established numbers would/do keep ward safe. New PDN appointed to support new starters and aid retention	No change to budgeted establishment
	32	43.22	32.4	10.82	3	60/40	1:5, 1:5, 1:9	3	18	1	1	36%/30%	staffing satisfactory when at establishment.	No change to budgeted establishment
	33	22.8	18.11	4.69	3	70/30	1:7, 1:7, 1:7	0	2	0	0	33%/98%	Ratios for RN:Pt reflect 14 in-patient beds. Establishment also covers EGAU which includes recover of miscarriage pts - average 2 per day.	No change to budgeted establishment

Maidstone and Tunbridge Wells NHS Trust

Nursing Establishment Review

Review of ward based nursing establishment

February 2018

NHS
Maidstone and Tunbridge Wells NHS Trust

Overview

- Ward establishments reviewed inline with National Quality Board Guidance (2016), NICE guidance (2017), Shelford Acuity & Dependency model and Professional Judgement (Telford) model, Carter Model Hospital (CHPPD).
- Inpatient areas.
- No significant changes to establishments recommended.
- Minor changes, primarily in medicine – increase in band 6 (average 1) funded from existing Band 5 monies (1wte band 6 = to 1.5wte band 5).
- Changes within establishment generally volunteered by Ward Manager & Matron.
- Finance engaged with process, so changes included within business planning
- No financial impact for Board to approve that has not already been included in business planning
- Data set reflect position as at December 2017.
- Vacancy total (bands 2 – 7) 219 wte
- Vacancy factor 21%

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Methodology

- Methodology used inline with NQB and NICE guidance.
- Triangulation of nurse sensitive indicators (pressure injury, falls, medication administration errors, nursing care complaints and FFT results)
- Review period November/December 2017
- Quarter 3 data used during and post-meeting analysis
- Consideration given to acuity & dependency (Shelford Acuity Tool/Safer Nursing Care Tool (SNCT).
- Consideration given to geography of ward and relationship with co-dependent departments (eg: surgical ward in relation to theatres).
- Discussion/review meetings included Ward Manager, Matron, Finance Manager, Associate Director of Nursing, Deputy Director of Nursing

Guiding Principles

- Ratios: RN:CSW = 65/35, RN:Pt 1:5 – 1:8
- Supervisory time 4 days (7.5hrs shift)
- Ward Clerk – not included in nursing numbers
- Headroom allowance 21% (to cover mandatory training, annual leave and sickness)

Carter Model Hospital comparisons

NHSI Model Hospital Data: Nursing, November 2017 (latest available update; accessed 20/02/18).

- Care Hours Per Patient Day:
  - National Median: 7.5 – 8
  - MTW 8
- Safety Thermometer:
  - National Median: 94.5% harm free
  - MTW 96%
- Weight Activity Unit (cost for average inpatient episode)
  - MTW in Quartile 1 (lower cost per episode)

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Key Changes (detail of review in attached table: Appendix A)

- Skill mix changes within budget:

  Medical Wards (Chaucer, Whatman, 21)

  - Increase of 1wte Band 6 per ward by decreasing Band 5 by 1.5wte
  - Whatman - increase CSW included in business planning, brought to review meeting for professional oversight.
  - CCU: increase of 3wte Band 5 to meet increased capacity demand, as part of business planning cycle
- Future/planned changes
  - Cornwallis (Surgical) on Foster Clarke; establishment agreed as part of decant/refurbishment plan. Move had not been completed at time of review.
  - Ward 2; Frailty Unit being developed. Skill mix & establishment being considered as part of approval & implementation plan.

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Recruitment & Retention

- Inpatient areas vacancy c21%
- Change in Band 6 to attract experienced RNs – some success.
- Discussion regarding emerging Nursing Associate role; to establish Band 4 posts within existing budget by merging some existing Band 2/3 with some Band 5 posts.
- Plans in place to commission Nurse Associate training via Apprenticeship levy. Liaison with HEKSS. Process approaching Training Provider procurement stage.
- International Recruitment; 1st RN cohort due to commence April 2018.
- 12 current CSWs with overseas nursing registration in pipeline to undertake the recently approved Occupational English Test (OET)
- 20+ expressions of interest from other CSWs to undertake OET
- c14 CSWs have expressed an interest in the Nurse Associate Programme (and meet the academic entry/acceptance requirements).

Conclusion

- Staffing establishment are appropriate for ward specialty and layout.
- Wards are safe when nursing levels are at establishment
- Vacancy and recruitment are key risks
- Capacity and demand impacts on both substantive and temporary fill rates.

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-15 Update on the Trust's 2018/19 planning — Director of Finance

The enclosed describes the key features and timescales of the planning guidance, and highlights areas of particular interest for Maidstone and Tunbridge Wells NHS Trust.

Which Committees have reviewed the information prior to Board submission?

▪

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

Introduction

The much delayed joint NHS England and NHS Improvement planning guidance was published in February 2018. The guidance had originally been scheduled for December 2017, however the announcements in the Autumn Budget required a significant rethink in the proposed approach. This document describes the key features and timescales of the planning guidance, and highlights areas of particular interest for Maidstone and Tunbridge Wells NHS Trust.

Additional Funding

In the Autumn 2017 Budget the Government announced an additional £1.6bn of revenue funding would be made available to the NHS in the 2018/19 financial year. At the time it was expected that the majority of the funding (£1bn) would go to the purchasing of additional activity to support improvements in elective waiting times, and a consequential improvement in the Referral to Treatment (RTT) measures, including a reduction in the backlog. The remaining funding (£0.6bn) was expected to go to providing resources to support Accident and Emergency. It was expected that the majority of the resources would be distributed into CCG allocations directly.

The planning guidance confirms the £1.6bn funding and a further £0.5bn made available from underspends at the Department of Health and Social Care, however only £0.6bn of funding has been allocated directly to CCGs. Although it should be noted, this is over and above the funding that had already been previously notified. In addition, the planning guidance confirms that the 0.5% of allocation previously held as a contribution to the national risk reserve can be released, and that a further 0.5% of allocation previously mandated to only be committed non-recurrently can now be committed recurrently.

Provider and Commissioner Sustainability Funds

The guidance changes the previous Sustainability and Transformation Fund (STF) to the Provider Sustainability Fund (PSF) and establishes a Commissioner Sustainability Fund (CSF). The PSF is increased from the previous value of £1.8bn by a further £0.645bn and now stands at £2.45bn nationally. The Trust's own share of the PSF has risen from £11m to £15m, and the requirements to access the fund remain the same – 70% tied to delivery of the financial plan and 30% to delivery of the A&E 4 Hour Access target, as set out in the guidance.

The CSF is established with £0.4bn of funding and will be issued to support CCGs returning to financial balance. As such it is likely to be utilised to support the most financially distressed CCGs across the country, and it is unlikely that any CCGs in Kent and Medway will receive any substantial amounts from the CSF.

The funding allocated to the PSF and CSF means that £1bn of additional funding is now "locked" as part of these initiatives rather than incorporated into operational delivery.

Constitutional Targets

As mentioned above, the A&E 4 Hour Access target remains a key focus. All providers must deliver at least 90% by September 2018 and be at 95% by March 2019, and deliver 95% sustainability into 2019/20.

The expected additional funding for RTT improvement has not been prioritised, and as such it is not surprising that the expectation for RTT waiting lists is that by March 2019 the waiting list should not increase further than the position at March 2018. It is also expected that nationally the number of patients waiting beyond 52 weeks should be halved.

All the cancer targets also remain, and in particular a focus on the 62 day target as the key measure in this area.

2018/19 Control Totals

Providers will remain subject to the control total process in 2018/19, although there have been amendments to individual organisations control totals. One particular area that has impacted MTW is changes to the control total to amend for a benefit from reduced contributions to the Clinical Negligence Scheme for Trusts (CNST) compared to funding in the national tariff. The national tariff was set for both 17/18 and 18/19 with assumptions of funding requirements for CNST, however the CNST requirement for 18/19 is lower than previously expected. NHS Improvement has decided not to amend the tariff calculation but instead amend each organisations control total for the benefit. In the development of its plans, MTW had taken this benefit to help support the movement towards its previously notified control total, however the change to the control total has increased it from a breakeven position to a surplus of £2m, before application of the PSF funding. Following application of the PSF funding, and assuming delivery of the necessary targets, the Trust will deliver a surplus of £17m.

Growth Assumptions

Within the planning guidance, NHSE and NHSI have set out the expected activity assumptions that they believe the funding covers.

From an emergency perspective, they allow for 2.3% growth in non-elective admissions and ambulance activity in 2018/19, as well as 1.1% growth in A&E attendances.

From an elective perspective:

- 4.9% growth in total outpatient attendances (4.0% per working day)
- 3.6% growth in elective admissions (2.7% per working day)
- GP referrals by 0.8% (no change per working day)

Role of the STP

The planning guidance describes a significantly enhanced role for the STP, particularly in ensuring that commissioner and provider plans are aligned – both in terms of absolute contract value, but also in expectation of how contracts will perform. In addition, should organisations within the STP fail to agree to delivery of their control totals, the STP is charged with delivering additional savings to offset any shortfall.

This perhaps gives the clearest signal that as well as the strategic mandate that the STP's have been working to, there is an increasing expectation of STP's operating in a local co-ordinating and performance management space as well.

Timetable

All organisations are expected to submit a draft organisational plan, including clarity on acceptance of the control total, by 8th March 2018. A final, board approved plan is expected to be submitted by 30th April 2018.

Contracts were already agreed for a two year period, so already cover 18/19. However, it is expected that contract variations will need to be put in place to reflect the changes required from the planning guidance and changes in local circumstance. Contract variations are expected to be agreed by 23rd March.

Conclusion

A more detailed look at the emerging organisational plan for 18/19 will be considered in Part 2 of the Trust Board. Further work is required ahead of the 8th March draft submission.

The final plan will be submitted to the Finance and Performance Committee and Trust Board in April.

Trust Board meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-17 Update on the working capital loan — Director of Finance

The Trust Board received a report in December 2017 detailing the Trust's position regarding working capital requirements in the light of the continuing pressures on operational finances and the consequential request that the Trust was making to the Department of Health for working capital finance, and approved the initial application in January 2018 for £5m of working capital finance. The report set out that the Trust would be likely to require further applications for working capital in February and March to a maximum of £15m.

The Trust's application for £5m in January 2018 was approved by NHS Improvement (NHSI) and the Department of Health and Social Care (DHSC), and was received on 15th January 2018. The interest rate applied was 3.5%. The full loan document and repayment details were enclosed in a supplement to the formal 'pack' of Board reports in January 2018.

The Trust's second application for £5m in February 2018 was also approved by NHSI and the DHSC. As the Trust was due to repay £2.235m previously advanced against the Sustainability and Transformation Fund quarter two payment, the loan was issued for the net difference of £2.765m, and paid to the Trust on 12th February 2018. The loan principal is repayable in February 2021 and the interest rate applied is also 3.5%. The full loan documentation has again been circulated as a supplementary report to the formal 'pack' of Board reports.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 27/02/ 8

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

For 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 – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-18	Summary report from the Workforce Committee, 25/01/18	Committee Chair (Non-Executive Director)

The Workforce Committee met on 25th January 2018. The key matters considered at the meeting were as follows:

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

Revised terms of reference for the committee were reviewed and agreed (Appendix 1). The committee noted the change in frequency of the committee which would now meet six times per annum. The change in membership of the committee was also noted and agreed.

Risk Register - The committee noted the existing workforce risk register and agreed for a number of potential additional risks to be put forward for agreement at the next meeting
Workforce Information The committee noted the most recent data and agreed the KPI targets for the forthcoming year.

Recruitment Update - The committee noted the implementation of the TRAC electronic recruitment system which would reduce administration required for the recruitment process and allow for further efficiencies to be made in the time taken to recruit new staff. It would also allow for a more timely use of data to monitor progress and throughput. The Chief Nurse updated the committee on the progress of the Overseas Recruitment campaign. 47 candidates were being processed. Overseas recruits would be started in small cohorts to ensure provision of strong support and efficient use of accommodation. The committee noted the revision of the bank rates for nursing staff so that they would be paid on their substantive point when carrying out a bank shift. This had been well received and would need to be assessed for its efficacy in increasing the use of bank shifts over agency usage. The challenges of obtaining temporary staff over the winter period was noted. It was agreed that the electronic rostering system should be prioritised to ensure the most effective deployment of staff and that planning of winter rosters be done in late summer to ensure appropriate testing and scrutiny to best manage risk. The committee noted the application of the STP wide Medical Locum 'Break Glass' rates that provided an upper limit for agency rates beyond which authorisation and review was required. These rates would be stepped down over time to achieve significant savings for the STP overtime.

Staff Flu Vaccination Campaign - The committee noted that 70% of staff had received flu vaccination as of the end of January 2018. The need for managers and departments along with Occupational health to proactively urge staff to be vaccinated was emphasised.

The Director of Medical Education - presented a report, which detailed work taken to streamline processes for recruiting medical staff to minimise rota gaps. Trainees had raised concerns with the quality of some locum medical staff. The need to feedback concerns to temporary staffing was reiterated. The potential for the increase in Physicians Associates was noted and welcomed. Positive feedback had been received from the initial postholder and the Trauma & Orthopaedic department. The increased provision of simulation training was proceeding well with a plan for 117+ sessions to be delivered in 2017/18

Guardian for Safer Working - The committee noted the report of the Guardian for Safer Working for the period October-December 2017 (Appendix 2). 97 exception reports were received for this period. 65 reports related to working hours of FY1 doctors divided equally between medicine and surgery, a further 31 reports related to higher trainee access to educational opportunities in ENT. The role was working well and the majority of exception reports were followed up in a timely manner. Two reports from Surgical FY1s of more than 72 hours being worked were being investigated. If found they may lead to the Guardian for Safer Working imposing fines on the trust under their powers

Leadership & Talent Management bid - The committee welcomed the award of £30k from the Leadership & Innovation fund. The money would be used to commission an external organisation

to scope the needs of the trust and propose a framework for delivering leadership development as well as talent management and succession planning

1. In addition to the actions noted above, the Committee agreed that:
N/A

2. The issues that need to be drawn to the attention of the Board are as follows:
- The full report from Guardian for Safe Working Hours is enclosed (Appendix 2) (The Junior Doctors' Contract requires that the Guardian to report to the Board each quarter)
- The revised Terms of Reference were agreed, and these are submitted to the Board for approval (see Appendix 1)

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
- The full report from Guardian for Safe Working Hours is enclosed (Appendix 2) (The Junior Doctors' Contract requires that the Guardian to report to the Board each quarter)
- The revised Terms of Reference were agreed, and these are submitted to the Board for approval (see 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

Workforce Committee

Terms of Reference

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 or Associate 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 (or Associate Non-Executive Directors) are in attendance.

4 Attendance

All other Non-Executive Directors (including the Chair 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 every two months~~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 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 approved by Trust Board: 29th November 2017
Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)

NHS
Maidstone and Tunbridge Wells NHS Trust

WORKFORCE COMMITTEE – January 2018

12/01/18	GUARDIAN FOR SAFE WORKING REPORT	MATT MILNER, GUARDIAN FOR SAFE WORKING

Summary / Key points

Report covers the period October – December 2017 (3rd Quarter)

- Total of 97 exception reports were received in this period.
- Medicine filed 32 exception reports, mainly due to FY1's working additional hours.
- Surgery filed 33 exception reports again FY1's working extra hours due to rota shortages.
- Two Surgical FY1's reported working in excess of 72 hours in one week and this is being investigated further.
- ENT raised 31 exception reports from higher trainees siting issues with their working and educational environment.
- No fines have been incurred for this period.
- Bank usage is £972,892.31
- Agency usage is £1,083,403.00

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: October - December 2017

Introduction:

This is the 5t[h] report from the Guardian for Safe Working and covers the period October to December 2017.

Issues raised

As previously advised there have been issues with regard to Clinical/Educational Supervisors responding to exception reports in an appropriate time frame.

This issue was escalated to the Medical Director, who contacted the various supervisors concerned. Following this intervention the response times for exception reports has been much improved.

In the three month period October 2017 – December 2017 a total of 97 exception reports were received from trainee doctors. This is broken down as follows:

Medicine	32
Surgery	33
ENT	31
Gynae	1

The thirty two raised in Medicine were almost all filed by FY1 doctors.

The main reason for reporting was excessive hours worked by Care of the Elderly FY1's on Ward 2 and FY1 doctors working late on AMU at weekends.

The reports from Ward 2 were discussed by the Guardian and Dr Jim Milton, Care of the Elderly consultant for Ward 2. Dr Milton feels there is an unwillingness of the junior doctors to pass on jobs to the late doctors covering the ward. He has raised this with his juniors.

The matter has also been discussed with the Clinical Director for Medicine, who feels Ward 2 is adequately covered with junior staff.

With regard to the issue of FY1's staying late on AMU at weekends, this has been discussed with Matthew Read, Medical Rota Manager, who has assured he will review the rota and if possible rota two additional FY1's on AMU after 4pm at weekends.

With regard to the reports received from Surgery FY1's during the period an update has been given by Lisa Brereton, General Manager for Surgery regarding staffing levels. She explained that although they are still 4 substantive FY1's short in the department, all vacancies are currently covered by locum doctors.

All exception reports in Surgery were related to trainees working extra hours.

The main areas of concern with regard to Surgery is two FY1's, 1 in Urology and 1 in General Surgery who have raised 13 exception reports between them explaining that they worked in excess of 72 hours in one week. This is non-compliant with the 2016 Terms & Conditions of their contract. If this is the case it will result in the first fines levied by the Guardian.

Mark Cynk, Consultant Urologist and Fazal Hasan, Consultant Surgeon have been asked to meet with their trainees and to compare the rota for the week in question, with the excessive hours which have potentially been worked, as the trainees have not fully detailed on their exception reports the extra hours worked. Once the information is received appropriate action will be taken.

The 31 exception reports received from ENT registrars report issues with starting work early by 1 hour before a theatre list, seeing more patients in a clinic compared to deanery guidelines, having duty on call shifts and not getting enough time in theatre compared to guidelines.

Dr Scott Maskell is the Educational/Clinical Supervisor for this area and he has been asked to discuss the issues raised but he has yet to report back.

Exception Reports

High level data:

Number of doctors in training on 2016 TCS (total):	278

a) Exception reports (with regard to working hours)

Exception reports by department: October – December 2017				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	32	12	20
Surgery	0	33	17	16
ENT	0	31	27	4
Gynae	0	1	1	0
Total	**0**	**97**	**57**	**40**

Exception reports by grade: October – December 2017				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	59	25	34
F2	0	1	1	0
CMT	0	0	0	0
GP VTS	0	0	0	0
ST	0	37	31	6
Total	**0**	**97**	**57**	**40**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	25	34
F2	0	0	1	
CMT	0	0	0	
GP VTS	0	0	0	
ST	0	0	31	6
Total	**0**	**0**	**57**	**40**

b) Work Schedule reviews October – December 2017

No work schedule reviews have taken place in the period.

c) Fines October – December 2017

No fines were issued in the period.

d) Locum bookings

i) Staff Bank: October – December 2017

Specialty	Number of shifts worked	Number of hours worked	Cost of Bank Cover £
Accident and Emergency	1176	6012.69	373711.70
General Medicine / Acute Medicine	486	3937.81	285564.10
Anaesthetics	168	1626.69	44287.17
Cardiology	0	0	0
Cytology	0	0	0
ENT	20	231.5	11093.00
General Surgery	121	1265.5	48568.01
GUM	7	67	4295.00
Haematology/Oncology	37	322.5	5175.00
Neurology	0	0	0
Obstetrics and Gynaecology	277	1663	85578.17
Occupational Health	8	60	7000.24
Oncology Consultants	2	16	1280.00
Ophthalmology	73	726	29431.99
Paediatrics	106	658.75	47326.25
Radiology	20	200	12350.00
Trauma & Orthopedics	36	390.88	17191.67
Urology	2	1	40.00
Total	**2539**	**17179.32**	**£972,892.31**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Bank Cover
F1	61	507.59	20205.39
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	991	5757.33	294243.30
ST3+, Specialty Doctor (Registrar Level)	997	6532.05	299552.92
Consultant	490	4382.35	358890.70
TOTALS	**2539**	**17179.32**	**972892.31**

ii) Agency October – December 2017

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover
Accident and Emergency	476	4098	141765.40
General Medicine / Acute Medicine	984	8367.5	340939.80
Anaesthetics	3	24	803.94
Cytology	0	0	0
ENT	60	492	15418.68
General Surgery	795	8314	253724.53
GU Medicine	0	0	0
Histopathology	0	0	0
Obstetrics and Gynaecology	149	1567.75	70797.13
Occupational Health	0	0	0
Oncology	44	352	25113.00
Ophthalmology	82	662	27578.05
Paediatrics	26	289	9645.95
Radiology	65	520	37098.75
Rheumatology	10	80	5707.50
Trauma & Orthopaedics	560	4525.5	136736.50
Urology	25	250	18073.75
Total	**3279**	**29541.75**	**£1,083,403.00**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Agency Cover
F1	55	446	8545.48
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1628	14581.5	395035.10
ST3+, Specialty Doctor (Registrar Level)	1005	9372.75	317205.90
Consultant	591	5141.50	362616.50
TOTALS	**3279**	**26541.75**	**£1,083,403.00**

e) Vacancies WTE

Vacancies by month						
Specialty	Grade	Oct 17	Nov 17	Dec 17	Total gaps (average)	Comments
Accident & Emergency	FY2		2	2	2	

General Medicine	FY1		1	1	1	
General Medicine/Surgery	FY1		2	2	2	Gap rotating to Surgery at next placement
General Medicine	FY2		1	1	1	
General Medicine	ST1-2					
General Medicine	ST3+					
Geriatric	ST3+			1	1	
General Surgery	ST3+					
Ophthalmology	FY2		1	1	1	
Ophthalmology	ST1-2			1	1	
Ophthalmology	ST3+	1				
Paediatrics	ST4+					
Trauma & Orthopaedics	FY2		1	1	1	
Trauma & Orthopaedics	ST1					
Trauma & Orthopaedics	ST3+	2	2	2	2	
Obstetrics & Gynaecology	ST1	1	1	1	1	
Obstetrics & Gynaecology	ST3+	2	2	2	2	
Medical Oncology	ST3+	1	1	1	1	
Clinical Oncology	ST3+	1				
				Total Vacancies	**16**	

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-19	Summary report from Quality Committee, 06/02/18	Committee Chair (Non-Executive Director)

The Quality Committee has met once since the last Trust Board, on 6th February (a Quality Committee 'deep dive' meeting)

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

- The **progress with actions** from previous meetings was noted
- A **Review of lessons learned from the Quality Impact Assessment (QIA) process** was held, for which the Head of Programme Management Office (PMO) attended. It was noted that the updated QIA process had been presented to the 'main' Quality Committee in September 2017, and this had highlighted that the existing QIA process had been in place since 2013, but the updated process included the following aspects:
  - Continued monthly QIA meetings, led by PM and COB, to review all new and outstanding QIAs (at which Clinical Directors (CDs) would present schemes for approval)
  - Bi-monthly reports would be submitted to the 'main' Quality Committee, from a developed QIA dashboard
  - A QIA database and risk register as the central source of QIA data, to populate the QIA dashboard, generate the Quality Committee reports and provide key project milestones for detailed QIA submissions
  - Reports had been submitted to the 'main' Quality Committee since November 2017
  - Divisional schemes arising from the business planning for 2018/19 would link to Key Performance Indicators (KPIs) from the Single Oversight Framework (SOF), further supporting the updated QIA process

  An example of a monthly QIA report (which were currently submitted to each 'main' Quality Committee meeting) was then reviewed, and the Medical Director agreed to ensure that future QIA reports to the 'main' Quality Committee include some background information on the QIA process. It was also highlighted that a 'deep dive' process would be undertaken for one project by the end of March 2018. The PMO would coordinate the deep dive, using a 5-step process. The 'deep dive' team was intended to comprise a Non-Executive Director, Medical Director (or Chief Nurse), original project team members (including representatives from Business Intelligence) and an independent PMO representative. The key next step was therefore to select the project to be subject to the 'deep dive' review

  The meeting also heard about the potential to use the Aspyre IT system which was used by many other Trusts, including East Kent Hospitals University NHS Foundation Trust (EKHUFT), who had used the system for several years. It was noted that staff from the Trust's PMO had therefore visited EKHUFT on 30/01/18 to review the system, but not all modules were utilised by EKHUFT, so the Trust had therefore requested that Aspyre conduct a demonstration to further explore modules

- The second main item was a **Review of the fully-developed plan for medical engagement**, for which one of the Deputy Medical Directors attended. The latest Medical Engagement Scale (MES) survey findings were discussed in some detail. It was noted that further work was required to develop an action plan in response, whilst the Medical Director acknowledged the need to sure the response aligned with the staff engagement strategy being developed by the Director of Workforce.

  The Committee then considered whether updates on Medical engagement should be scheduled for the Quality Committee or Trust Board. It was noted that the Quality Committee 'deep dive' meeting held on 18/12/17 had requested that a "Review of clinical engagement" be scheduled for the 'main' Quality Committee in March 2018. Following a discussion, it was agreed that that item should be replaced by an item in which each CD would submit a brief report outlining the actions they intended to take in response to the MES survey findings for their Directorate.

It was further agreed that the Medical Director and Chief Nurse should liaise with the rest of the Executive Team to confirm the proposed scheduling of an item on wider clinical engagement at the 'main' Quality Committee meeting in May 2018, taking into account the Best Care programme and the aforementioned staff engagement strategy

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

- The Trust Secretary should schedule a "Review of the work being taken regarding patient falls" item at the Quality Committee 'deep dive' meeting in June 2018
- The Medical Director and Chief Nurse should Liaise to consider how Never Events should be considered by the Trust Board and/or Quality Committee
- The Chief Nurse should Consider the most appropriate time to schedule a "Review of nutrition and fluid balance" at the Quality Committee 'deep dive' meeting, and inform the Trust Secretary

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-20	Summary report from the Trust Management Executive (TME), 21/02/18	Committee Chair (Chief Executive)

The TME met on 21st February.

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

- The progress with previous actions was noted, which included notification that the likely final rate of clinical staff receiving their influenza vaccination would be circa 71%
- In the Safety Moment, the Chief Nurse highlighted the key actions required to prevent Venous Thromboembolism (VTE). It was agreed that the Chief Nurse would circulate comparative VTE risk assessment data to TME members & liaise with the Chief Pharmacist to consider the further action/s required to improve thromboprophylaxis prescribing
- Members of the Trust's Stroke teams attended to give a presentation regarding the Trust's response to the "Improving urgent stroke services in Kent and Medway" public consultation. Following the subsequent discussion, the Deputy Chief Executive was asked to arrange for a draft response to be developed, and circulated for comment prior to being finalised
- The Trust's approach to NHS England's current procurement of a Laboratory Hub to provide genomic testing for rare diseases and Cancer was reviewed, and supported
- An amendment to the TME's Terms of Reference (for the Director of Medical Education to join the membership) was approved
- The Clinical Lead for Research attended, and sought the TME's support for the reimbursement of commercial income to the Research and Development Department. It was agreed that the Clinical Lead should liaise with the Director of Finance to agree the specific arrangements, and report the outcome to the TME
- An update on progress with the Best Care programme was given, and the point was made that the approach would be used as the basis for the Trust's financial plan for 2018/19
- The Chief Nurse submitted draft proposed quality priorities for comment, noting that these would be further discussed at the Patient Experience and Quality Committees before being considered by the Trust Board
- An update was given on the development of Strategic Clinical Service Plans, which noted the initial aims to develop a Trust level, and two site-specific development control plans (DCPs), as well as create emergent DCPs for the Trust's anchor or leading services (which were defined as services that had a direct impact on the overall success of the Trust, and that played a key role in defining what is delivered by other services)
- The Deputy Director of Finance (Financial Performance) reported progress on the development of Divisional business plans, and it was agreed that the Deputy Chief Executive would liaise with the Director of Finance to ensure that specific requirements were issued regarding the development of Directorate-level objectives for 2018/19
- The initial draft 5-year Capital programme was submitted, and the prioritisation to be undertaken by the 3 existing capital meetings was noted
- An update on engagement plans (including the next steps for Listening into Action) was given
- The final report of the acute site visit by the Emergency Care Improvement Programme to the Trust's hospitals in January 2018 was considered
- Performance for month 10 was noted, and the Director of Infection Prevention and Control gave an update on the latest situation regarding influenza cases
- The latest developments with the Kent and Medway Sustainability and Transformation Partnership were reported
- The key issues from the clinical Divisions were reported
- The key issues from Clinical Directors' Committee and Executive Team Meetings were noted
- An update on the national 7 day service programme was given
- Reports were noted re a review of the BAF & Trust Risk Register; update on the 2017/18 Internal Audit plan; recently-approved Business Cases; a mid-year update from Estates & Facilities; a draft "Lessons Learned Report" following the implementation of the replacement PAS+; & summary reports from the Health & Safety and Policy Ratification Committees
- Under Any Other Business, the Chief Nurse reported on the status of recent Never Events

2. **In addition to any 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:** 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.)

Information and assurance

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-22	**Finance and Performance Committee, 27/02/18 (quarterly progress update on Procurement Transformation Plan)**	**Chair of Finance and Performance Committee**

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 would be published in April with data from January, February and March 2017 that would track and benchmark the Trust's progress.

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 (27/02/18)

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 – FEBRUARY 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-13	QUARTERLY PROGRESS UPDATE ON PROCUREMENT TRANSFORMATION PLAN	DIRECTOR OF FINANCE

The Procurement Transformation Plan (PTP) was originally 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. This report highlights the revised Carter model hospital metrics following the new guidance issued in January 2018.

Reason for receipt at the Finance and Performance 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 January 2018, NHSI issued new amended procurement model hospital metrics. These metrics are very similar to the PTP metrics but with further guidance on what is included in the metrics. It is the intention the new model hospital metrics will replace the PTP metrics.

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.

Carter Metrics

2.2 On 8 December 2017, the procurement team had their peer review for the procurement standards level 1 assessment. The recommendation to the procurement standard board is that Level 1 has been achieved; however the board has not met so far this year.

2.3 The peer review covered 6 areas of assessment Strategy and Organisation, People and skills, Strategic procurement, Supply chain, Data, systems and performance management, policies and procedures. In all these areas Maidstone and Tunbridge Wells NHS Trust was assessed as green with sufficient evidence for level 1. The team are now preparing for a level 2 assessment which is likely to happen in the autumn. Appendix 2 at the end of the report outlines some of the key highlights in the report.

2.4 NHSI originally published a template for reporting the Carter metrics in August 2016. Guidance on these revised metrics was published in January 2018, with the first submission in February 2018. There is the opportunity to resubmit the data for January in March as a webinar will be held end of February to explain any errors NHSI see with the initial submissions. It is expected that the data will then be submitted monthly.

2.5 The table on the following page is an update on the changes to the metrics reported to the Committee in October 2016 and the Trust January 2018 position. The commentary outlines whether there has been a change to the metric.

METRICS		ACTUAL			COMMENTARY	JANUARY 18 ACTUAL
		FEB 2017	SEPT 2017	TARGET		
1	Monthly cost of clinical and general supplies per 'WAU' (Weighted Activity Unit)	**£280 per WAU**	**TBC by NHSI**	**TBC by NHSI**	This metric has been removed from procurement reporting.	Now removed
2	Total % purchase order lines through a catalogue (target 80%)	**97%**	**97.18%**	**80%**	No change to this metric. This metric relates to the proportion of Integra POs that utilise the approved e-catalogues.	98%
3a	Total % of **expenditure** through an electronic purchase order (target 80%) up to and including PO issue	**75%**	**75.5%**	**Old target- 80%** **New metric has no target**	Previously this metric covered all invoices. This has now been limited to clinical and general supplies only.	83%
3b	Total % of **transactions** through an electronic purchase order (target 80%) up to and including PO issue	**94%**	**80%**	**Old Target- 80%** **New target – 90%**	This metric has been changed to cover clinical and general supplies only	86%

METRICS		ACTUAL			PERFORMANCE	
					COMMENTARY	JANUARY 18 ACTUAL
		FEB 2017	SEPT 2017	TARGET		
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	Not Reported	50%	Old target - 80% No new target has been set	Metric 3c cover the process for purchase orders for clinical and general supplies only. The Trust is 100% compliant on this metric.	100%
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	Not Reported	70%	Old target - 80% No new target has been set	Metric 3d – This definition now requires no manual intervention by our Trust. At MTW we scan our invoices following which the full process is electronic. We have not reported on this metric as strictly we would be 0% but the majority of Trusts would be in a similar position.	0%
4	% of spend on a contract (target 90%)	62%	62%	90%	The Trust is reviewing this area and a programme of work is planned to ensure the contract info is captured on Integra.	65.12%
5a	Inventory Stock Turns - Dynamic			No Target has been set	The metric provides an indication of the efficiency of capital employed, the supply chain and the risk of stock obsolescence. A lower stock level suggests better stock management and reduced variety of stock held	20.43 Days

5b	Inventory Stock Turns-Static	**Days**	**Days**	**No target has been set**	This metric is calculated by comparing the total end of year stock value on omnicell by the total spend of C&G supplies and multiplying by 365.	Annual metric to be calculated in April for end of March
6	NHS Standards Self-Assessment Score (average total score out of max 3)	**1.24**	**1**	**Oct 17 target – 1** **Oct 18 target - 2**	Peer review completed. Recommendation is that Level 1 has been achieved	1
7	NHSI's Purchase Price Index Benchmarking (PPIB) Tool	**£2,348,000**		**No target has been set**	Targets have not been set for this due to the variance across trusts.	£792,354

NB Metric 3d – The procurement team have had some discussions with NHSI to understand this metric. The feedback has been clear that no manual intervention from the Trust must be carried out on any invoices. The Trust current system Integra has the functionality to accept electronic invoices however this will be a development for the trust to implement. Discussions with Capita have begun on how best to implement this development and what process within the Trust would be required to support an external to internal invoice workflow.

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.

Procurement objective	Action
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.
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. Procurement CIP progress

2.1 The Procurement Cost improvement programme 2017/18 end of year delivery is a projection of £2.3million savings. A further £2.2million will be a roll over into 2018/19 from schemes commenced in 2017/18. Procurement has identified an additional £1million savings for new schemes, of which £604,000 will be realised in 2018/19. These savings are on top of the £4.3million savings the team delivered in 2016/17.

2.2 There is wider scope analysis taking place on 3 managed services within the Trust which will yield further savings if progressed. The first area being explored is refurbishment of the Tunbridge wells Cardiac Catheter laboratory.

2.3 The savings of £4.5million (arising in or commencing in 2017/18) have been across 85 projects across the year. The biggest saving for the Trust was the STP Orthopaedics savings which realised a saving of £933k for MTW and £500k for Medway FT, led by the MTW Procurement team. This is also the largest STP procurement saving in the year.

2.4 The trust uses NHS Supply chain for a number of products. This year they identified £142k saving for the Trust. Unfortunately they also identified £116k cost pressure from the renewal of Supply chain contracts for existing products. This has meant the Trust has had to look at alternative products to reduce and remove some of the cost pressures. The Trust has switched over 20 products this year to achieve savings and avoid cost pressures.

2.5 Stock Management – The inventory management team have been rolling out the Omnicell system to support the Trust with stock management. This system is now live in 8 areas at Tunbridge wells hospital and 5 areas at Maidstone with one area to be completed. This implementation has supported areas in understanding stock levels. It

also allows the Trust to immediately identify which areas hold certain stock items, which supports emergency planning if we need to get additional stock at short notice. There have been some challenges in setting up the system but the team have undertaken site visits to GSTT and one planned for Imperial in March to understand how they have overcome some of these challenges.

4. Risks and issues

3.1 The previous report noted the risk of a shortage of procurement skills within the region. One Interim has been supporting the MTW team in 2017/18 for the delivery of the CIP savings. New projects being identified require in depth procurement knowledge and strong ability to ensure the change is implemented in the Trust. Some of the procurement team need to develop this knowledge. It will mean some projects will be staggered for the more experienced staff to progress and train the junior staff.

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.

5. RECOMMENDATION

5.1 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. The team are now exploring an additional 2 apprenticeship roles to develop as part of the future planning for the team.
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.. 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. The team have held 2 LIA events on procurement as part of the communications strategy.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.	A procurement manual has been 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.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.	A peer review was conducted on 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.
	Alignment of procurement work plans across the region	This is being progressed for 2018/19

Procurement objective	**Action**	**Update**
	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.	
	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.

Appendix 2
Procurement standards Level 1 Procurement assessment feedback

	MTW evidence
Level 1 – Procurement and Supplies Focus	
Procurement strategy in place and developed in support of the organisation's strategy.	Strategy in place to end of 2019. Annual review of strategy detailing progress and any updates added and signed off. Procurement strategy reflects the trust's strategy. The strategy and review demonstrates the influence of procurement - it covers all areas except medicines procurement.
Procurement annual work plan agreed.	A comprehensive rolling workplan in place detailing all areas of activity, workplan shared with all business units, trusts execs and Procurement Strategy Committee. Workplan details all forecasts, timelines and stakeholders. All projects and savings validated by business units and finance.
Clear accountability at Executive level for the Procurement strategy.	Procurement Strategy presented and reviewed by Procurement Strategy Committee. The Procurement Strategy was presented to the Trust Management Executive in June 2016. It was then sent to Finance Committee in July 2016. Minutes of finance committee demonstrate that the procurement strategy was discussed. Procurement strategy presented to Trust Management Executive. Procurement Strategy Committee is chaired by Steve Orpin, Director of Finance and has clinical representation as part of the committee.
Identified Non Exec Director and/or Governor link to provide challenge/scrutiny for Procurement activity.	The Trust non-executive is Tim Levitt. This was previously Sarah Dunnett. A Trust Non-exec is responsible for procurement and attends the Procurement Strategy Committee meetings.

	MTW evidence
The Procurement leader is involved in some strategic decisions; mainly focused around procurement activity.	Comprehensively evidenced through the Associate Director of Procurement (ADOP) attendance at fortnightly meetings with the divisions to discuss all aspects procurement and is included in meetings/ business cases regarding areas of transformation as well as strategic procurement decisions. The ADOP attends the financial directorate Section heads meetings. The ADOP attends divisional CIP meetings to discuss procurement progress, workplan updates and initiatives. The ADOP is present at all Trust resilience committee meetings and 3 procurement members were part of a Trust resilience table top exercise to review business continuity.
Evidence that the Procurement leader communicates regularly with customers, stakeholders and suppliers.	Comprehensive evidence that the ADoP communicates with a wide range of stakeholders. Evidence of regular intranet communication on discretionary spend, project and savings initiatives. ADoP currently managing a survey with suppliers to understand areas for improvement. There is an Intranet page on procurement outlining processes and wider communications with divisions. The ADOP presents a section on procurement as part of the Trust management development program, annually. Evidence of regular team communications with trust stakeholders. Procurement is part of the mandatory induction, there is a mandatory eLearning module. ADoP sits on the NHS Southern Customer Board. ADoP and procurement have arranged and led a number of events; Supplier Event//Agency STP supplier events/Clinical governance meetings - surgeons; HSCN Board N3/COIN tender.

The Full report is available if any of the Finance & Performance Committee would like a copy.

Trust Board Meeting – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-22	Summary report from Finance and Performance Committee, 27/02/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 27th February 2018. The inclement weather took its toll on the attendance, but notwithstanding this, it was agreed that the Chief Executive would discuss the wider issue of Non-Executive Directors' attendance at Trust Board sub-committees with the Chair of the Trust Board.

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

- The actions from previous meetings were reviewed, which included an action relating to the recent Committee evaluation, and it was agreed that the Trust Secretary should liaise with the Chair of the Trust Board to incorporate a review of the evaluation findings into a wider review of sub-committee evaluations
- Under the "Safety Moment", the Trust Secretary reported that February's theme was VTE
- The Director of Finance gave an update on the Aligned Incentives Contract (AIC)[1]. The submitted report included the Audit Planning Memorandum for a forthcoming Internal Audit review of the AIC, as well as details of the Joint Programme Management Office in place. A detailed discussion was held of the impact of the AIC during 207/18 & the issues that needed to be improved for the 2018/19 AIC were agreed. It was noted that further discussion on the AIC would be held at the Trust Board, but further AIC updates at the Finance and Performance Committee would be incorporated within the 2018/19 planning reports
- The quarterly "Update on the Workforce Transformation programme" report was noted (as neither the Medical Director nor Director of Workforce were in attendance), and it was agreed that the item should be deferred the meeting on 27/03/18, unless the Committee Chair was content to just consider the next scheduled quarterly update (in May 2018)
- The month 10 financial performance, including that on the Cost Improvement Programme (CIP), was discussed in detail
- The month 10 non-finance, non-quality, related performance was noted (as the Chief Operating Officer was unable to attend), but it was agreed that the Trust Secretary should allocate a significant time slot at the meeting on 27/03/18 for discussion of the 2018/19 plans for Referral to Treatment and Cancer activity
- The progress with the 2018/19 Planning submissions was discussed in detail & it was noted that draft plans were required to be submitted to NHS Improvement by 08/03/18, with the final submissions made by 30/04/18 (so the Finance and Performance Committee and Trust Board would be able to review the proposed final submissions at their meetings in April 2018)
- The usual monthly update on the Lord Carter efficiency review was received, as was the quarterly progress update on Procurement Transformation Plan (which has been submitted separately to the Board – see Attachment 14)
- The Committee was apprised of the status of the working capital loan application that had been reviewed by the Committee in December 2017
- The Director of Finance updated the Committee on the STP-wide discussions regarding shared services in finance and procurement, and a report on post-project review of approved Business Cases was noted
- The relevant aspects of the Board Assurance Framework (BAF) and Risk Register were reviewed, and it was agreed that external factors should be included within the "What could prevent this objective being achieved?" section of the 2018/19 BAF
- The standing "breaches of the external cap on Agency staff pay rate" report was reviewed

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

- The Chief Operating Officer should submit a "Review of Outpatient activity in 2017/18" report to the Committee meeting on 27/03/18
- The Director of Finance should ensure that the "Commentary" section for the "4f. West Kent

[1] The Chief Finance Officer for West Kent CCG had been scheduled to deliver the update jointly, but was unable to attend because of the weather

Aligned Incentives Contract Performance" slide within future monthly financial performance reports reflected the points made at the Committee meeting on 27/02/18 in relation to the AIC

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 – February 2018

NHS Maidstone and Tunbridge Wells NHS Trust

2-24	To approve revised Terms of Reference for the Remuneration & Appointments Committee	Chair of the Remuneration and Appointments Committee

The Terms of Reference for the Remuneration and Appointments Committee are due their routine annual review. A review was duly undertaken at the Remuneration and Appointments Committee meeting on 25/01/18, and a number of changes were agreed.

The changes are shown as 'tracked' below. Many of the changes represent 'housekeeping', or amendments that better reflect what currently happens in practice (e.g. for the Committee's reporting to the Trust Board, and the role of Vice Chair). However, the 2 significant changes are:

1. The removal of the Chief Executive from the membership. This reflects the expected arrangements dating back to when Remuneration Committees were first established, in 1994 (via the Code of Conduct and Code of Accountability for NHS Boards)
2. To reduce the minimum number of meetings each year from two to one

The Trust Board is required to approve the Terms of Reference & is therefore requested to do so.

Which Committees have reviewed the information prior to Board submission?

- Remuneration and Appointments Committee, 25/01/18

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

Approval

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

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

Maidstone and Tunbridge Wells NHS Trust

~~REMUNERATION AND APPOINTMENTS COMMITTEE~~

~~TERMS OF REFERENCE~~

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- The Chair~~man~~ of the Trust Board (Chair of Committee)
- All Non-Executive Directors
- ~~Chief Executive*~~

~~* for all elements other than the Chief Executive's remuneration and terms and conditions.~~

The Vice Chair of the Committee will be the Vice Chair of the Trust Board.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chair and 2 Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Director of Workforce
- Associate Non-Executive Directors

Other staff may be invited to attend, to meet the Committee's purpose and duties.

5. Frequency of Meetings

Meetings will be scheduled according to need, but t~~T~~here will be a minimum of ~~two~~ one meeting~~s~~ per year.

~~The Chair may arrange meetings as required.~~

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of members of the Executive Team~~Executive Directors~~ and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 To ~~R~~review, on behalf of the Trust Board, and at least annually, the remuneration, allowances and terms of service of member of the Executive Team~~Executive Directors~~ and other staff appointed on VSM contracts, to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

[2] Department of Health, 1994 (and subsequent revisions)

6.3 To r~~R~~eview, with the Chief Executive, the performance of member of the Executive Team ~~Executive Directors~~ and other staff appointed on VSM contracts, at least annually.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate. Any non-contractual payment to a staff member must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant change, e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[3].

7. Parent Committee and reporting procedure

The Remuneration and Appointments Committee is a sub-committee of the Trust Board.

The Chair of the Remuneration and Appointments Committee will determine the extent (and format) to which the detailed activities of the Committee are reported to the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no 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. Administration

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

The Committee will be serviced by administrative support from the Human Resources Directorate.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration and Appointments Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted the Chief Executive. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

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

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 25/01/17
- Revised Terms of Reference approved by the Trust Board, 22/02/17
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 23/01/18
- Revised Terms of Reference approved by the Trust Board, 01/03/18

[3] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff